CASE REPORT

# A rare vaginal birth after four caesarean sections: a case report of a rural area

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## Abstract

Vaginal Birth after Caesarean section (VBAC) is an approach to promote normal deliveries and decrease the growing inclination towards Caesarean Section (CS). Attempts at normal vaginal deliveries are now considered conclusive for proceeding in women with a history of caesarean section. Although there are potential risks involved, clinical practice often favours repeat caesarean sections. This case report highlights a prospective approach towards the normal vaginal delivery in patients with a history of multiple CS. This case report describes a rare case of a 32 -year-old patient with four previous caesarean sections, who was admitted as an emergency case at the government hospital, District headquarters Landikotal, Peshawar, District Khyber. She had no scheduled antenatal care, and no previous antenatal records were available. Despite this, she experienced a spontaneous advanced vaginal delivery. There were no signs of previous caesarean scar rupture, and full dilatation of 10cm was achieved.

**Keywords:** Normal vaginal delivery (NVD), vaginal birth after Caesarean-section (VBAC), caesarean section (CS), lower uterine segment (LUS), Appearance, Pulse, Grimace, Activity and Respiration (Apgar score).

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## Introduction

The frequent practice of unsafe caesarean sections has become an alarming health concern internationally. The prevalence of unnecessary and frequently used operations are predicted to continue increasing until 2030. If timely global interventions are not undertaken to revert this trend, the rate of births by caesarean section is expected to reach 28.5% (38 million caesareans annually) by 2030, with sub-Saharan Africa ranging from 7.1% to 63.4%, and Eastern Asia showing similar concerning trends. As a result, both morbidity and mortality will co-exist and increase.[1] In low to middle income countries, a study showed that CS had led to adverse results, including postpartum blood loss, infection, widening of blood vessels and excessive endometrial curettage, hysterectomy and maternal mortality.[2] A famous aphorism by Cragin (1916) states, "once a caesarean, always a caesarean section". This traditional practice of repeated CS has greatly evolved over time. Today, the guided principle has shifted to "once a caesarean section, always an institutional delivery in a well-equipped hospital". These changes were mainly brought by a thorough evaluation of the previous CS scars, better facilities in emergency situation and an experienced doctor on the spot, able to handle it skillfully.[3]

Over time, one of the criteria considered for predicting Vaginal Birth after Caesarean section (VBAC) success has been the assessment of scar thickness from the previous CS. However, the use of sonographic lower uterine segment (LUS) thickness measurement in VBAC management has not yet been clearly standardised in any guidelines.[4] The increasing number of reported cases has expanded the expertise of specialized doctors in the field. Their cautious attempts, taking into account various factors that promote successful VBAC, have gradually helped reduce the rising trend of multiple caesareans.

The guidelines indicated for VBAC being most suitable for those women with a single previous LUS caesarean and they are contraindicated in patients with earlier uterine ruptures and poorly healed caesarean scars. While for those with multiple previous caesareans there should be a prior history of vaginal delivery. The success rate for planned VBAC is (72-75%). The basic purpose of these guidelines was to deliver evidence-based information.[5] The objective of reporting this rare case with four prior caesarean sections is to contribute comparative data to the literature, helping to guide the management of similar cases and maintain pregnancy integrity.

## Case Report

A 32-year-old female, Pushto and Persian speaking, was admitted to the emergency department on 07-08-2024 at a government hospital, belonging to a remote area of Pakistan. She had not received any antenatal care throughout her pregnancy. The patient was pregnant with Gravidity (G9) Parity (P8), presenting with a full term

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**Table-1:** Obstetric history of patient.

| No. of Child | Gender (M/F) | Delivery gap (yrs.) | Mode of delivery | Pre and Post-delivery condition of child |
|---|---|---|---|---|
| First | F | 15 | NVD | Alive and healthy |
| Second | F | 14 | NVD | Alive and healthy |
| Third | M | 12 | C/sec | Fetus was in distress before delivery |
| Fourth | M | 10 | C/sec | Delivered after past delivery dates |
| Fifth | F | 8 | VBAC | Alive and healthy (delivery at home) |
| Sixth | M | 6 | VBAC | Alive and healthy (delivery at home) |
| Seventh | M | 5 | C/sec | Alive and healthy |
| Eighth | M | 3 | C/sec | Alive and healthy |
| Ninth | M | present | VBAC | Alive and healthy |

No: Number, M/F: Male/Female, Yrs. (years) NVD: Normal Vaginal Delivery
VBAC: Vaginal Birth After Caesarian C/Sec: Caesarian Section

pregnancy. She arrived in advanced labour and underwent a spontaneous vaginal delivery despite a history of four previous caesarean sections. She gave birth to an alive male baby with 39 weeks of gestational age. Due to sudden emergency, no history was obtained before delivery. On examination, the previous caesarean scars appeared well-healed and were not visibly evident, permitting the continuation of normal vaginal delivery. Obstetric history was obtained post-delivery and confirmed the history of four prior caesarean sections, making this a rare case of successful vaginal delivery after multiple previous caesareans. The baby was in cephalic position, station of vertex +2 with fully effaced cervical dilatation of 10 cm. Basic investigations, including blood grouping, were conducted at the delivery table. The baby was in cephalic position and after delivery had a good Apgar score of 8/10 at the time of delivery and 10/10 five minutes after the delivery. The birth weight was recorded as 3.5 Kg. There was no significant medical and family history available. Obstetric history was taken, as mentioned in Table 1. The follow-up of the patient after 2 weeks showed no visible postpartum haemorrhage and scar dehiscence. Verbal consent was taken from the patient for publishing her case.

## Discussion

A study showed that among 93 pregnant women with a history of previous CS, 60 patients (64.52%) underwent repeat caesarean delivery, while 33 (35.48%) patients achieved successful VBAC. Notably 100% of the VBAC patients had an Apgar score >6 at 5 minutes. In comparison, 20% of neonates born via repeat CS required admission to Neonatal Intensive Care Unit (NICU), the VBAC had none. Fetomaternal outcomes were better in the VBAC group compared to the CS group.[6] This study which included patients with age ranging from 20-35 years, presenting with spontaneous labour at 37-41 weeks of gestation with a history of previous lower segment CS, found that out of 150 patients, 28.67% had successful vaginal births. In 2.33% patients postpartum haemorrhage was found, scar dehiscence was none, and babies with low birth weight in 16.28% and 2.32% patients with an Apgar score of 7 at 1 minute.[7] A study conducted in Rawalpindi aimed to form a model that would predict a possible picture of VBAC success rate at the time of admission for pregnant women with a history of CS. They maintained all the medical, family and obstetric records throughout the delivery, the patient was also counselled about the trial of normal delivery. The model was based on these six variables: the age of patient (in years), Body mass index (BMI), the gestational age (in weeks), previous CS (on medical history), VBAC history, and Bishop score (on physical examination).[8] The success rate was considerably higher in birth through the vaginal route compared to CS patients. The majority of women, were less than 35 year age with gestational age >36 weeks. The common complication observed was postpartum haemorrhage.[9]

## Conclusion

In this case, a full-term pregnant patient with spontaneous onset of labour and complete cervical dilation underwent an emergency vaginal delivery. Favourable factors contributing to the successful vaginal birth after caesarean (VBAC) included the adequate birth weight of the neonate, maternal age, good Apgar scores at delivery, favourable cervical dilation, minimal or absent postpartum bleeding, and the absence of previous caesarean scar dehiscence.

The increasing numbers of caesarean sections can be reduced by having a complete knowledge of the ideal condition for VBAC's in the patient by following adequate guidelines that will cater one of the most important issue in modern obstetrics.

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