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"TRIAL OF LABOUR , TRIUMPH OF BIRTH : VAGINAL BIRTH AFTER CAESAREAN SECTION: CASE SERIES "

Obstetrics & Gynaecology

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ABSTRACT

Background: Vaginal birth after cesarean section (VBAC) is one of the strategies developed to control the rising rate of cesarean sections (CSs). It is a trial of vaginal delivery in selected cases of a previous CS in a well-equipped hospital (1) . Previously there was a dictim saying once a caesarean section always a caesarean section . Previously everyone used to conduct classical caesarean section , now most of them are performing lower segment caesarean sections . There are several reasons which led to development of VBAC , assessment of scar integrity, fetal well being , improved facilities for emergency caesarean section . Most of the women who have had undergone a caesarean section previously will always complain that they didn't experience vaginal birth . Their might be several complications associated with VBAC , but a multicare hospital setting with all equipment available , there's always a benefit for conducting a TOLAC . **Methods :** The study was a retrospective observational study, carried out in the R L jalappa hospital,kolar. Status of women who had undergone caesarean section in various institutions among them who was in labour and whom had delivered vaginally post caesarean section , this was studied between J JANUARY 2023 and MARCH 2025 after taking exclusion and inclusion criteria into consideration. Following details were noted which included clinical history, examination, investigations and treatments including post delivery ultrasound reports were reviewed and obtained. **Inclusion Criteria:** Women who gave birth to a singleton baby,First birth via cesarean section **Exclusion Criteria:** women who were not willing for trial of labour after caesarean section **Results :** These 23 cases who had VBAC in RL JALAPPA hospital from January 2024 to March 2025 , out of 23, 13 were preterm VBAC , which were induced with foleys and syntocin augumented, and delivered more than 1 kgs baby weight.one case was delivered using forceps . A 31 weeks 4 days gestation with DCDA twin gestation with RH negative pregnancy has delivered through VBAC, on arrival she was already in active stage of labour , she delivered twins through VBAC. The other 10 cases were term pregnancies with previous lscs who had a VBAC , among these one case has a vaccum assisted VBAC , one case has an assisted breech delivery, one case was previous caesarean section followed by 2 VBAC deliveries, she had a 3 rd VBAC delivery by oxytocin augumentation. Irrespective of the gestation we have induced and augumented some cases and conducted VBAC, the other cases were left for spontaneous progression and then conducted VBAC. Giving TRIAL OF LABOUR even in cases with medical disorders in pregnancy can be considered, out of these 23 cases 4 were preeclampsia cases which were delivered through VBAC. In all these cases post delivery uterine contour has been maintained, no complications noted , vitals were stable throughout. **Conclusion:** TRIAL OF LABOUR , as an option to be given for all previous one caesarean section women , except who had classical caesarean section previously. Maternal and fetal risks and complications and outcomes associated with VBAC should be clearly explained to them . Once the parents have opted for the type of delivery they chose , it should be documented properly.If the patient is admitted and plan was for spontaneous progression of labour , proper evaluation to be done by the obstetrician , and continuous fetomaternal monitoring to be done . If one notices failure to progress by more than 1 cm per hour dilatation over 4 hours , and no decent of head for more than 60 mins , alternative delivery procedures can be considered (6) .

KEYWORDS

VBAC , Previous caesarean section ,trial of labour , post partum

INTRODUCTION

Vaginal birth after cesarean section (VBAC) is one of the strategies developed to control the rising rate of cesarean sections (CSs). It is a trial of vaginal delivery in selected cases of a previous CS in a well-equipped hospital [1]. Previously there was a dictim saying once a caesarean section always a caesarean section. Previously everyone used to conduct classical caesarean section, now most of them are performing lower segment caesarean sections. There are several reasons which led to development of VBAC, assessment of scar integrity, fetal well being , improved facilities for emergency caesarean section . Most of the women who have had undergone a caesarean section previously will always complain that they didn't experience vaginal birth . Their might be several complications associated with VBAC , but a multicare hospital setting with all equipment available, there's always a benefit for conducting a TOLAC.

Repeat caesarean sections increase the possibility of maternal morbidity, the need for a trial of labor after caesarean delivery is gaining more ground in selected cases [2]. Some of the high risks posed by caesarean section are: anesthesia risks, excess bleeding, blood transfusion, adjoining organ injury, neonatal respiratory distress syndrome, infections, repeated caesareans and related risks (placenta accreta spectrum (PAS), rupturing of the uterus, intra-abdominal adhesion) [2] . Maternal mortality for Elective repeat caesarean section (ERCS) is higher than for TOLAC (0.013 vs. 0,004%). On the contrary, perinatal mortality is significantly increased for TOLAC (0.13 vs. 0.05% for ERCD) [3]. VBAC can be a safe option for women with a history of a single LSCS, provided there are no contraindications [4]. Some of the advantages of VBAC are no abdominal surgery , shorter recovery period , low risk of infection , less blood loss [5]

MATERIALS & METHODS

The study was a retrospective observational study, carried out in the R L jalappa hospital,kolar. Status of women who had undergone caesarean section in various institutions among them who was in labour and whom had delivered vaginally post caesarean section , this was studied between J JANUARY 2023 and MARCH 2025 after taking exclusion and inclusion criteria into consideration. Following details were noted which included clinical history, examination, investigations and treatments including post delivery ultrasound reports were reviewed and obtained.

Inclusion Criteria:

- Women who gave birth to a singleton baby
- First birth via cesarean section

Exclusion Criteria:

Women who were not willing for trial of labour after caesarean section

Objective

To study the fetomaternal outcome in cases of vaginal birth after caesarean section

Case Series

Case -1 : A 25 year old G3 P2 L2 with 38 weeks 6 days gestation with cephalic presentation with previous two caesarean sections with hypothyroidism in active stage of labour with intrauterine fetal demise , vitals were table on the time of admission, investigations were sent and reported as normal , on per abdomen examination- uterus term size , cephalic presentation, 3C/35"/10' , fhr could not be localised with stethoscope, obstetric scan showing IUD , on per vaginal examination , cervix 7 cm dilated , 0.5 cm long cervix , soft , mid position , ppvx at 0 station with bulging bag of membranes . She had full term vaginal delivery after caesarean section , She had a single dead female baby of birth weight 2.62 kgs at 7:05 AM on 5/3/2025. Lactation suppression

advised.Post delivery vitals were stable , uterine counter maintained confirmed from scan report . Puerperium period was uneventful.

Case -2

A 20 year old G2 P1L1 with 36 weeks 3 days gestation with cephalic presentation with previous caesarean section with preeclampsia in active labour .vitals were stable on the time of admission, investigations were sent and reported as normal , on per abdomen examination- uterus term size , cephalic presentation, 2C/35"/10' , fhr could not be localised with stethoscope, obstetric scan showing IUD , on per vaginal examination , cervix 6 cm dilated , 1 cm long cervix , soft , mid position , ppvx at 0 station with bulging bag of membranes . She had full term vaginal delivery after caesarean section , She had a single dead male baby of birth weight 2.04 kgs at 10:50 PM on 9/3/2025. Post delivery vitals were stable , uterine counter maintained confirmed from scan report .Lactation suppression advised. Puerperium period was uneventful. Patient was started on antihypertensives and tapered accordingly .

Case -3

A 20 year old G3 P1 L1 A1 with 39 weeks 2 days gestation with cephalic presentation with previous caesarean section in active labour . vitals were table on the time of admission, investigations were sent and reported as normal , on per abdomen examination- uterus term size, cephalic presentation, 3C/30"/10', fhr present, on per vaginal examination , cervix 7cm dilated , well effaced , ppvx at 0 station with bulging bag of membranes . She had full term vaginal delivery after caesarean section , She had a single live female baby of birth weight 2.94 kgs at 4:55AM on 13/3/2025. Baby cried immediately after birth , baby shifted to mothers side , exclusive breast feeding initiated , baby shifted to mothers side. Post delivery vitals were stable , uterine counter maintained confirmed from scan report . Puerperium period was uneventful.

Case -4

A 34 year old G3 P2 L1 D1 with 35 weeks 5 days gestation with cephalic presentation with cephalic presentation with previous two caesarean sections with hypothyroidism, vitals were table on the time of admission, investigations were sent and reported as normal , on per abdomen examination- uterus 35 weeks size , cephalic presentation, relaxed , fhr present , on per vaginal examination cervix uneffaced , os closed . on obstetric scan baby had growth lag of 4 weeks , with Doppler changes reverse end diastolic flow . She foleys induced , syntocin augumented preterm vaginal delivery after caesarean section , She had a dead female baby of birth weight 1.94 kgs at 6:35 PM on 18/3/2025. Lactation suppression advised. Post delivery vitals were stable , uterine counter maintained confirmed from scan report . Puerperium period was uneventful.

Case -5

A 34 year old G2P1L1 with 32 weeks 6 days gestation with cephalic presentation with previous caesarean section in preterm labour with gestational diabetes mellitus, vitals were stable on the time of admission, investigations were sent and reported as normal, on per abdomen examination- uterus 32 weeks size, cephalic presentation, 2C/15"/10', fhr present, on per vaginal examination cervix 4 cm dilated , 50% effaced , membranes present , ppvx 0 station, she was left for spontaneous progression of labour, she had forceps assisted preterm vaginal delivery after caesarean section , she had a male baby of birth weight 2.30 kgs at 2:29 pm on 21/7/2024.APGAR of 1,7/10 and 5'9/10 . Baby shifted to NICU in view of respiratory distress and preterm care, baby given mothers side on post natal day 3, Post delivery vitals were stable , uterine counter maintained confirmed from scan report . Puerperium period was uneventful.

Case -6

A 30 year old G2 P1 L1 with 31 weeks 4 days gestation with dichorionic diamniotic twin gestation with previous caesarean section with 1 st twin in cephalic presentation with RH negative pregnancy in active labour, vitals were table on the time of admission, investigations were sent and reported as normal, on per abdomen examination- uterus 36weeks size, cephalic presentation, 3C/20"/10' , fhr present both twins, on per vaginal examination cervix 6cm dilated , well effaced, membranes present, ppvx 0 station, she had preterm vaginal delivery after caesarean section , she had twin A , female baby of birth weight 1.22 kgs at 1 pm on 22/10/2024 , baby cried immediately after birth , APGAR of 1' 6/10 , 5' 8/10 , twin B of 920 gms at 1:05 pm , female baby , baby cried immediately after birth APGAR of 1'6/10 and 5'8/10 , both babies shifted to NICU in view of preterm and low birth weight care , Post delivery vitals were stable , uterine counter maintained confirmed from scan report. Puerperium period was uneventful.both twins shifted to mothers side on post natal day 20,And day 24.

Case -7

A 28 year old G2 P1 L1 with 36 weeks 6 days gestation with cephalic presentation with previous caesarean section in second stage of labour with status post VSD closure, vitals were table on the time of admission, investigations were sent and reported as normal, on per abdomen examination- uterus term size, cephalic presentation, 3C/30"/10', fhr present, on per vaginal examination, cervix 7cm dilated, well effaced, ppvx at 0 station with bulging bag of membranes. she had vaginal delivery after caesarean section , she had a female baby of birth weight 2.46 kgs, at 3:55 AM on 30/10/2024 , baby cried immediately after birth, APGAR of 1'7/10 and 5'9/10, baby shifted to mothers side. Post delivery vitals were stable, uterine counter maintained confirmed from scan report. Puerperium period was uneventful, cardiologist opinion was taken and there was nil intervention from their side .

Case -8

A 25 year old G3 P2 L2 with 28weeks 1 day gestation with previous two caesarean sections with intrauterine fetal demise , vitals were table on the time of admission, investigations were sent and reported as normal, on per abdomen examination- uterus 24 weeks , cephalic presentation, fhr couldn't be localised, relaxed , pv- uneffaced, os closed , she had foleys induced syntocin augumented vaginal delivery of a single dead female baby of birth weight 1 kgs, at 2 pm, 5/2/2025, Post delivery vitals were stable , uterine counter maintained confirmed from scan report. Puerperium period was uneventful.

Case -9

A 30 year old G6P3L3 A2 With 39 weeks gestation with cephalic presentation with previous lscs with previous 2 VBAC in latent labour, vitals were table on the time of admission, investigations were sent and reported as normal, on per abdomen examination- uterus term size , cephalic presentation, 2C/15"/10', fhr present, on per vaginal examination cervix 3 cm dilated, 50% effaced, membranes present , ppvx 0 station, she had syntocin augumented vaginal delivery of a single single live female baby of birth weight 2.96 kgs at 4:04 pm on 28/10/2025, baby cried immediately after birth , APGAR of 1'7/10 and 5'9/10 , baby shifted mothers Side , Post delivery vitals were stable, uterine counter maintained confirmed from scan report. Puerperium period was uneventful. She was advices for tubectomy.

Case -10

A 26 year old G3 P2 L2 with 29 weeks 2 days gestation with previous two lscs with intrauterine fetal demise with RH negative pregnancy, on arrival vitals were stable, investigations sent and reported normal, ICT-negative. on per abdomen examination- uterus 30 weeks size, cephalic presentation, relaxed, fhr could not be localised with stethoscope, obstetric scan showing IUD, on per vaginal examination - cervix uneffaced, os closed, she had foleys induced syntocin augumented vaginal delivery of a dead male baby of birth weight 1.02 kgs at 1:45 pm on 22/1/2025, Post delivery vitals were stable, uterine counter maintained confirmed from scan report. Puerperium period was uneventful. She was advices for tubectomy. Inj ANTI D 300 mcg given.

Case -11

A 22 year old G3 P1 L1 A1 with 34 weeks 6 days gestation with previous caesarean section with intrauterine fetal demise, on arrival vitals were stable , investigations sent and reported normal, on per abdomen examination- uterus 34 weeks size, cephalic presentation, relaxed, fhr could not be localised with stethoscope, obstetric scan showing IUD, on per vaginal examination - cervix uneffaced , os closed, she had foleys induced vaginal delivery after caesarean section, she had a dead female baby of weight 1.09 kgs at 4:30 AM on 10/1/2025, Post delivery vitals were stable, uterine counter maintained confirmed from scan report. Puerperium period was uneventful.

Case -12

A 20 year old G2 P1 L 1 with 37 weeks 3 days gestation with cephalic presentation with previous caesarean section in active stage of labour, vitals were table on the time of admission, investigations were sent and reported as normal , on per abdomen examination- uterus term size, cephalic presentation, 3C/15"/10', fhr present, on per vaginal

examination cervix 6 cm dilated , 50% effaced , membranes present , ppvx 0 station,she had vaginal birth after caesarean section of a single live term female baby of birth weight 2.72 kgs at 12:07 AM on 8/1/2025, baby cried immediately after birth , APGAR of 1'7/10 , 5'9/10, baby shifted to mothers side , Post delivery vitals were stable , uterine counter maintained confirmed from scan report . Puerperium period was uneventful.

Case -13

A 28 year old G5P1L1A3 with 29 weeks 5 days gestation with previous caesarean section with preeclampsia in second stage of labour, vitals were table on the time of admission, investigations were sent and reported as normal, on per abdomen examination- uterus 30 size, cephalic presentation, 3C/15"/10', fhr present, on per vaginal examination cervix fully dilated , fully effaced , membranes present, ppvx 0 station,she had vaginal birth after caesarean section of a single live preterm male baby of birth weight 1 kgs at 7:12 pm on 4/1/2025, baby cried immediately after birth , APGAR of 1'6/10 and 5' 8/10, baby shifted to NICU in view of low birth weight and preterm care, baby shifted to mothers side on post natal day 25 , Post delivery vitals were stable, uterine counter maintained confirmed from scan report. Puerperium period was uneventful.

Case -14

A 30 year old G3 P2 L2 with term gestation with footling presentation with previous caesarean section in active labour , vitals were table on the time of admission, investigations were sent and reported as normal, on per abdomen examination-uterus term size, cephalic presentation, 3C/35"/10' , fhr present, on per vaginal examination cervix 8 cm dilated , well effaced , membranes present , ppvx 0 station,she had assisted breech delivery of vaginal birth after caesarean section , she had a female baby of birth weight 2.82kgs , 4:22pm on 17/3/2025, baby cried immediately after birth , APGAR of 1'7/10 and 5'9/10 , baby shifted to NICU for observation, Post delivery vitals were stable , uterine counter maintained confirmed from scan report . Puerperium period was uneventful.

Case -15

A 23 year old G2 P1 L1 with 30 weeks 2 days gestation with previous Caesarean section with severe preeclampsia with IUGR with oligohydromnios with hypothyroidism with moderate anaemia , vitals were stable on the time of admission, investigations were sent and reported as normal , on per abdomen examination- uterus 30 weeks size , cephalic presentation, relaxed , fhr present , on per vaginal examination cervix uneffaced , os closed .she had foleys induced syntocin augumented vaginal delivery of a preterm female baby of birth weight 1 kg at 6:13 AM , 27/3/2024,baby intubated , shifted to NICU for post resuscitation care , APGAR 1'4/10 and 5' 6/10. Baby shifted to mothers side on post natal day 37 , Post delivery vitals were stable , uterine counter maintained confirmed from scan report . Puerperium period was uneventful.

Case -16

A 21 year old G3 P1L1 A1 with 38 weeks 2 days gestation with cephalic presentation with previous caesarean section in active stage of labour , vitals were table on the time of admission, investigations were sent and reported as normal , on per abdomen examination- uterus term size , cephalic presentation, 3C/15"/10' , fhr present , on per vaginal examination cervix 6 cm dilated , 50% effaced , membranes present , ppvx 0 station,she had vaginal birth after caesarean section of a single live term female baby of birth weight 2.8 kgs , at 7:30 am on 3/4/2024, baby cried immediately after birth , APGAR of 1'7/10 and 5'9/10 , baby shifted to mothers side , Post delivery vitals were stable , uterine counter maintained confirmed from scan report . Puerperium period was uneventful.

Case - 17

A 30 year old G3 P2 L2 with 38 weeks 2 days gestation with cephalic presentation with previous caesarean section in second stage of labour with moderate anaemia , vitals were table on the time of admission, investigations were sent and reported as normal , on per abdomen examination- uterus term size , cephalic presentation, 3C/15"/10' , fhr present , on per vaginal examination cervix fully dilated , fully effaced , membranes present , ppvx 0 station,she had vaginal birth after caesarean section of a single live term male baby of birth weight 2.68 kgs at 1:30 am on 4/4/2024 , baby cried immediately after birth , APGAR of 1'7/10 and 5'9/10 , baby shifted to mothers side , one unit prbc was transfused Post delivery vitals were stable , uterine counter maintained confirmed from scan report . Puerperium period was uneventful.

Case -18

A 31 year old G2 P1L2 with 40 weeks 1 day gestation with cephalic presentation with previous caesarean section in active labour , vitals were stable on the time of admission, investigations were sent and reported as normal , on per abdomen examination- uterus term size , cephalic presentation, 3C/15"/10' , fhr present , on per vaginal examination cervix fully dilated , fully effaced , membranes present , ppvx 0 station,she had vacuum assisted vaginal birth after caesarean section of a single live term female baby of birth weight 2.66kgs at 9:13 AM ON 16/4/2024 , baby cried immediately after birth , APGAR of 1'7/10 and 5'9/10 , baby shifted to mothers side , one unit prbc was transfused Post delivery vitals were stable , uterine counter maintained confirmed from scan report . Puerperium period was uneventful.

Case -19

A 28 year old G2 P1 L1 with 42 weeks 2 days gestation with cephalic presentation with previous caesarean section in latent labour with hypothyroidism, vitals were stable on the time of admission, investigations were sent and reported as normal , on per abdomen examination- uterus term size , cephalic presentation, 3C/15"/10' , fhr present , on per vaginal examination cervix 4 dilated , well effaced , membranes present , ppvx 0 station,she had vaginal birth after caesarean section of a single live term female baby of birth weight 2.32 kgs at 11:36 am , on 17/4/2024 , baby cried immediately after birth , APGAR of 1'7/10 and 5'9/10 , baby shifted to mothers side , Post delivery vitals were stable , uterine counter maintained confirmed from scan report . Puerperium period was uneventful.

Case -20

A 26 year old G3 P1L1A1 with 36 weeks 5 days of gestation with cephalic presentation with previous Caesarean section with pprom more than 4 hours prior to admission with morbid obesity , vitals were stable on the time of admission, investigations were sent and reported as normal , on per abdomen examination- uterus term size , cephalic presentation, 3C/15"/10' , fhr present , on per vaginal examination cervix 8 dilated , well effaced , membranes present , ppvx 0 station,she had preterm vaginal birth after caesarean section of a single live term male baby of birth weight 2.94 kgs at 12:32 am on 21/4/024 .baby cried immediately after birth , APGAR of 1'7/10 and 5'9/10 , baby shifted to mothers side , Post delivery vitals were stable , uterine counter maintained confirmed from scan report . Puerperium period was uneventful.

Case -21

A 20 year oldG2 P1 L1 with 29 weeks 5 days gestation with cephalic presentation with previous caesarean section in preterm labour , vitals were stable on the time of admission, investigations were sent and reported as normal , on per abdomen examination- uterus 30 weeks size , cephalic presentation, 3C/15"/10' , fhr present , on per vaginal examination cervix 8 dilated , well effaced , membranes present , ppvx 0 station,she had preterm vaginal birth after caesarean section of a single live preterm female baby of birth weight 1.3 kgs at 8:43 pm on 22/4/2024 , baby cried immediately after birth , APGAR of 1'7/10 and 5'9/10 , baby shifted to NICU in view of preterm care , Post delivery vitals were stable , uterine counter maintained confirmed from scan report . Puerperium period was uneventful.

Case -22

A 26 year old G3 P1L1 A1 with 25 weeks 4 days gestation with previous caesarean section with imminent eclampsia with intrauterine fetal demise, vitals were stable on the time of admission, investigations were sent and reported as normal , on per abdomen examination- uterus 24 weeks size , cephalic presentation, 2C/35"/10' , fhr could not be localised with stethoscope, obstetric scan showing IUD , on per vaginal examination, cervix uneffaced , os closed . She had foleys induced syntocin augumented assisted breech preterm vaginal delivery after caesarean section, She had a single dead female baby of birth weight 790gms at 3:30 PM on 26/4/2024. Post delivery vitals were stable, uterine counter maintained confirmed from scan report. Lactation suppression advised. Puerperium period was uneventful. Patient was started on antihypertensives and tapered accordingly .

Case - 23

A 23 year old G2 P1 D1 with 38 weeks 6 days gestation with cephalic presentation with previous caesarean section with severe preeclampsia

in active labour , vitals were stable on the time of admission, investigations were sent and reported as normal , on per abdomen examination- uterus term size , cephalic presentation, 3C/35"/10' , fhr present , on per vaginal examination cervix 6 dilated , well effaced , membranes present , ppvx 0 station,she had vaginal birth after caesarean section of a single live term female baby of birth weight 2.40 kgs at 8:18 pm on 29/4/2024, Post delivery vitals were stable , uterine counter maintained confirmed from scan report . Puerperium period was uneventful.

RESULTS :

These 23 cases who had VBAC in RL JALAPPA hospital from January 2024 to March 2025 , out of 23, 13 were preterm VBAC , which were induced with foleys and syntocin augumented, and delivered more than 1 kgs baby weight.one case was delivered using forceps . A 31 weeks 4 days gestation with DCDA twin gestation with RH negative pregnancy has delivered through VBAC, on arrival she was already in active stage of labour , she delivered twins through VBAC. The other 10 cases were term pregnancies with previous lscs who had a VBAC , among these one case has a vaccum assisted VBAC , one case has an assisted breech delivery, one case was previous caesarean section followed by 2 VBAC deliveries, she had a 3 rd VBAC delivery by oxytocin augumentation. Irrespective of the gestation we have induced and augumented some cases and conducted VBAC, the other cases were left for spontaneous progression and then conducted VBAC. Giving TRIAL OF LABOUR even in cases with medical disorders in pregnancy can be considered, out of these 23 cases 4 were preeclampsia cases which were delivered through VBAC. In all these cases post delivery uterine countour has been maintained, no complications noted , vitals were stable throughout.

CONCLUSION: TRIAL OF LABOUR , as an option to be given for all previous one caesarean section women , except who had classical caesarean section previously. Maternal and fetal risks and complications and outcomes associated with VBAC should be clearly explained to them . Once the parents have opted for the type of delivery they chose , it should be documented properly.If the patient is admitted and plan was for spontaneous progression of labour , proper evaluation to be done by the obstetrician , and continuous fetomaternal monitoring to be done . If one notices failure to progress by more than 1 cm per hour dilatation over 4 hours , and no decent of head for more than 60 mins , alternative delivery procedures can be considered [6] .

DISCUSSION:

The success for VBAC always depends on the reason for the previous caesarean section , higher sucess rates are noticed when caesarean was performed for a non recurring cause , such as breech presentation, fetal distress will have a better success rate in comparision . Epidural anaesthesia to be considered when the pregnant women reaches active phase , which will again show a higher success rate . Previous VBAC history also favours high chance of VBAC second time also . The risk of uterine rupture should always kept in mind ,the risks of bladder injury , risk of haemorrhage should always be kept in mind with previous caesarean section. Risk of placenta Previa, placenta acreta , abruptio placenta and ectopic pregnancy should always be considered as a potential risk factors . VBAC is not advisable in cases of cephalopelvic disproportionate as the risk of failure rate is more . VBAC is not advisable in cases with medical disorders in pregnancy[7]. Vaginal birth subsequent to cesarean section trial of labor should be conducted in hospitals, with adequate facilities for immediate delivery and resuscitation of the newborn as well as high quality care is available[8].

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