

Assessing the safety and efficacy of vaginal birth after cesarean (vbac) in low-risk pregnancies.

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Abstract

The term "trial of labour after caesarean delivery" (TOLAC) describes a woman's deliberate attempt to give birth vaginally after a previous caesarean section, regardless of the result. With the help of this procedure, ladies who prefer vaginal birth following caesarean delivery can potentially achieve their aim (VBAC). In addition to satisfying a patient's preference for vaginal delivery, VBAC is linked to lower rates of maternal morbidity, a lower risk of difficulties in subsequent pregnancies, and a lower overall caesarean delivery rate in the community on an individual level. Although TOLAC is suitable for many women, a number of factors raise the possibility of a failed labour trial. which, when contrasted with a successful trial of labour (i.e., VBAC) and an intentional repeat caesarean birth, is linked to greater maternal and perinatal morbidity. So, while deciding who is an acceptable candidate for TOLAC, it's crucial to consider both the individual risks as well as the chance of VBAC. As a result, this document's goals are to discuss the advantages and disadvantages of TOLAC in various clinical contexts and to offer helpful advice for patients who plan to try giving birth vaginally after a previous caesarean delivery.

Keywords: Outcome, Vaginal birth after cesarean, Previous cesarean, Pregnancies.

Introduction

Repeat caesarean section (CS) patients are more likely to experience bladder and intestinal damage, blood transfusions, and hysterectomies. According to a World Health Organization (WHO) report, women who have already had a caesarean section and singleton pregnancies are the main causes of the total caesarean delivery rate. According to a meta-analysis by Ellen and Eileen, a successful vaginal birth after caesarean section (VBAC) may lower risks of febrile morbidity, blood transfusion, and hysterectomy while having a little increase in uterine rupture and foetal death compared to an elective repeat CS. In comparison to elective repeat CSs, the authors found that VBAC lowers the rates of maternal febrile morbidity, blood transfusion, and hysterectomy. Moreover, VBAC lowers the probability of repeat CS with subsequent postoperative morbidities and raises the likelihood of consecutive vaginal deliveries [1].

In this study, the number of women with height was statistically higher in the failure VBAC group than in the successful VBAC group, and the mean height was considerably higher in the successful VBAC group than in the unsuccessful VBAC group. Kirchengast and Hartmann also noted a substantial correlation between small stature and a higher incidence of surgical deliveries and CSs. In this study, the number of women with BMI was much higher in the failure group whereas the

BMI was significantly lower in the successful VBAC group. Also, successful VBACs had mean gestational ages that were much lower than those of unsuccessful ones, and the number of women admitted for labour who had gestational weeks was significantly higher in the unsuccessful group [2]. Moreover, logistic analysis and OR of the study women revealed a strong relationship between successful VBAC and BMI and weeks of gestation. Abdelazim et al. concluded that the BMI and gestation weeks were linked with failure trial of labour after previous CS.

Juhasz observed that the likelihood of a successful VBAC decreased with increasing BMI, while Landon showed that obese patients had a much lower success rate of VBAC than nonobese patients. Tessmer-Tuck also came to the conclusion that maternal age 30 years, BMI 30, past vaginal delivery, and prior VBAC were independently related to VBAC success. Coassolo reported VBAC failure at 40 gestational weeks or beyond against gestational weeks, and Smith came to the conclusion that VBAC is likely to be failed at gestational weeks compared with VBAC at 40 weeks [3]. Furthermore, Tita came to the conclusion that among labouring nulliparous women past the gestational week mark, the risks of maternal morbidity and caesarean birth increased dramatically but not those of neonatal morbidity.

Women who have a balanced risk/probability of success (as high as possible) that is agreeable to both the patient and

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the obstetrician or other obstetric care provider are good candidates for planned TOLAC. Yet, the risk-benefit ratio that is acceptable for one patient could be intolerable for another [4]. Following a caesarean delivery, decisions taken regarding delivery during the first pregnancy will probably have an impact on subsequent pregnancies. For instance, the number of caesarean sections has been shown to be inversely correlated with maternal morbidity, and placenta accreta has been linked to past caesarean sections, particularly when placenta previa is present. Consequently, it is optimal for TOLAC decisions to take future pregnancies into account [5].

Conclusion

The three years that this study was conducted in a tertiary hospital, the size of the population that was studied, the comparative nature of the study, and the accurate statistical analysis make it strong. The main restriction encountered throughout this study was women who were eligible for VBAC in accordance with hospital procedure but refused to sign the agreement for VBAC and chose to deliver by elective caesarean.

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