

# Vaginal Cesarean Section, an Alternative to High-Risk Trigger on Scarred Uterus

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## Abstract

**The objective** is to report a clinical case of vaginal cesarean section performed to expel a dead fetus in scarred uterus. For this indication, vaginal hysterectomy constitutes an alternative to vaginal expulsion with a high risk of uterine rupture and to classic abdominal cesarean section with risk of significant surgical trauma, particularly adhesions. However, this surgical technique, described since the 19th century, remains unknown to many practitioners and few publications exist on the subject throughout the world. Considered obsolete by some practitioners, it retains all its advantages in the practice of modern obstetrics. We report this case of expulsion of fetal death on a tri-scarred uterus performed by vaginal cesarean section at the Health District Reference Health Center (District Hospital) of Commune I in Bamako, Mali in a 37-year-old patient with a pregnancy of 27 weeks of amenorrhea.

## Keywords

Vaginal Cesarean Section, Birth on Scarred Uterus, In Utero Fetal Death

## 1. Introduction

Described for the first time in 1896 by Dürrssen, vaginal cesarean section is defined as extraction of the fetus from a hysterotomy performed vaginally [1]. For a long time, it was opposed to dilators as an alternative for late-term abortions, although each of the two methods had its own advantages and limitations. Despite its distribution in France by Malinas and his collaborators [2]-[5], it re-

mains unknown to many practitioners. The bibliography on the subject is rare and the majority of articles are old. This is a surgical technique little taught to young doctors and therefore little used. Its practice requires experience in vaginal surgery. From 1987 the practice of intervention has experienced a certain growth in France with recent publications and the description of the technique on audiovisual educational supports [6]-[8]. These publications have highlighted the advantages of vaginal cesarean section in certain obstetric situations. Experiences reported in Africa on the subject are rare. After a review of the indications in Mali, our team decided to document and to report each case of vaginal cesarean section to contribute to the popularization of this surgical technology which still has its place in the practice of modern obstetrics. Here we report a case of expulsion of a dead fetus from a tri-scarred uterus.

## 2. Presentation of the Case

This is a 37 year old patient, housewife, domiciled in Bamako, Commune I, 4 deliveries, 4 live children including 3 by cesarean section at term, the indications for which were respectively: acute fetal distress, breech position and delivery on a bi-scarred uterus.

Admitted on March 9, 2023 at the district hospital of Commune I of Bamako for fetal death in utero at 27 weeks on tri-scarred uterus.

Poorly monitored pregnancy, date of last period unknown, 2 prenatal consultations carried out, the last of which by a doctor in a private medical office on March 6, 2023 following bleeding.

The ultrasound performed during this consultation noted a single fetus in cephalic presentation with overlapping skull bones, weight 1200 g, and absence of cardiac activity.

She was therefore referred to the team at the District Hospital of Commune I for management of the expulsion of a fetus in utero on a tri-scarred uterus.

On admission, the patient's desire for new pregnancies is still noted.

The physical examination noted a satisfactory general condition, blood pressure at 110/70 mm Hg, temperature at 37°C, pulse at 79 beats/min, presence of a thick transverse scar on the lower abdomen, uterine height at 24 cm, absent fetal heart sound, mobile cephalic presentation, presence of irregular uterine contractions of low intensity, short cervix, soft and open to 2 cm, flat membranes. It was concluded that a single-fetal pregnancy was arrested at 27 weeks in cephalic presentation on a tri-scarred uterus and a normal pelvis not in labor with the desire for a subsequent pregnancy.

The indication for fetal expulsion was made. The method and route of expulsion were discussed within the team's obstetric staff and in a virtual group of specialists and experts.

Vaginal cesarean section was chosen based on the following arguments:

- Desire for new pregnancies
- High risk of rupture in the event of scarring of the uterus (hemorrhage+++ , possible hysterectomy, prolonged stress)

- Probability of life of the fetus: 0
- Low fetal weight
- Short duration of hospitalization
- Use of fewer inputs (low cost)
- Low risk of surgical trauma
- Low risk of intra-peritoneal adhesion

The cesarean section was therefore carried out vaginally under spinal anesthesia in the gynecological position according to the technique described by Racinet and Lavec [7] [8] with a small variance at the level of the vaginal incision: After whitewashing, installation of the anterior and posterior valves, exposure of the cervix using the POZI forceps, CROSSEN incision 2 cm from the external orifice on the anterior surface of the cervix, separation and repression of the bladder via the anterior valve, trachelo-hysterotomy from the lip anterior cervix, cephalic extraction by application of a small forceps to the fetal head, placental expulsion and uterine revision, extra-mucous hysterorrhaphy continuous with Vicryl No. 1 and colporrhaphy with Vicryl 2/0. The child weighed 2100 g. No traumatic or hemorrhagic complications were recorded. The difficulties in expulsion of the fetus in cephalic presentation were resolved by the application of a small forceps. The intervention lasted 32 minutes. She received 2 g of Amoxicillin as an IVG during the procedure. Post-operatively, she received a vaginal toilet twice a day. She left the hospital 72 hours after the cesarean section without complications. The examination on the 42nd post-operative day noted a normal evolution with a linear vaginal scar.

### 3. Discussion

The indications for cesarean section were described very broadly by Dührssen [1]. It has long been used as a technique for legalized abortion of more than 12 weeks of amenorrhea [9]; then abandoned in favor of obstetric dilators. The ideal indications for the operation have been summarized by some authors as the absence of cervical dilatation, the occurrence of severe maternal hemorrhage during the pregnancy termination procedure, or during the expulsion of uterine contents towards the end of the second trimester, asking whether there is a place for vaginal cesarean section when the fetus is alive [10]. Certain learned societies of practitioners, such as the National College of French Gynecologists and Obstetricians, had held consensus and update days on the subject.

In Mali, the first cases were reported by Traoré and his collaborators in a series of cases [11].

In recent literature on the subject, there are cases of live newborns and indications for fetal rescue. Thus, in a series of 7 cases in Senegal, Gueye and colleagues [12] reported 3 cases of live newborns with an average Apgar score of 5 out of 10 at birth. Verma and colleagues [13] reported in India a case of cesarean section for fetal suffering by cervical dystocia to uterine prolapse which saved a 2500 g newborn. This case that we report is a practice of vaginal cesarean section

to avoid the risks of uterine rupture on the scarred uterus of a triggering and the significant trauma of the laparotomy of an abdominal cesarean section.

#### 4. Conclusion

Vaginal cesarean section is a surgical technique that retains its place in modern obstetric practice. It makes it possible to circumvent certain obstetric impasses linked to vaginal delivery and abdominal cesarean section.

#### Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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