Review Article
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Psychological Behavior of the Counselor in Counseling Patient for Trail of Labor after Cesarean Section

Abstract

Trail of labor after lower segment cesarean section (TOLAC) is defined as successful vaginal delivery of the fetus for pregnant ladies with a previous history of primary lower segment cesarean delivery instead of elective repeat cesarean delivery (ERCD).[1] However, each pregnant lady with a previous history of a primary lower segment cesarean has the right to choose the mode of her delivery at the end of pregnancy which can be either TOLAC or ERCD.[2] Moreover, TOLAC is encouraged to be attempted with each patient after a primary lower segment cesarean in order to decrees the prevalence of repeated cesarean section. The rate of achieving successful TOLAC was noted to be decreasing in the last decades.[3] TOLAC considered to be a safe route of delivery in the absence of contraindications.[4] Furthermore, it seems that health care providers are not comprehending appropriate counselling and they may misguide the patients during the counselling sessions.[5]

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Sali Z Talab, Afnan Bashikh, Haitham A Badr
Security Forces Hospital, KSA

Correspondence: Haitham A Badr, Security Forces Hospital, KSA, Tel 00966-505274423, Email haithambadr@gmail.com

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Objectives

To estimate the psychological behavior of the counselor to avoid the possible complications of TOLAC to stay out of litigations.

Methods

It is a retrospective cohort study. Conducted in Security Forces Hospital – Riyadh – Kingdom of Saudi Arabia. Patients enrolled all pregnant women with primary lower segment cesarean section (n= 456) throughout the period from September 2014 to September 2015 were included. P values <0.05 was considered statistically significant. All statistical analyses were performed with Statistical package for social Science software (SPSS).[6-9]

Results

Among 456 patients 181 (39.7 %) of women were counselled. Among who delivered by cesarean section, we found that the commonest reported indications for cesarean section were refusing from the beginning to deliver normally (30.6 %) and FTP (24.8 %). Among cases of FTP, latent phase found among (44.6 %) of them whereas (42.9 %) were in active phase and failure to descend was observed among 12.5 % of them. male counselors were more likely to end with women agreeing to try TOLAC more than female counselor (67.2% versus 47.2%). The highest agreement rate was reported among those counseled by obstetrician with 2-4 years of experience (83.3%). Counseling in outpatient department was more effective in resulting in women`s agreement compared to counseling in inpatient department (63.3% versus 27.3%), p=0.001.[10-15] In the first counseling session, the highest success rate was reported by women in the age group 26-35 years (69.4 %), p=0.002. In the second counseling, the highest success rate was reported among women aged between 15 and 25 years (58.8 %) while the lowest was reported among those aged between 36 and 45 years, p=0.008. If the last delivery was cesarean section was accompanied by higher success rate than if it was not (53.1 % versus 33.3 %), p<0.001. parity of 1 also were more likely to agree for TOLAC compared to those over 4 parity (55 % versus none), p<0.001. Also, we noted that if the last delivery was cesarean section, it was accompanied by higher success rate than if it was not (53.1 % versus 33.3 %), p<0.001. Among cases of failure to progress, CS was indicated at less than 5cm in 44.6 % of cases. Receiving a complete course of augmentation by syntocinon was reported by 43.6 % of cases while having regular effective uterine contractions was observed among majority of them (82.7).[16-18] Surprisingly, among cases of complete augmentation by syntocinon, more than one-third of women (38.7%) were not given enough time in the labor ward to progress. Majority of women (96.8%) didn't complete the course of augmentation. Bilateral tubal ligation (BTL) per se was an indication for cesarean section among 11 women (5.3 %). Statistically significant association between offering bilateral tubal ligation and doing CS with bilateral tubal ligation as an isolated indication, p<0.001.[19-22]

Discussion

The decision for trail of labor after cesarean TOLAC or ERCD should be made by the woman and her treating physician after explaining all the risks and benefits. We proved in this study that the psychological elements involving characteristics of the counselor to avoid the possible complications of TOLAC has an impact in counselling those patients. Counseling was performed to (39.7%) of women while the rest were not counselled at all. There was a defect in counselling patients for TOLAC as only (39.7%) were counselled which could be due to either unintentional ignorance or unconsciously predicting that having previous vaginal delivery they are going to have successful VBAC. Furthermore, physicians should be alert to pregnant ladies' age before repeating the counselling session as patients categorized between (26-35 years) age group should be limited to one counselling session. On the other hand, patients between (15-25 years) need to be counselled twice for the sake of accepting TOLAC. By studying FTP as an indication for the second cesarean we found that it was done for (24.8%). 44.6% of them were in latent phase. Moreover, in the second counseling session, if the last delivery was cesarean section was accompanied by higher success rate than if it was not, p<0.001. As a result, the only explanation could be secondary tokophobia which is known as fear of labor pain or getting normal childbirth due to last pregnancy experience.[24-26]. If patients are worried from pain or about the fetus, they can express their fears and we can release their concerns. We looked for any other associated

reason for the cesarean and surprisingly, we found that majority of women didn't complete the course of augmentation (≤6 hours of syntocinon).[25,27] In regards BTL, although we could avoid exposing patients to the risk of major surgery which is the cesarean section and its associated complications by minimal invasive procedures such laparoscopy BTL after postpartum period as both have same effect in permanent sterilizations.[27-29]

Conclusion

Male counselors were found more likely to result in women agreeing for a trial of labor after cesarean section (TOLAC). The highest agreement rate was reported among those counseled by registrars with 2-4 years of experience. Counseling in outpatient department was more likely to result in women agreeing for a trial as well. Success rate after second counseling session was higher than first counseling session alone Majority of women were found to decide for a TOLAC after the second counselling session much more than after the first counseling session only specially if pregnant ladies between 15 and 25 years compared to those patients between 36 and 45 years who were found to change their mind after the second counselling sessions.

Recommendations

Thus, we recommend to counsel the patient for TOLAC in outpatient department at earlier gestational age and to include the registrar at least once. Creating and following hospital protocols to deal with each patient with previous primary lower segment cesarean section when they are in labor.

Acknowledgments

None.

Conflicts of interest

None

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