43. VAGINAL BIRTH AFTER CAESAREAN SECTION

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Introduction. Caesarean section is a modern part of today's obstetrics that preserves both maternal and fetal interests. Increasing world wide rates of caesarean section are a global concern since this is now the most commonly performed major surgery around the world, raising the most serious problems of all time not only among professionals but also in the whole society. In Europe, the caesarean section rate is 24%, while in the United States it is 33%. Worldwide the caesarean section rate is 12.4% an average annual increase of 4.4%. In first place is Brazil with 55%. The caesarean section rate in Moldova in 2020 was 19%. Simultaneously with the increase of the number of repeat caesarean, increases significantly the risk of pathological insertion of placenta, placenta accreta, ectopic pregnancy, bladder, bowel or ureter injury, hemotransfusions, prolonged duration of hospitalisation, etc. Primary caesarean section, which accounts for 2/3 of the overall C-section rate, is an important target for reduction as it increases the risk of repeat caesarean section. Vaginal birth after caesarean section (VBAC) could be considered a reasonable and safe option for most women with a single caesarean section in their history. To achieve success, women need professional care in a level II-III perinatal centre. The benefits of VBAC compared to Caesarean section are: lower maternal morbidity, shorter hospitalisation, lower rate of deep vein thrombosis and lower incidence of postoperative complications. One strategy to reduce perinatal and maternal morbidity rates, and to protect medical staff from malpractice, is the management per vias naturales approach in possible cases, as recommended by international protocols.

Aim of study. The aim of the study was to investigate the specific features of the evolution of vaginal birth after caesarean section in the anamnesis.

Methods and materials. Was performed a retrospective, descriptive analysis of all vaginal births in patients with cicatricial uterus in the obstetric unit No. 2 of IMSP SCM 'Gheorghe Paladi' from 2021.

Results. Analysis of clinical trial data showed that during 2021, 3072 births took place in Obstetric Unit No. 2, of which 2474 were vaginal births and 598 by cesarean section. Were analysed 21 medical charts of patients who gave birth vaginally with a caesarean section in their medical history. The following were analysed: patient age, gestational age, parity, comorbidity, course of delivery, complications, volume of hemorrhage, and newborn data. From the total number of vaginal births, it was determined that the average maternal age was 30-34 years (52.38%). Gestational age was found to be at 39-40 weeks (23.80% - 33.33%). It was observed that secundiparity predominated with 42.85% as compared to multiparity. Maternal comorbidities included: gestational hypertension - 14.28%, obesity - 4.76%, anamnestic preterm birth - 4.76% and antenatal fetal death - 4.76%. Of the total number of vaginal births after caesarean section 9.52% were completed by vacuum extraction, the underlying indication being acute fetal hypoxia. Labour stimulation with uterotonics was not required in any patient. The labour analgesia rate was only 19.04%. We can note that the absence of pathological haemorrhage in the third period of labour was 100%. Uterine cavity control was performed in 9.52% of cases, the cause being placental tissue defect. Among the birth canal trauma was determined to be laceration of perineum in 28.57% and vagina in 19.04%, in 33.33% cases the birth proceeded without trauma. The weight of newborns has varied between 2500 and 3700 g, with an average of 3200 g. Perinatal outcomes were good, with newborns scoring 7/8 points (13.63%) and 8/9 points (40.90%) by Apgar score. No cases of uterine scar insufficiency have been registered. Of the total number of vaginal births after caesarean section, has been registered one case of spontaneous birth with bicorionic, biamniotic duplex.

Conclusion. Term pregnancy and spontaneous start of labour are factors that increase the chance of successful Vaginal Birth After Caesarean. Thanks to the implementation in obstetrics practice of the national protocol for the management of vaginal birth after cesarean section, following the criteria of the age, fetal mass, physiological evolution of pregnancy, spontaneous debut of labour, we can choose the tactic of vaginal birth, after informing the patient about the maternal and perinatal risks and benefits, with qualified medical care and an adequate level of perinatological attendance.