Patients Undergoing Normal Birth After a Previous Cesarean Section in a Birth House

RESUMO

OBJETIVO: analisar a viabilidade de partos normais com histórico de uma cesárea prévia, realizados por enfermeiras obstetras em uma casa de parto do Distrito Federal e suas consequências para parturientes e neonatos. MÉTODO: estudo descritivo, exploratório, com abordagem quantitativa e busca de dados retrospectivos de puérperas com histórico de uma cesárea prévia, que foram internadas na Casa de Parto de São Sebastião, para assistência ao parto normal de risco habitual, durante o período de julho de 2020 a julho de 2023. A coleta de dados se deu através de questionário estruturado do perfil obstétrico das pacientes respondido através da análise dos prontuários. RESULTADOS: participaram 39 pacientes, das quais apenas 03 apresentaram intercorrências. Dessas, 5,13% foram relacionadas a hemorragia pós-parto e 2,56% foram casos de distócia de ombros. CONCLUSÃO: as Casas de Partos se apresentam como uma forma segura para a assistência ao parto normal assistidos por enfermeiras obstetras, em pacientes que apresentam histórico de uma cesárea prévia.
DESCRITORES: nascimento vaginal após cesárea; centros de assistência à gravidez e ao parto; enfermagem obstétrica; parto normal.

ABSTRACT

OBJECTIVE: To analyze the feasibility of vaginal births with a history of one previous cesarean section, performed by nurse-midwives in a birth center in the Federal District, and their outcomes for mothers and newborns. METHOD: A descriptive, exploratory study with a quantitative approach and retrospective data collection from postpartum women with a history of one previous cesarean section, who were admitted to the São Sebastião Birth Center for routine-risk vaginal birth assistance between July 2020 and July 2023. Data were collected through a structured questionnaire on the patients' obstetric profiles, completed via medical record analysis. RESULTS: A total of 39 patients participated, of whom only 3 experienced complications. Of these, 5.13% were related to postpartum hemorrhage and 2.56% were cases of shoulder dystocia. CONCLUSION: Birth centers represent a safe option for providing vaginal birth care by nurse-midwives to patients with a history of one previous cesarean section.
KEYWORDS: vaginal birth after cesarean; maternity and childbirth centers; obstetric nursing; normal labor.

RESUMEN

OBJETIVO: Analizar la viabilidad de partos vaginales en mujeres con antecedente de una cesárea previa, realizados por enfermeras obstétricas en una casa de parto del Distrito Federal, y sus consecuencias para las parturientas y los recién nacidos. MÉTODO: Estudio descriptivo, exploratorio, con enfoque cuantitativo y recolección retrospectiva de datos de puérperas con antecedente de una cesárea previa, que fueron internadas en la Casa de Parto de São Sebastião para la atención de parto vaginal de riesgo habitual, durante el período de julio de 2020 a julio de 2023. La recolección de datos se realizó mediante un cuestionario estructurado sobre el perfil obstétrico de las pacientes, respondido a través del análisis de historias clínicas. RESULTADOS: Participaron 39 pacientes, de las cuales solo 3 presentaron complicaciones. De estas, el 5,13% estuvieron relacionadas con hemorragia posparto y el 2,56% fueron casos de distocia de hombros. CONCLUSIÓN: Las casas de parto se presentan como una opción segura para la atención del parto vaginal asistido por enfermeras obstétricas en pacientes con antecedente de una cesárea previa.
DESCRIPTORES: parto vaginal después de cesárea; centros de atención al embarazo y parto; enfermería obstétrica; parto normal.

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INTRODUCTION

The childbirth care model in Brazil is marked by the excessive use of obstetric and neonatal interference. Improving the quality of obstetric care, particularly in labor and birth care, with the consequent reduction in maternal morbidity and mortality, is one of the obstacles of the Sustainable Development Goals (SDGs) for the years

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2016 to 2030.Clinical practice based on scientific evidence, grounded in the latest research, has been identified as an effective strategy to ensure patient care and safety, contributing to improving the quality of obstetric care.[1]

The rise in caesarean section rates has alarmed scientists, public policy makers and health workers, as the procedure is associated with negative consequences for parturients and their newborns, as these women may have a higher risk of morbidity and mortality, of having other children with prematurity and the chance of developing placental abnormalities in future pregnancies.(2)

The increase in cesarean sections in Brazil and around the world has a history of previous cesarean sections as a determining factor; However, VBAC, the acronym for "Vaginal Birth After Cesarean", which in Portuguese means "vaginal birth after cesarean", has shown low rates of complications, corroborating systematic reviews that indicate the viability of VBAC, since exposure to elective cesarean section according to the Ministry of Health (MS) is only indicated when there has been more than one previous cesarean section or in situations of absolute contraindication for vaginal delivery.[3]

The World Health Organization (WHO) points out that caesarean sections of between 10 and 15% do not help to reduce maternal and perinatal morbidity and mortality. C-sections without a clinical recommendation negatively affect maternal and neonatal health outcomes, causing the death of the couple, an increase in hysterectomies, a greater need for blood transfusions, an increase in postpartum bleeding, problems related to anesthesia and shock, and can also cause complications in subsequent pregnancies, due to placental changes and uterine rupture. Complications for the newborn also include breathing difficulties and admission to the intensive care unit (ICU).[4]

Public and private hospitals in Brazil are constantly striving to reduce the high incidence of cesarean births. In 2015, the Parto adequado project was set up, supported by various private institutions and public institutions such as the Ministry of Health (MS) and the National Health Agency (ANS), aimed at measures such as: improving the quality of care and safety in childbirth, new scientific and innovative methods of care, family participation and valuing the autonomy of pregnant women and the natural evolution of childbirth.[5]

Vaginal delivery should be encouraged because of its wide-ranging benefits, such as faster recovery, less chance of risks in future pregnancies and less chance of childhood diseases, including obesity, asthma and allergies.[6] According to the literature, parturients who undergo vaginal delivery after a previous cesarean section have an instant recovery after delivery and report less pain in the puerperium, leading to a decision to make a healthier choice for the mother and the newborn.[7]

Pregnant women at normal risk have the option of delivering their babies in Normal Birth Centers (CPN), where they will be assisted autonomously by obstetric nurses/obstetricians. Birth centers work in collaboration with a referral hospital, where obstetricians, anesthesiologists and neonatologists are available to provide support for complications involving the removal of the binomial, when necessary. [8]

The work of obstetricians and midwives in Birth Centers and/or Normal Birth Centers is regulated by COFEN Resolution No. 0478/2015, Article 3 of which outlines the duties of these professionals. Among them is the assessment of all maternal health conditions (clinical and obstetric), as well as those of the fetus; promotion of a model of care focused on women, labor and birth and the promotion of an environment conducive to physiologically evolving labor and birth; as well as adopting practices based on scientific evidence, when referring women and/or newborns to a more complex level of care if complications or risk factors are observed that justify such transportation, and also guaranteeing comprehensive care for women and newborns through the articulation of points of care, taking into account the health care network.[9]

The Centro de Parto Normal de São Sebastião (CPNSS), known as the Casa de Parto de São Sebastião, is recognized by the Ministry of Health as a peri-hospital CPN.[10] The peri-hospital unit, called Centro de Parto Normal (CPNp), offers assistance to pregnant women at normal risk during labour, delivery and the puerperium. The facility is considered a reference model for humanized childbirth care in the Federal District, and care is provided by referral or spontaneous demand. Located in São Sebastião-DF, it was created in 2001 and since 2009 care has been provided exclusively by the nursing team (obstetric nurses and nursing technicians), with the aim of offering humanized care in normal childbirth with a focus on parturients and newborns based on the guidelines of the Stork Network.[11]

In 2020, during the COVID-19 pandemic, the CPNSS expanded its protocol for admitting parturients to make it feasible to admit pregnant women at usual risk with a history of a previous caesarean section. The latter, until then, was a factor in the exclusion of parturients from the CPNSS, but during the COVID-19 pandemic and given the lethality of the virus in pregnant women, who were considered a risk group, it was concluded that the CPNSS was safer for the delivery of patients with a previous cesarean section than exposing these healthy patients to a hospital environment with free circulation of the coronavirus.

In view of the above, the question arises: is it safe to assist normal childbirth in a birthing center for patients with an obstetric history of a previous

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cesarean section? Therefore, this study aims to analyze the feasibility of normal deliveries with a history of a previous cesarean section, performed by obstetric nurses in a birthing center in the Federal District and its consequences for parturients and newborns.

METHOD

This is an observational study with a descriptive design and exploratory approach, based on retrospective data. The methodological structure followed the recommendations of the STROBE (Strengthening the Reporting of Observational Studies in Epidemiology) checklist, which guides the conduct and reporting of observational studies, ensuring greater scientific rigor and transparency.

The participants in the study were puerperal women with a history of one previous caesarean section who had been admitted to the CPNSS for normal-risk childbirth. The exclusion criteria were: high-risk pregnancy, a history of more than one previous caesarean section and minors.

This study used a structured questionnaire and analysis of medical records as a data collection tool. Firstly, 60 medical records were analyzed, covering a period of 4 years, from July 2020 to July 2023. Of this total, 39 medical records were selected for the study as they met the inclusion criteria. The survey instrument included data on socio-demographic and obstetric characteristics, such as age, parity, gestational age, as well as information on prenatal care, including the number of visits.

Data was also collected on childbirth and postpartum, information on interventions made by health professionals and complications in labor and puerperium, among others.

The data was collected after approval by the Research Ethics Committee (CEP), according to opinion no. 7.128.769, linked to Certificate of Submission for Ethical Appraisal (CAAE) no. 83112424.7.0000.5553. The data was organized in spreadsheets and analyzed using simple descriptive statistics, with absolute and relative frequencies, using Microsoft Excel.

RESULTS

Of the 39 medical records analyzed, the vast majority of patients were between 25 and 29 years old, showing a peak in this category. On the other hand, patients aged between 30 and 34 and those aged 35 or over showed an identical distribution, with 23.08% each. The lowest proportion was found among patients aged 20 to 24. This analysis reveals a diverse age distribution, with a predominance in the 25-29 age group, followed by an even split between the 30-34 and 35+ age groups.

With regard to gestational age, all were between 38 and 41 weeks; 39 weeks was the most prevalent, accounting for more than a third of cases, followed by 40 weeks and 38 weeks, with the same number of cases, and 41 weeks, with the smallest proportion, as shown in Table 1.

The distribution of the number of pregnancies among the patients was as follows: 10.26% had five pregnancies, 12.82% had four, 30.77% had three and 43.59% had two. It is important to note that all the patients had a history of a previous caesarean section.

Analysis of the number of prenatal consultations revealed that only 10.26% of patients had up to 6 consultations, while the vast majority (89.74%) had more than 6 prenatal consultations.

The results of the rapid HIV tests were all non-reactive. There was one reactive test for syphilis. These data are shown in Table 1.

Table 1: Demographic and Clinical Characteristics of Patients Delivering at the São Sebastião Birth Center, DF (2025) - N=39.

		Quantity	%
Age	20-24 years	7	17,95
	25-29 years	14	35,90
	30-34 years	9	23,08
	≥35 years	9	23,08
Gestational age	38 weeks	11	28,21
	39 weeks	15	38,46
	40 weeks	11	28,21
	41 weeks	02	5,13
N° of consultations	≤6 appointments	04	10,26
	>6 appointments	35	89,74
Parity	G2	17	43,59
	G3	12	30,77
	G4	05	12,82
	G5	04	10,26
Negative Rapid Tests	Syphilis	38	97,44
	HIV	39	100
Total			100%

Source: author (2025).

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With regard to the period of ruptured membranes, more than half of the patients had less than two hours, followed by those with more than four hours of ruptured membranes until delivery. Table 2 shows the information collected from the sample.

Table 2: Rota Bag Time: Data from the São Sebastião Birth Center, DF (2025).

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Category	Average (minutes and hours)	N° of cases	%
Rota Scholarship	≥00:00 hours and < 02:00 hours	23	58,97
	≥2h and <4h	4	10,26
	≥4h	12	30,77
Total		39	100%

Source: author (2025).

The use of oxytocin during the expulsion period did not prove necessary in any of the patients.

During the expulsion period, the patients used five different birthing positions: stool, four-legged, lateral decubitus, semi-sitting, lithotomy and others. The vertical and lateralized positions prevailed, corresponding to a total of 82.05%. Horizontalized and other positions accounted for less than a fifth of patients' choices.

With regard to lacerations, 71.79% of the patients had some degree of laceration, while 28.21% had no laceration. The prevalence of grade II lacerations was the most common, as shown in Table 3.

Table 3: Use of Oxytocin, Position and Lacerations, Dequitation in Childbirth: Analysis of the São Sebastião Birth Center, DF (2025).

Variable		Quantity	%
Use of Oxytocin in the expulsion period	Yes	0	0
	No	39	100
Childbirth positions	Stool	13	33,33
	Four supports	10	25,64
	Lateral position	09	23,08
	Semi-sitting	05	12,82
	Lithotomy	01	2,56
	Other	01	2,56
Lacerations	Yes	28	71,79
	No	11	28,21
Degree of laceration	I	11	28,21
	II	16	41,03
	III and IV	1	2,56
Discharge time	< 30 minutes	39	100
Total		39	100%

Source: author (2025).

During labor and the immediate postpartum period, the following complications occurred: postpartum hemorrhage (n=2) and shoulder distortion (n=1), which corresponded to only 7.69% of the total 39 medical records analyzed. Only 3 patients required transfer to tertiary care due to complications such as lacerations, neonatal jaundice and postpartum hemorrhage. The vast majority did not require additional specialized care, as shown in Table 4.

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Table 4: Obstetric complications and referrals: Casa de Parto São Sebastião, DF (2025).

Criteria	Types	N° of Cases	%
Intercurrences	Shoulder dystocia	01	2,56
	Bleeding postpartum	02	5,13
	No complications	36	92,31
Removal	Yes	3	7,69
	No	36	92,31
Reason for removal	Jaundice	1	33,3
	Postpartum hemorrhage	1	33,3
	Laceration	1	33,3
Total			100%

Source: author (2025).

After birth, all the newborns (NB) had an Apgar score greater than or equal to 7 in the fifth minute. Almost all of them had skin-to-skin contact throughout the first hour of life and only 1 newborn remained with the mother for less than 1 hour after birth.

With regard to breastfeeding, of the 39 medical records analyzed, 05 had no information on this item. Approximately three quarters of the patients breastfed in the first hour of life (n=29) and 05 newborns were not breastfed during this period. Of the patients who were unable to breastfeed in the first hour, the reasons given were: difficulty in management, the mother's clinical condition and the newborn's clinical condition. The data is compiled in Table 5.

Table 5: Neonatal Health Indicators: Apgar, Skin-to-Skin Contact and Breastfeeding. Casa de Parto São Sebastião, DF (2025).

Indicators	Criteria	Quantity	%
Apgar at the fifth minute	≥7	39	100
	<7	0	0
Skin-to-skin contact in the first hour of life	≥1 hour	38	97,44
	<1 hour	1	2,56
Breastfeeding in the first hour of life	Yes	29	74,36
	No	5	12,82
	Unregistered	5	12,82
Reasons not to start breastfeeding	Clinical condition of the puerperal woman	2	40
	Clinical condition of the newborn	1	20
	Difficulty breastfeeding	2	40
Total		39	100%

Source: author (2025).

DISCUSSION

The study showed that the majority of the sample studied did not have advanced maternal age and the outcomes of patients undergoing normal delivery after a cesarean section were positive for mothers and babies. Corroborating this data, a study carried out in Brazil in 2022 revealed that advanced maternal age, over 35, is a risk factor for maternal and fetal mortality. [12] Another study concluded that patients with advanced maternal age who had a normal delivery after a previous cesarean had a high risk of failure to thrive and uterine rupture. [13] Thus, as observed in this study, maternal age below 35 years can contribute to favorable maternal and fetal outcomes, but there was disagreement regarding failure to progress or risk of uterine rupture, as no patient needed to be transferred for these causes.

Another factor that also contributed to favorable outcomes was the number of prenatal consultations. The Ministry of Health recommends a minimum of six appointments, which should be alternated between nurses and doctors,

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with an earlier start, and the first appointment should be no later than the 12th week of pregnancy.[14] It is therefore clear that proper prenatal care, together with close monitoring, has significant benefits for a safe normal birth after a previous cesarean section.

The majority of pregnancies were at term, with a significantly higher incidence at a gestational age of 39 weeks. The literature shows that patients have greater success in vaginal delivery after a previous cesarean section when they have a gestational age equal to or greater than 39 weeks.[15] Given the findings of the study and the data in the literature, it is possible to infer that patients with a gestational age equal to or greater than 39 weeks may have favorable outcomes for normal delivery after a previous cesarean section.

There are studies which show that the presence of repeated previous caesarean sections is a risk factor for placental incarceration and the formation of placental anomalies which make dequitation difficult or even impossible, due to the presence of repeated uterine scars which lead to local fibrosis.[16] The Casa de Parto de São Sebastião only admits patients with a history of a previous caesarean section, i.e. a previous uterine scar, which minimizes the risk of placental incarceration. In all of the patients analyzed, there was no dequitation lasting longer than 30 minutes. The 2022 National Guideline for Normal Childbirth Care establishes that a dehydration time of up to 30 minutes is considered normal. This period, which occurs between the exit of the newborn and the expulsion of the placenta, has an average duration of between 5 and 6 minutes. However, a time between 10 and 19 minutes is already associated with an increased risk of hemorrhage, and this risk increases progressively with each additional 10 minutes. [17] Gestational age is also pointed out as one of the main factors influencing the duration of dechallenge, with full-term newborns having a shorter period of placental expulsion compared to premature infants.[17] In this way, the dechallenge time observed in the study remained within normal parameters, indicating no complications in placental removal and favoring the success of normal delivery after a previous cesarean section.

The vast majority of patients experienced rupture of the amniotic membrane before the onset of active labor or in the early stages of labor, which had no negative repercussions during labor. Corroborating this finding, one study confirmed that ruptured pouch is related to vaginal delivery after cesarean section as a sign of success, where it is justified by the release of natural prostaglandins, which help labor progress and reduce the chances of abnormalities during labor and ineffective uterine contractions.[18] Thus, the results of this study suggest that rupture of the amniotic membrane may be a factor favoring successful vaginal delivery after cesarean section, corroborating the literature which associates this finding with a positive outcome for patients.

It was also observed that patients with a previous caesarean section who had a normal delivery had a low rate of removal to the referral hospital. Of the reasons given in the study (jaundice, postpartum hemorrhage and laceration complications), only postpartum hemorrhage can be directly associated with the presence of a previous uterine scar. Although there are differences in the literature regarding the risk of bleeding in vaginal delivery after caesarean section, some studies indicate that women with a history of caesarean section may be more likely to require blood transfusion. In addition, hysterectomy is reported more frequently among those who have undergone cesarean section, suggesting that when bleeding episodes occur, they tend to be more severe.[19] In this study, only one case of postpartum hemorrhage was recorded, which reinforces the importance of close monitoring of these patients in the immediate puerperium. Another important etiology of postpartum hemorrhage is placental retention. However, as previously reported, most of the participants maintained a dehydration time within normal parameters, indicating that there were no complications associated with this cause.

Another highlight was the high rate of successful breastfeeding in the first hour of the newborns' lives, which indicates the quality of obstetric care received by the patients. The literature shows that the presence of a companion throughout hospitalization, vaginal delivery assisted by an obstetric nurse and the accreditation of the hospital unit in the Baby-Friendly Hospital Initiative (BFHI) increase the chances of breastfeeding in the first hour of life.[20] An additional study shows that breastfeeding in the first hour brings early interaction between mother and baby, reduced stress for the newborn, regulation of the neonate's breathing and a drop in the neonatal mortality rate. [21] Breastfeeding in the first hour of life is an important indicator of excellence in neonatal care.

The study also revealed that all the newborns had an Apgar score of 7 or more in the fifth minute of life. One study points out that an Apgar score of less than 7 in the fifth minute is an indicator of inadequate conditions of neonatal vitality, indicating a greater possibility of the need for tertiary care. Recent research has reinforced the importance of this prognostic tool in identifying children at risk of hypoxia. In population studies, analysis of the Apgar score in the fifth minute is one of the best tools for assessing the newborn's birth conditions.[22] Thus, there was no association of negative birth outcomes in normal deliveries after a previous caesarean section.

It is worth noting that the use of oxytocin during the expulsive period was

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not necessary in any of the patients. The literature indicates that the use of oxytocin in parturients with a previous caesarean section can increase the risk of uterine rupture. However, the absolute risk of rupture is low and comparable to that observed in patients with a previous cesarean section who go into labor spontaneously.[13] Another study indicates that the risk of uterine rupture is higher when prostaglandins and oxytocin are used together.[23] The parturients in this study went into labor spontaneously, without the need for induction or the use of medication, and had a natural delivery without complications.

CONCLUSION

The study showed that patients who had a normal birth after a previous caesarean section in the Casa de Parto, assisted exclusively by obstetric nurses, had significant positive results, with a low risk of maternal and neonatal complications.

Although one of the limitations of the study is the number of patients observed (small sample), it was possible to observe that maternal age below 35, prenatal care with more than 6 visits, early breastfeeding and the absence of oxytocin during labor are factors that may be related to positive perinatal outcomes in normal deliveries after a previous cesarean section, when assisted by obstetric nurses in birthing centers.

However, the current literature is limited and suggests the need for more in-depth research to improve understanding of the factors that influence the success of normal childbirth after a previous caesarean section.

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