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MAIN ASPECTS OF DELIVERY IN WOMEN AFTER CAESAREAN SECTION

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Annotation: The frequency of caesarean section is the main reason for the increase in the number of women with a uterine scar. The choice of tactics of pregnancy, the optimal timing and methods of delivery in such patients presents considerable difficulties in each specific case and should be addressed individually.

Key words: caesarean section, a uterine scar, abdominal birth, vaginally birth, consistency of the uterine scar.

According to many obstetricians and gynecologists, there is a concept that after a cesarean section, it is necessary to perform another cesarean section. However, recently, especially in foreign countries, as a result of advances in medicine and operative techniques, the postoperative period, the tactics of conservative management of women with scars on the uterus are increasing. According to the literature [2,6], 60-80% of women, i.e. 3-4 out of every 5 women who underwent a first-time cesarean section, can give birth through natural childbirth.

According to the American College of Obstetricians and Gynecologists (ACOG), the risk of uterine rupture is 0.2 to 1.5% if the previous cesarean section was performed through a transverse incision in the lower uterine segment, which corresponds to a ratio of 1:500 [7]. According to ACOG experts, vaginal delivery after cesarean delivery is safer than repeat cesarean delivery, with fewer complications [7,9].

T.D. Metz and other authors [8] prepared 1100 women with a history of one cesarean section for vaginal delivery and using multivariable logistic regression method, created a scoring scale for predicting vaginal delivery after cesarean section. On the basis of the scale, the assessment of cervix before delivery according to Bishop, then history of vaginal births, age of the woman under 35 years, absence of somatic pathology, body weight index up to 30 before pregnancy were obtained.85% of women with a prognostic scale score of 16 and above had a vaginal delivery, while only 50% of women with a score of 10 and below had a vaginal delivery. According to the authors, the degree of cervical dilatation plays a major role in the success of natural childbirth after cesarean section, but creating a prognostic model of vaginal delivery is one of the modern and actual problems.

According to the literature, vaginal deliveries after cesarean section are prevented by the following anamnestic data: the previous cesarean section was performed due to a narrow groin, labor anomalies, preeclampsia, premature migration of the normally located placenta, prolongation of the period of dehydration. In addition, obesity, anemia, and chronic infectious diseases often affect childbirth through natural childbirth. Often, scars after corporal and minor cesarean sections are defective [1,4,6].According to the ACOG, factors that ensure successful vaginal delivery after cesarean delivery include: a history of

natural childbirth, the sudden development of regular labor, a dilated cervix, the absence of indications for a previous cesarean, preterm labor, obesity, rapid weight gain during pregnancy, short intergravid interval, woman over 40 years old, large fetus size, induction of labor, gestational age greater than 41 weeks, gestational diabetes prevent vaginal delivery after cesarean section. According to ACOG experts, the risk of uterine rupture in vaginal deliveries is increased after 2 or more cesarean sections in the anamnesis, double sutures in the uterus, labor induction, prostaglandin use, small intergravid interval, infectious complications after cesarean section [7,9,10].

D.M. Stamilio and other authors [11] conducted a multicenter retrospective cohort study of 13,331 women, and through univariate and multivariate linear regression analysis, the interval between pregnancies and complications in 3 mothers: uterine rupture, complex complications (bladder rupture, bowel injury, uterine artery rupture), analyzed hemotransfusion. As a result of the examinations, if the interval between pregnancies is up to 6 months, the risk of uterine rupture, complex complications and cases of hemotransfusion increase. The authors concluded that if the interval between pregnancies is small, the risk of uterine rupture and other complications increases by 2-3 times.

Taking into account the above, it can be said that vaginal births are successful in 70-80% of cases after caesarean section, so all patients should make their own decisions knowing the possibility of vaginal births after caesarean section, the advantages and risk factors of vaginal births. Every woman should know that repeated caesarean section has high complexity, high risk factors, high risk of maternal morbidity and mortality. Also, repeated caesarean section causes respiratory distress syndrome in the fetus, decreased adaptation, babies are in the risk group for the development of complications in the neonatal period and need constant monitoring by doctors [1,5,6].

N.E. According to Kahn and other authors [4], vaginal births are successful in women with a scar in the uterus under the following conditions: cesarean section performed through the transverse section of the uterine wall, absence of obstetric instructions during the first cesarean section, uncomplicated postoperative period, completeness of the scar in the lower segment of the uterus, localization of the placenta further from the area of the scar, delivery of the fetus head-on, matching the size of the fetus to the size of the mother's pelvis, cardiomonitoring during labor, availability of conditions for emergency cesarean section, presence of professional medical personnel, availability of conditions for operation within 15 minutes when cesarean section is necessary and conducting births when a ready operating room is available.In the anamnesis, corporal cesarean section, anchor-shaped section in the uterus, previous uterine rupture, localization of the placenta in the area of the scar, cases of impossibility of childbirth due to other natural birth routes, and the patient's refusal are absolute contraindications to vaginal birth after cesarean section.

The presence of more than one scar in the uterus, the size of the fetus, the shape of the uterine incision, the presence of the fetus in the groin, multiple fetuses are considered relative contraindications for vaginal delivery after cesarean section.

A scar after a cesarean section does not prevent the use of other obstetric and anesthesiological tools, that is, labor induction and induction. If induction of labor with oxytocin increases the risk of uterine rupture, induction (amniotomy) is not prohibited. Amniotomy and subsequent administration of oxytocin can be performed when the obstetric situation is carefully evaluated and all risk factors are taken into account (level of confidence IIB) [1,2]. Prostoglandins are not recommended after caesarean section due to their higher risk than oxytocin (level of confidence IIB), and E1 (misoprostol) should not be used in vaginal deliveries when the risk of uterine rupture is high. Prostaglandin E2 has also been shown to have good results when used to induce labor [3]. A large number of reviews by ACOG experts do not rule out the possibility of induction of labor after caesarean section (confidence level IIB), but uterine rupture along the scar is much higher than spontaneous labor [7,9,10].

In the second period of labor, it is possible to carry out the procedure of cutting the interval and vacuum extraction of the fetus. It is recommended to actively carry out the 3rd stage of childbirth, after childbirth, manual control of the uterine cavity is necessary, because the scar area can spontaneously rupture. Symptoms of rupture of the uterus appear after a long time after childbirth. In addition, knowing the state of the scar in the uterus helps to develop the tactics of childbirth. Manual inspection of the uterine cavity should be done slowly, because this procedure, performed roughly, can cause uterine rupture. During delivery, the fetus should be directly monitored by cardiomonitor. Deterioration of the condition of the fetus also indicates the beginning of uterine rupture [3,6].

Signs of the beginning of uterine rupture include: pathological cardiotocogram, presence of local pain on the groin, bleeding from the genital tract, severe pain in the epigastric region, nausea, vomiting, tachycardia, cessation of labor.

Thus, at present, any scar on the uterus cannot be considered completely full, so it cannot be said with confidence that vaginal births after cesarean section are safe for both the mother and the child. V.I. Agreeing with Krasnopolsky [5], determining the fullness of the scar after cesarean section, and carrying out childbirth through natural birth canals should be carried out in all medical institutions.If the caesarean section was performed in the lower segment of the uterus, the postoperative period passed without complications, complications were not observed during the current pregnancy, and women with a scar on the uterus, if there are no signs of scar failure, can give birth through natural birth canals [4, 5, 7]. Childbirth in women through natural childbirth should be carried out individually, taking into account all complications, in a highly qualified institution of childbirth treatment (a place where an emergency caesarean section can be performed). After caesarean section, childbirth through natural birth canals is among the factors that reduce repeat caesarean sections. Protocols and recommendations should be developed for natural delivery of women after cesarean section. Carrying out births in women with uterine scars through natural birth canals is also a risk for obstetricians and gynecologists and requires their professionalism. The experience of foreign countries has shown that it is appropriate to take women with a scar on their uterus through natural childbirth.

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