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Original Research Article

Maternal complications and success rates of vaginal delivery in women with a previous caesarean section: experience from Dhaka Medical College Hospital

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ABSTRACT

Background: Caesarean section rates are rising globally, with previous caesarean sections being a leading reason for repeats. Vaginal birth after caesarean section (VBAC) is key to reducing this trend. However, local data on VBAC outcomes in Bangladesh are scarce. This study evaluated the success rate of vaginal delivery and maternal complications among women with previous caesarean sections who underwent a trial of labour at a tertiary hospital in Dhaka, Bangladesh.

Methods: This cross-sectional observational study was conducted at the Department of Obstetrics and Gynaecology, Dhaka Medical College Hospital, from April to October 2023. One hundred women with one or two previous caesarean sections who were planned for vaginal delivery were enrolled. Descriptive statistics were used for the analysis.

Results: The mean age of the participants was 29.8 ± 11.4 years, with 62.0% living in urban areas. Most (82.0%) were at term gestation and fetal distress was the main reason for prior caesarean section (57.0%). VBAC success was 76.0%. Of the 24 failed labour trials, non-progress with impending uterine rupture led to repeat caesarean (19 cases). The maternal complication rate was 17.0%, with postpartum hemorrhage, wound infection and perineal injury rates of 9.0%, 5.0% and 3.0%, respectively. No cases of uterine rupture were recorded.

Conclusion: VBAC is feasible and safe for carefully selected women in tertiary settings in Bangladesh. A 76.0% success rate and low serious complication rate support structured labour trial programs in well-equipped institutions.

Keywords: VBAC, Trial of labour, Maternal outcome, Caesarean section

INTRODUCTION

Caesarean section (CS) is the most commonly performed major obstetric operative procedure worldwide. It is generally indicated when vaginal delivery poses a risk to the life or health of the mother or the fetus, although in recent decades it has increasingly been performed upon maternal request without a strict obstetric or medical indication. When medically justified, caesarean section can effectively prevent maternal and perinatal mortality and morbidity. However, unnecessary or unjustified caesarean sections may adversely affect maternal and neonatal outcomes, increase anaesthetic risk and impose a substantial burden on healthcare systems.¹

For a woman with a history of prior caesarean delivery, two fundamental options exist in subsequent pregnancies. The first is a trial of labour after caesarean (TOLAC) to achieve vaginal birth after caesarean section (VBAC). If caesarean delivery becomes necessary during the trial, the outcome is classified as a failed trial of labour. The second option is elective repeat caesarean delivery, which encompasses both scheduled and unscheduled planned caesarean procedures.² The risks associated with a failed trial of labour, including uterine rupture, hysterectomy and long-term urinary incontinence, have been well documented.³ Nevertheless, improvements in obstetric care over the past three decades have made TOLAC considerably safer for both mother and infant, gradually

replacing the long-held dictum of "once a caesarean, always a caesarean" with a more nuanced clinical approach.⁴

Prior caesarean sections are associated with significant risks in subsequent pregnancies, including placental abruption and placenta previa, which carry implications for perinatal mortality and premature birth. Chiniwar reported that among 942 women with a previous history of caesarean section, TOLAC was planned in 412 cases, of whom 311 achieved successful vaginal delivery. Maternal morbidity including adhesions was observed in 11.25% of cases and maternal mortality was recorded in 0.15%.⁵ Postpartum haemorrhage has been identified as a major complication in this patient group.⁶ The safety data on VBAC remain conflicting; one study reported a VBAC success rate of 87.1% among women with spontaneous onset of labour, with uterine rupture occurring in only 0.3% and uterine dehiscence in 1.0% of cases.⁷ By contrast, prior CS now accounts for 8 to 40 percent of all repeat caesarean sections and both TOLAC and repeat CS carry risks including haemorrhage, infection, operative injury, hysterectomy and mortality.⁸

Candidate selection for VBAC is critical to optimising outcomes. Women with a low transverse uterine incision, singleton pregnancy and no contraindication to vaginal delivery are generally considered appropriate candidates.^{9,10} Successful VBAC has been shown to shorten hospital stay, avoid abdominal surgery, reduce the risk of infection and haemorrhage and decrease bladder and bowel injury compared with repeat caesarean delivery.¹¹ A systematic review and meta-analysis identified age, obesity, labour induction, birth weight, Bishop score, indication for the previous CS and prior vaginal birth as factors associated with VBAC success.¹² An institutional cross-sectional study of 416 women found an overall VBAC success rate of 41%, with prior spontaneous vaginal delivery, cervical dilatation at admission and duration of labour emerging as significant predictors.¹³

Beyond the clinical considerations, vaginal birth confers immunological advantages to the neonate through exposure to maternal vaginal flora, which contributes to the development of the neonatal immune system and may reduce the risk of asthma, food allergies and transient tachypnoea of the newborn.¹⁴ Despite these advantages, caesarean delivery rates have continued to rise globally, driven by factors including advanced maternal age, maternal comorbidities, antepartum haemorrhage, cord prolapse, malpresentation and previous caesarean history.¹⁵ When successful, VBAC is associated with reduced maternal morbidity and a lower risk of complications in future pregnancies.¹⁶

In Bangladesh, the population-based caesarean section rate stands at approximately 35% of all deliveries, yet local data on maternal outcomes following VBAC remain scarce.¹⁷ The present study was therefore conducted to

evaluate the success rate of VBAC and the associated maternal complications among women with a previous caesarean section at Dhaka Medical College Hospital (DMCH), a major tertiary referral center in Bangladesh.

METHODS

This was a hospital-based observational descriptive cross-sectional study conducted in the Department of Obstetrics and Gynaecology, Dhaka Medical College Hospital (DMCH), Dhaka, Bangladesh. Data were collected prospectively over six months from 16 April 2023 to 15 October 2023. The study population comprised pregnant women with a previous history of one or two caesarean sections who were admitted to the department and planned for vaginal delivery during the study period. A total of 100 patients were enrolled. Participants were selected by purposive sampling from among eligible women admitted to the labour ward.

Inclusion criteria

Pregnant women planned for vaginal birth with a previous history of caesarean section, longitudinal fetal lie, including cephalic presentation, gestational age of 34 weeks or more and singleton pregnancy and presence of a live fetus were included.

Exclusion criteria

Women with a previous caesarean section performed for a recurrent cause, multigravid women with a history of more than two previous caesarean sections, malpresentation including face presentation, malposition, including transverse lie and women unwilling to participate in the study were excluded.

Data collection procedure

Following enrolment, informed written consent was obtained from all eligible participants. A structured, pretested questionnaire was administered to collect sociodemographic information, including age, residence, educational level, occupation and income, as well as detailed obstetric history covering parity, number of previous pregnancies and abortions, indication for previous caesarean section and any relevant comorbidities.

Clinical examination and relevant laboratory investigations were performed for all participants. Women were counselled regarding the risks and benefits of TOLAC compared with elective repeat caesarean section and those consenting to trial of labour were monitored throughout labour.

During the trial of labour, intravenous access was established and maintained and at least one unit of blood was typed and cross-matched for each woman. A partogram was established and fetal cardiac activity, maternal vital signs and uterine contractions were assessed

every 30 minutes in the first stage and every 15 minutes in the second stage. The uterine scar was evaluated at 30-minute intervals for signs including maternal tachycardia, scar tenderness, fetal tachycardia, haematuria, vaginal bleeding and loss of station of the presenting part. Labour augmentation with oxytocin, where required, was administered at 2.5 units in 500 ml of dextrose or normal saline at 10 drops per minute, with increments of 10 drops per minute every 30 minutes until an adequate contraction pattern was achieved. All women had continuous cardiotocography monitoring and pain relief was provided in the form of intramuscular ketorolac or tramadol hydrochloride. Emergency repeat caesarean section was performed for non-progress of labour, impending uterine rupture, or fetal distress. Intraoperative and postoperative findings were recorded and maternal outcome data including wound infection, postpartum haemorrhage and perineal injury were documented for all participants.

Ethical considerations

The research protocol was reviewed and approved by the Ethical Committee of Dhaka Medical College Hospital before commencement of the study. The aims, objectives, procedures, potential risks and anticipated benefits of the study were explained to each participant in a language she could understand and written informed consent was obtained before enrolment. Participation was entirely voluntary. All data collected were treated as strictly confidential and were used solely for this research.

Statistical analysis

Data were coded, verified for consistency and entered into a computer using statistical package for the social sciences (SPSS) version 6. Descriptive statistical analysis was performed for all variables. Quantitative data were expressed as mean with standard deviation, while qualitative data were presented as frequency and percentage. Results were displayed in the form of tables and figures, including bar charts and pie charts, as appropriate.

RESULTS

Table 1 presents the sociodemographic and anthropometric profiles of the 100 women enrolled in the study. The majority of participants (58.0%) were between 20 and 30 years of age, with a mean age of 29.8 ± 11.4 years. A substantial proportion (62.0%) resided in urban areas, while 38.0% were from rural backgrounds. Regarding educational attainment, nearly half (48.0%) had completed only primary level education, 28.0% had secondary level education, 18.0% had education higher than secondary level and 6.0% were illiterate. Socioeconomically, the majority of participants (54.0%) belonged to the poor income class, 30.0% were from the middle class and 16.0% were from the high-income class. In terms of body mass index (BMI), 10.0% of women had a normal BMI (18.5 to 24.9 kg/m²), 44.0% were

overweight (25.0 to 29.9 kg/m²), 38.0% had class I obesity (30.0 to 34.9 kg/m²) and 8.0% had class II obesity (35.0 to 39.9 kg/m²). No patient had a BMI exceeding 40.0 kg/m² and overall, 46.0% of the study participants were obese.

Table 2 summarizes the obstetric profile of the current pregnancy and the characteristics of the previous caesarean section. The majority of participants (82.0%) had a gestational age greater than 37 weeks at the time of enrolment. Regarding antenatal care (ANC) attendance, 54.0% had regular ANC, 30.0% had irregular ANC and 16.0% had received no antenatal care. Tetanus immunization was complete in 75.0% of participants, incomplete in 13.0% and absent in 12.0%. At the time of admission, the fetal membranes were intact in 52 women (52.0%) and ruptured in 48 women (48.0%).

Concerning the previous caesarean section, fetal distress was the most frequently recorded indication, accounting for 57.0% of cases. Other indications included premature rupture of membranes with cervical dystocia (24.0%), cephalopelvic disproportion (21.0%), prolonged or obstructed labour (18.0%), hypertensive disorder (15.0%) and primi breech presentation (8.0%). Cord prolapse was the indication in 7.0% of cases. All previous caesarean sections had been performed for non-recurrent indications. Of these, 55.0% had been performed electively and 45.0% as emergency procedures.

Table 3 presents the distribution of induction-to-delivery interval times. The majority of women (64.0%) achieved delivery within 7 to 12 hours of induction and 14.0% delivered within 6 hours or less. In 22.0% of cases, delivery occurred after more than 12 hours from induction. Overall, delivery was achieved within 12 hours in 78 women (78.0%). The mean induction-to-delivery interval for the entire cohort was 8.37 ± 5.3 hours. After drug administration, all patients were monitored using a partogram with regular assessment of labour progress, maternal vital signs and fetal heart rate. In cases where labour had not commenced within 24 hours, a clinical decision regarding operative delivery was made based on the overall clinical condition.

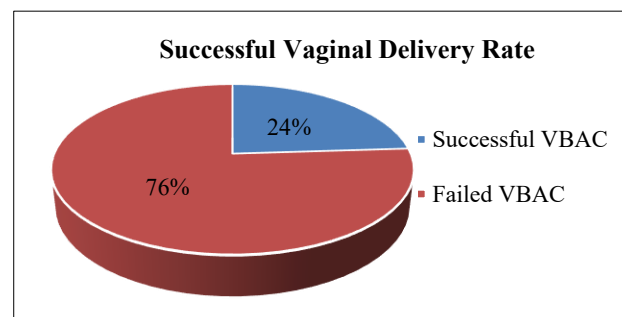


Figure 1: Prevalence of successful vaginal delivery after trial of labour (n=100).

Figure 1 shows the prevalence of successful vaginal delivery. In this study 76.0% patients had successful

VBAC or vaginal delivery of the foetus after undergoing a trail of labour regardless of foetal and maternal complications. Women who failed to deliver vaginally and ended up with repeat caesarean delivery after undergoing a trail of labour.

Table 4 details the clinical indications for emergency repeat caesarean section among the 24 women in whom TOLAC was unsuccessful. Non-progress of labour with impending uterine rupture was the most common indication, recorded in 19 cases (19.0% of the total cohort). Fetal distress necessitated repeat caesarean in 12 cases (12.0%) and obstructed labour was the indication in 5 cases (5.0%).

Two cases (2.0%) required operative delivery for other indications. It should be noted that percentages in this table are expressed relative to the total study population of 100 to allow direct comparison across the cohort.

Table 5 presents the maternal complications observed in the study cohort. The majority of women (83.0%) experienced no complication following trial of labour. Among the 17 women who developed complications, postpartum haemorrhage (PPH) was the most frequent, occurring in 9 women (9.0%). Wound infection was observed in 5 women (5.0%) and perineal injury was recorded in 3 women (3.0%). No case of uterine rupture was recorded in this series.

Table 1: Sociodemographic and anthropometric characteristics of the study participants (n=100).

Characteristic		Number (N)	Percentage (%)
Age group (years)	20-30	58	58.0
	31-40	36	36.0
	>40	6	6.0
	Mean age±SD (years)	29.8±11.4	
Residence	Urban	62	62.0
	Rural	38	38.0
Educational level	Illiterate	6	6.0
	Primary	48	48.0
	Secondary	28	28.0
	Higher than secondary	18	18.0
Socioeconomic class	Poor	54	54.0
	Middle	30	30.0
	High income	16	16.0
Body mass index (kg/m ²)	18.5-24.9 (normal)	10	10.0
	25.0-29.9 (overweight)	44	44.0
	30.0-34.9 (class I obesity)	38	38.0
	35.0-39.9 (class II obesity)	8	8.0

Table 2: Obstetric profile of the current pregnancy and characteristics of previous caesarean section (n=100).

Obstetrics profile		Number (N)	Percentage (%)
Gestational age (weeks)	<37	18	18.0
	>37	82	82.0
Antenatal care attendance	Regular	54	54.0
	Irregular	30	30.0
	No ANC	16	16.0
Tetanus immunisation	Regular	75	75.0
	Irregular	13	13.0
	Not immunised	12	12.0
Membrane status at admission	Intact	52	52.0
	Ruptured (PROM)	48	48.0
B. previous caesarean section			
Indication	Fetal distress	57	57.0
	Cord prolapse	7	7.0
	Prolonged/obstructed labour	18	18.0
	PROM with cervical dystocia	24	24.0
	Hypertensive disorder	15	15.0
	Cephalopelvic disproportion	21	21.0
	Primi breech	8	8.0

Continued.

Obstetrics profile	Number (N)	Percentage (%)	
Mode of previous operation	Elective	55	55.0
	Emergency	45	45.0

Table 3: Induction-to-delivery interval time among study participants (n=100).

Time interval (hours)	Number (N)	%
<6	14	14.0
12-Jul	64	64.0
>12	22	22.0
Mean±SD (hours)	8.37±5.3	

Table 4: Indications for repeat caesarean section among failed VBAC cases (n=100).

Indication	Number (N)	%
Non-progress of labour/ impending uterine rupture	19	19.0
Fetal distress	12	12.0
Obstructed labour	5	5.0
Others	2	2.0
Total repeat CS	24	24.0

Table 5: Maternal complications following trial of labour (n=100).

Maternal outcome	Frequency (N)	%
No complication	83	83.0
Wound infection	5	5.0
Uterine rupture	0	0.0
Postpartum haemorrhage	9	9.0
Perineal injury	3	3.0
Total with any complication	17	17.0

DISCUSSION

This observational descriptive cross-sectional study examined the success rates and maternal complications of vaginal birth after caesarean section among 100 women who underwent trial of labour at Dhaka Medical College Hospital over six months. The findings contribute institutional data from a high-volume tertiary referral center in Bangladesh, where local evidence on VBAC outcomes remains limited.

The sociodemographic profile revealed that the majority of participants (58.0%) were between 20 and 30 years of age, with a mean age of 29.8±11.4 years. These findings are broadly consistent with those of Frass and Al Harazi, who reported a mean age of 23.3±5.3 years among women undergoing VBAC and Mekonnen and Bulto, who found that nearly two-thirds of VBAC cases fell within the 25 to 29 year age group.^{7,18} The predominance of younger women likely reflects higher fertility rates and closer inter-pregnancy intervals in this demographic in Bangladesh. Urban residence was recorded in 62.0% of participants,

consistent with the referral catchment of DMCH. A majority of women (48.0%) had only primary level education and 54.0% belonged to the poor socioeconomic class, findings that highlight the importance of making VBAC services accessible to economically disadvantaged women who carry a disproportionately higher obstetric risk.

The obstetric profile showed that 82.0% of participants were at term gestation, 54.0% had regular antenatal care and 48 women presented with premature rupture of membranes at admission. Among the indications for the previous caesarean section, fetal distress was the most frequent (57.0%), followed by premature rupture of membranes with cervical dystocia (24.0%), cephalopelvic disproportion (21.0%), prolonged or obstructed labour (18.0%), hypertensive disorder (15.0%), primi breech (8.0%) and cord prolapse (7.0%). All prior caesarean sections had been performed for non-recurrent indications, which is a well-established positive predictor of VBAC success, with 55.0% having been elective and 45.0% emergency procedures.

The primary finding of this study was a VBAC success rate of 76.0%, which falls within the commonly reported range of 60% to 80% for women with one previous lower-segment caesarean incision.¹¹ Considerable variation in reported success rates exists across different settings. Girma et al documented a rate of 41% in Southwest Ethiopia, Siraneh and Tesfaye recorded 44.5% in South Ethiopia and Birara and Gebrehiwot reported 49% in Addis Ababa.^{13,19,20} Higher rates of 87.1% and 84.9% were reported by Frass and Al Harazi from Yemen and Tsai and Wu from Taiwan.^{7,21} These differences likely reflect variation in institutional protocols, candidate selection, intrapartum monitoring capacity and patient-level predictors. Mekonnen and Asfaw identified prior spontaneous vaginal delivery, previous successful VBAC, cervical dilatation of 4 cm or more at admission and spontaneous membrane rupture as independent determinants of VBAC success, factors that may have differentially influenced outcomes across these settings.¹⁸

Among the 24 women with failed trial of labour, non-progress of labour with impending uterine rupture was the leading indication for emergency repeat caesarean section, recorded in 19 cases, followed by fetal distress in 12 cases and obstructed labour in 5 cases. Flamm and Geiger identified age below 40 years, prior vaginal birth, a non-recurrent indication for the previous caesarean section and cervical dilatation of 4 cm or more at admission as factors favouring successful VBAC, underscoring the importance of careful intrapartum assessment.²² Handler and Bujold further demonstrated that women with a prior successful VBAC achieved success in 94.0% of subsequent attempts,

with significantly shorter labour stages, reinforcing the value of prior delivery history in candidate counselling.²³

Regarding maternal complications, 83.0% of women experienced no adverse outcome. Postpartum haemorrhage was the most frequent complication, occurring in 9.0% of cases, consistent with findings reported by Aktera and Shirin in a comparable Bangladeshi cohort.⁶ Wound infection was observed in 5.0% and perineal injury in 3.0%. Critically, no case of uterine rupture was recorded, a finding that aligns with the low rupture rate of 0.3% reported by Frass and Al Harazi and reflects the effectiveness of structured intrapartum monitoring.⁷ George et al confirmed that overall maternal morbidity with VBAC remains low when appropriate institutional safeguards are maintained.²⁴

Collectively, these findings support the safe implementation of structured trial of labour programmes for appropriately selected women in tertiary care settings in Bangladesh.

Limitations

This study has several limitations, which were small sample size of the study population, it was a single-centre study. Only patients admitted to DMCH were included in the study. So, this will not reflect the overall picture of the country.

A large-scale study needs to be conducted to reach a definitive conclusion, the study was conducted in a tertiary care hospital, which may not represent a primary or secondary centre and samples were taken by the PUA positive method, in which the question of personal bias arises.

CONCLUSION

The present study concluded that 76.0% patients had successful VBAC or vaginal delivery. Vaginal birth after caesarean section would be a viable option to decrease caesarean section rates and gynaecologists or other health care providers should consider the identification of factors among women that lead to a higher likelihood of successful vaginal birth after caesarean section. Routine antenatal care with proper monitoring for complications both during antenatal and intrapartum increased the chance for vaginal birth after caesarean section and improved maternal and perinatal outcomes.

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