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Original Research Paper

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STUDY OF FETOMATERNAL OUTCOMES IN PREGNANCY WITH PREVIOUS TWO OR MORE LOWER SEGMENT CAESAREAN SECTIONS AT A TERTIARY HOSPITAL

Dr Shweta Sonawane

Dr Anurag Sonawane Associate Professor

Dr Shrinivas Gadappa Professor And Head Of The Department

ABSTRACT Background: Pregnancy with previous two lower segment caesarean sections is considered high-risk because of increased surgical difficulty, adhesions, scar thinning, placenta accreta spectrum, hemorrhage, transfusion requirement, and neonatal morbidity. Present study was aimed to study maternal demographic and obstetric characteristics, intraoperative and postoperative maternal complications, fetal outcomes, postoperative maternal morbidity, and overall fetomaternal outcome in pregnancies with previous two or more lower segment caesarean sections. Methods: This prospective observational hospital-based study was conducted at Government Medical College, Chhatrapati Sambhajinagar, Maharashtra, from April 2024 to March 2026. **Results:** Most women were aged 25–29 years (50.31%), followed by 30–34 years (34.36%). Rural women constituted 61.50%. Previous two LSCS were present in 992 women (87.40%), and 143 women (12.60%) had ≥3 previous LSCS. Most women were booked (99.65%) and delivered at 37–38+6 weeks (63.70%). Elective LSCS was performed in 714 cases (62.91%), while 421 cases (37.09%) underwent emergency LSCS. Adhesions were present in 593 women (52.25%), PAS in 39 cases (3.44%), placenta previa/low-lying placenta in 96 cases (8.46%), and scar dehiscence/rupture in 32 cases (2.82%). Blood transfusion was required in 328 women (28.90%), hysterectomy in 49 (4.32%), ICU admission in 81 (7.14%), and maternal mortality occurred in 4 cases (0.35%). NICU admission was required in 168 neonates (14.80%), and neonatal mortality was 1.67%. **Conclusion:** Pregnancies with previous two or more LSCS are associated with measurable maternal and neonatal risks, but favourable outcomes are achievable with antenatal surveillance, elective planning, surgical preparedness, blood-bank support, and neonatal care.

KEYWORDS : Previous two LSCS, repeat caesarean section, fetomaternal outcome, placenta accreta spectrum, adhesions, neonatal outcome, tertiary care

INTRODUCTION

Caesarean section is a life-saving obstetric procedure when performed for appropriate maternal or fetal indications; however, the sustained global rise in caesarean rates has created an increasing burden of repeat caesarean pregnancies. The World Health Organization has stated that population-level caesarean section rates above 10–15% are not associated with further reduction in maternal or neonatal mortality.[1]

Global estimates show that caesarean section rates have continued to rise across regions, with projections suggesting a further increase in coming decades.[2] India has shown a similar trend, with NFHS-5 reporting a national caesarean section rate of 21.5%, while Maharashtra has reported higher institutional rates, particularly in urban and tertiary-care settings.[3,4] This increasing primary caesarean section rate has resulted in a growing number of women presenting with two or more previous caesarean scars in subsequent pregnancies.

Pregnancy after previous two LSCS is clinically important because each additional caesarean section increases the risk of adhesions, difficult abdominal entry, scar thinning, scar dehiscence, uterine rupture, placenta previa, placenta accreta spectrum, increased blood loss, blood transfusion, bladder injury, bowel injury, hysterectomy, ICU admission, wound morbidity, and prolonged hospital stay.[5,6,7] Present study was conducted to evaluate maternal demographic and obstetric characteristics, intraoperative and postoperative maternal complications, fetal outcomes, postoperative maternal morbidity, and overall fetomaternal outcome in pregnancies with previous two lower segment caesarean sections.

Materials and Methods

This was a prospective observational hospital-based study. The study was conducted in the Department of Obstetrics and Gynaecology at Government Medical College, Chhatrapati Sambhajinagar, Maharashtra. The study was conducted over two years, from April 2024 to March 2026. Institutional ethics committee approval was obtained before commencement of the study.

Inclusion criteria

Women were included if they fulfilled the following criteria:

- Singleton pregnancy
- Gestational age ≥ 28 weeks
- History of two or more previous lower segment caesarean sections
- Delivered at Government Medical College, Chhatrapati Sambhajinagar
- Willing to participate in the study
- Provided written informed consent

Exclusion criteria

- Refusal to participate
- History of previous two LSCS but delivery outside the study institution
- Gestational age less than 28 weeks
- Fetal anomaly

All eligible women admitted during the study period were screened and enrolled after obtaining informed consent. No randomization or intervention allocation was performed, as the study was observational.

All women underwent detailed history taking, including age, residence, education, socioeconomic status, gravida, parity, number of previous caesarean sections, indication of previous caesarean sections, interpregnancy interval, booking status,

antenatal complications, and referral details. Clinical examination included general examination, abdominal examination, fetal assessment, scar tenderness, and systemic examination. Baseline investigations included hemoglobin estimation, blood grouping and Rh typing, urine examination, and other investigations as clinically indicated. Ultrasonography was used for gestational age assessment, placental localization, fetal wellbeing, and suspicion of placenta previa or placenta accreta spectrum where relevant. Anaesthesia fitness and neonatal team preparedness were ensured before operative delivery.

The decision for elective or emergency repeat caesarean section was based on standard institutional protocol and clinical judgement. During surgery, the type of abdominal incision, adhesions, bladder dissection difficulty, lower uterine segment status, scar thinning, scar dehiscence, rupture, placental location, placenta accreta spectrum, operative time, blood loss, transfusion requirement, visceral injury, and additional surgical procedures were documented.

Postoperative monitoring included pulse, blood pressure, respiratory rate, temperature, oxygen saturation, urine output, uterine tone, vaginal bleeding, abdominal distension, wound condition, hemoglobin status, blood transfusion requirement, ICU admission, and duration of hospital stay. Postoperative morbidity such as fever, wound infection, postpartum hemorrhage, paralytic ileus, sepsis, thromboembolic events, and need for re-exploration were recorded. Neonatal outcome was assessed using gestational age at delivery, birth weight, Apgar score at 1 and 5 minutes, need for resuscitation, NICU admission, indication for NICU admission, respiratory distress, prematurity, low birth weight, neonatal sepsis, and neonatal death.

\Data were entered into a master chart and analyzed using descriptive statistics. Categorical variables were expressed as frequency and percentage. Continuous variables were expressed as mean and standard deviation where available. Associations reported in the dissertation were interpreted only where available.

Written informed consent was obtained from all participants in the local language. Confidentiality of patient data was maintained throughout the study.

RESULTS

A total of 1135 pregnant women with previous two or more LSCS were included in the study. Women aged 25–29 years constituted 571 cases (50.31%), followed by 30–34 years with 390 cases (34.36%). Rural residence was present in 698 cases (61.50%). Upper lower and lower middle socioeconomic classes constituted 451 (39.74%) and 437 (38.50%) cases, respectively.

Table 1. Sociodemographic profile of study participants

Variable	Category	Number	Percentage (%)
Age group	20–24 years	54	4.76
	25–29 years	571	50.31
	30–34 years	390	34.36
	35–39 years	109	9.60
	≥40 years	11	0.97
Residence	Rural	698	61.50
	Urban	437	38.50
Socioeconomic class	Upper	45	3.96
	Upper middle	202	17.80
	Lower middle	437	38.50
	Upper lower	451	39.74
	Lower	0	0.00

Previous two LSCS were present in 992 women (87.40%), while 143 women (12.60%) had three or more previous LSCS. Gravida 3 constituted 771 cases (67.93%), and para 2 constituted 984 cases (86.69%). No previous abortion was reported in 889 women (78.34%). Interpregnancy interval of 25–36 months was present in 479 women (42.20%).

Table 2. Obstetric profile

Variable	Category	Number	Percentage (%)
Previous LSCS	Previous 2 LSCS	992	87.40
	Previous 3 LSCS	132	11.63
	Previous ≥4 LSCS	11	0.97
Gravida	G3	771	67.93
	G4	247	21.76
	≥G5	117	10.31
Parity	Para 2	984	86.69
	Para 3	118	10.40
	≥Para 4	33	2.91
Previous abortions	None	889	78.34
	One	179	15.77
	≥Two	67	5.90
Interpregnancy interval	<18 months	98	8.63
	18–24 months	326	28.72
	25–36 months	479	42.20
	>36 months	232	20.44

Booked cases constituted 1131 women (99.65%). Gestational age at delivery was 37–38+6 weeks in 723 women (63.70%), followed by 34–36+6 weeks in 238 women (20.97%). Elective LSCS was performed in 714 women (62.91%), while 421 women (37.09%) underwent emergency LSCS. Moderate to severe anemia was present in 363 cases (31.98%), and hypertensive disorders were present in 164 cases (14.45%).

Table 3. Antenatal and admission characteristics

Variable	Category	Number	Percentage (%)
Booking status	Booked	1131	99.65
	Unbooked	4	0.35
Gestational age at delivery	28–33+6 weeks	72	6.34
	34–36+6 weeks	238	20.97
	37–38+6 weeks	723	63.70
	39–40+6 weeks	99	8.72
	>40 weeks	3	0.26
Type of LSCS	Elective	714	62.91
	Emergency	421	37.09
Comorbidity	Moderate to severe anemia	363	31.98
	Hypertensive disorders	164	14.45
	Diabetes/GDM	72	6.34
	Hypothyroidism	69	6.08
	Cardiac/other disorders	48	4.23
	No comorbidity	419	36.92

Adhesions were present in 593 women (52.25%), including moderate adhesions in 197 cases (17.36%) and dense/severe adhesions in 77 cases (6.78%). Operative duration was 45–60 minutes in 512 women (45.11%) and 61–90 minutes in 401 women (35.33%). Blood loss was ≥1000 mL in 141 women (12.43%). Scar dehiscence was present in 28 women (2.47%), and rupture was present in 4 women (0.35%). PAS was present in 39 women (3.44%), and placenta previa/low-lying placenta in 96 women (8.46%).

Table 4. Operative details and intraoperative findings

Variable	Category	Number	Percentage (%)
Adhesion grade	No adhesions	542	47.75
	Mild	319	28.11
	Moderate	197	17.36
	Dense/severe	77	6.78
Operative time	<45 min	178	15.68
	45–60 min	512	45.11
	61–90 min	401	35.33
	>90 min	44	3.88
Blood loss	<500 mL	521	45.90
	500–999 mL	473	41.67
	1000–1499 mL	102	8.99
	≥1500 mL	39	3.44
Scar status	Intact	1008	88.81
	Thinned out	95	8.37
	Dehiscence	28	2.47
	Rupture	4	0.35
PAS	Present	39	3.44
Placenta previa/low-lying placenta	Present	96	8.46

Blood transfusion was required in 328 women (28.90%). Bladder injury occurred in 9 cases (0.79%), and bowel injury occurred in 4 cases (0.35%). Hysterectomy was performed in 49 women (4.32%), and ICU admission was required in 81 women (7.14%). Maternal morbidity was present in 121 women (10.66%), while maternal mortality occurred in 4 cases (0.35%).

Table 5. Maternal intraoperative and postoperative complications

Maternal parameter	Category	Number	Percentage (%)
Blood transfusion	Yes	328	28.90
Visceral injury	Bladder injury	9	0.79
	Bowel injury	4	0.35
Hysterectomy	Yes	49	4.32
ICU admission	Yes	81	7.14
Maternal	Present	121	10.66
Maternal outcome	Maternal	4	0.35

Low birth weight <2.5 kg was observed in 341 neonates (30.04%). Apgar score <7 was present in 156 neonates (13.74%) at 1 minute and 62 neonates (5.46%) at 5 minutes. NICU admission was required in 168 neonates (14.80%). Respiratory distress was the commonest indication for NICU admission, contributing 52 cases (30.95% of NICU admissions). Neonatal death occurred in 19 cases (1.67%).

Table 6. Neonatal outcomes

Neonatal parameter	Category	Number	Percentage (%)
Birth weight	<2.5 kg	341	30.04
	2.5–3.0 kg	499	43.96
	3.1–3.5 kg	201	17.71
	>3.5 kg	94	8.28
Apgar at 1 minute	<7	156	13.74
	≥7	979	86.26
Apgar at 5 minutes	<7	62	5.46
	≥7	1073	94.54
NICU admission	Yes	168	14.80
	No	967	85.20
Indication for NICU admission	Respiratory distress/TTN/RDS	52	30.95*
	Prematurity	38	22.62*
	Low birth weight	29	17.26*
	Birth asphyxia/low Apgar	21	12.50*
	Meconium aspiration syndrome	11	6.55*
	Neonatal sepsis	9	5.36*
	Others	8	4.76*
Neonatal outcome	Alive	1116	98.33
	Neonatal death	19	1.67

*Percentage calculated among NICU admissions, n=168.

Maternal morbidity occurred in 121 women (10.66%), and maternal mortality occurred in 4 women (0.35%). Neonatal morbidity requiring NICU admission was present in 168 neonates (14.80%), and neonatal mortality was 19 cases (1.67%). Among elective LSCS cases, NICU admission occurred in 73/714 cases (10.22%), while in emergency LSCS, NICU admission occurred in 95/421 cases (22.57%).

Table 7. Summary of fetomaternal outcomes

Outcome	Number	Percentage (%)
Maternal morbidity present	121	10.66
Maternal mortality	4	0.35
Neonates alive	1116	98.33
Neonatal death	19	1.67
NICU admission	168	14.80
NICU admission after elective LSCS	73/714	10.22
NICU admission after emergency LSCS	95/421	22.57
Maternal complications in previous 2 LSCS	88/992	8.87
Maternal complications in ≥3 previous LSCS	33/143	23.08

DISCUSSION

The present prospective observational study included 1135 women with previous two or more LSCS delivered at Government Medical College, Chhatrapati Sambhajinagar. The study population mainly consisted of women aged 25–29 years (50.31%) and 30–34 years (34.36%), with a mean age of 29.4 ± 4.1 years. This age distribution is consistent with Indian studies on repeat caesarean section, where most women undergoing repeat LSCS are in the late twenties or early thirties. Singh et al.,[12] reported that women with previous two caesarean sections commonly belonged to the 25–30-year age group, while Choudhary et al.,[13] reported a similar concentration in the 26–34-year range. The predominance of this age group reflects peak reproductive age and completion of family size after two previous caesarean deliveries.

Previous two LSCS constituted 87.40% of cases, while 12.60% had three or more previous LSCS. The majority were gravida 3 (67.93%) and para 2 (86.69%), reflecting the expected obstetric profile of women presenting after two previous caesarean births. Similar observations have been reported by Choudhary et al., Lakshmi et al.,[12] and Singh et al.,[14] who identified prior LSCS as the major indication for repeat caesarean delivery and documented increasing morbidity with increasing number of previous caesarean sections.

Most women in the present study delivered between 37 and 38+6 weeks (63.70%), and elective LSCS was performed in 62.91% cases. This is clinically relevant because planned delivery reduces the likelihood of scar tenderness, emergency surgery, fetal compromise, and uncontrolled hemorrhage. RCOG guidance supports individualized delivery planning in

women with previous caesarean birth, and NICE recommends planned caesarean birth based on maternal and fetal risk assessment.[8,9] Singh et al.,[12] and Nazaneen et al.,[15] also reported that term elective repeat LSCS was associated with more controlled operative conditions and reduced emergency morbidity. In the present study, emergency LSCS was associated with higher NICU admission than elective LSCS, with NICU admission in 22.57% of emergency cases compared with 10.22% of elective cases.

Adhesions were present in 52.25% of women in the present study, with moderate adhesions in 17.36% and dense/severe adhesions in 6.78%. Morales et al. reported adhesions in approximately 46% of repeat caesarean deliveries and showed that post-caesarean adhesions may delay delivery of the infant [10]. Nazaneen et al.,[12] reported adhesions in around one-third of repeat caesarean cases, while Gohil et al.,[15] and Singh et al.,[16] observed that repeat caesarean delivery was associated with increased surgical difficulty compared with primary caesarean section. The present study therefore supports the established association between repeated caesarean surgery and altered pelvic anatomy.

Scar integrity was intact in 88.81% of women, while scar thinning was noted in 8.37%, dehiscence in 2.47%, and rupture in 0.35%. The low rupture rate may be explained by high booking status and predominance of elective delivery. Similar findings were reported by Singh et al.,[12] and Mahale et al.,[17] who observed that scar thinning and dehiscence were more common than frank rupture in repeat LSCS. The findings support the policy of careful antenatal surveillance and timely repeat LSCS before advanced labour in women with previous two caesarean scars.

Placenta accreta spectrum was found in 3.44% of women, and placenta previa/low-lying placenta in 8.46%. Silver et al. demonstrated that placenta accreta and hysterectomy risk increase with each successive caesarean delivery.[6] FIGO[5] and ACOG[18] also emphasize that previous caesarean section with placenta previa is a major risk factor for placenta accreta spectrum and requires multidisciplinary planning. In the present study, hysterectomy was required in 4.32% of cases, and PAS was the leading indication for hysterectomy, accounting for 31 of 49 cases. This finding is consistent with international evidence showing a strong relationship between PAS and peripartum hysterectomy.[5,6,18]

Blood transfusion was required in 28.90% of women, and blood loss was ≥1000 mL in 12.43%. Silver et al.,[6] Nisenblat et al.,[12] Singh et al.,[15] and Nazaneen et al.,[19] have reported increasing hemorrhagic morbidity and transfusion requirement with multiple repeat caesarean sections. The present transfusion rate reflects the burden of adhesions, placenta previa, PAS, scar problems, and operative difficulty. ICU admission was required in 7.14% of women, with postpartum hemorrhage forming the commonest indication. Maternal morbidity was present in 10.66%, and maternal mortality occurred in 0.35%. The low mortality despite high-risk profile suggests the benefit of tertiary-care management, surgical planning, blood-bank support, and ICU availability.

Visceral injury was uncommon, with bladder injury in 0.79% and bowel injury in 0.35%. Phipps et al.,[20] reported that previous caesarean delivery is a risk factor for bladder injury during caesarean section. Dense adhesions and distorted bladder anatomy are recognized contributors to injury risk. In the present study, visceral injury was more common among women with moderate or dense adhesions, supporting the importance of senior surgical involvement during repeat caesarean delivery.

Neonatal outcomes were acceptable. Birth weight between 2.5 and 3.0 kg was observed in 43.96%, while low birth weight occurred in 30.04%. Apgar score ≥7 at 5 minutes was achieved in 94.54% of neonates. NICU admission occurred in 14.80%, mainly due to respiratory distress, prematurity, low birth weight, and low Apgar. Tita et al.,[7] reported that elective repeat caesarean delivery before 39 weeks is associated with higher neonatal respiratory morbidity. Hotkar et al.,[13] and Choudhary et al.,[21] also reported that prematurity, asphyxia, and respiratory morbidity contribute to NICU admission in repeat caesarean pregnancies. In the present study, neonatal mortality was 1.67%, which is within the range reported in high-risk tertiary-care repeat caesarean populations.

Overall, the present study shows that pregnancy with previous two or more LSCS is associated with significant operative and postoperative risks, particularly adhesions, scar thinning, hemorrhage, PAS, transfusion, hysterectomy, and NICU admission. However, outcomes can remain favourable when cases are booked, delivered electively at an appropriate gestational age, and managed in a tertiary centre with blood-bank, anaesthesia, neonatal, and ICU support. The findings also reinforce the need to reduce unnecessary primary caesarean sections to prevent cumulative morbidity in future pregnancies.

The major strengths of the present study were its prospective observational design, large sample size of 1135 cases, focus on a clinically important high-risk obstetric group, and detailed assessment of both maternal and neonatal outcomes, including adhesions, scar status, placenta accreta spectrum, blood loss, transfusion, visceral injury, ICU admission, NICU admission, and neonatal mortality. The limitations were that it was a single-centre study conducted at a tertiary government medical college, so the findings may not be generalizable to all healthcare settings; there was no comparison group of women with one previous LSCS or primary caesarean section; rare complications such as uterine rupture, bowel injury, and maternal mortality require larger multicentric studies for more precise estimation; and long-term maternal and neonatal follow-up after discharge was not assessed.

CONCLUSION

Pregnancy following two or more previous lower segment caesarean sections remains a significant obstetric challenge with increased maternal and perinatal risks. Most women can achieve favorable outcomes when managed through regular antenatal follow-up, timely identification of complications, and appropriate delivery planning. The risk of operative difficulties, including dense adhesions, scar-related complications, abnormal placentation, and increased blood loss, rises with the number of previous caesarean deliveries. Elective repeat caesarean section performed in a well-equipped healthcare setting is associated with better maternal and neonatal outcomes than emergency procedures. A multidisciplinary approach involving obstetricians, anaesthesiologists, neonatologists, and blood-bank services is crucial for optimizing outcomes. Efforts to promote evidence-based indications for primary caesarean section and comprehensive counselling regarding future reproductive risks are important strategies for reducing the burden of complications in women with multiple previous caesarean sections.

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