



**G2P1A0 38 WEEKS PREGNANT INPARTUM STAGE 1 PROLONG LATENT PHASE WITH 18 HOURS PROM AND FAILED VBAC HISTORY OF SC 1 TIME SINGLE FETUS LIVE HEAD PRESENTATION: CASE REPORT**

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**ABSTRACT**

The latent phase is the period from the onset of labor which generally starts from the onset of contractions to the dilatation of 3-4 cm within 7-8 hours. a prolonged latent phase occurs when the latent phase is more than 20 hours in nulliparas and 14 hours in multiparas. In this case, we report a 27-year-old woman with the initial complaint is discharge from the genitals since 18 hours before entering the hospital which was not accompanied by pain, contraction and blood mixed with mucus. The patient claimed to be pregnant aterm and still felt fetal movement. The patient had a history of cesarean section surgery once in his first child due to complications in the form of severe oligohydramnios. Physical examination revealed compos mentis consciousness, BP 110/80 mmHg, pulse 98 x/minute, RR 20 x/minute, temperature 36.5°C and SpO2 99%. The general status of the patient was within normal. On obstetry external examination, uterine fundal height was 32 cm. On examination, Leopold 1 felt soft round with the impression of the buttocks, Leopold 2 felt elongated to the left of the mother with left back impression, Leopold 3 felt hard round with a bouncy head impression, Leopold 4 obtained a divergent result that the fetal head had entered the upper pelvic door. HIS 4x/10/20". FHR 180x/minute. On internal examination, it was found that the portio with soft consistency, 25% flattening, 3 cm opening, membranes (-), the lowest part of the fetus is the head, Hodge II head descent, Vertex indication. the VBAC score was 4 (58%). The patient in this case was diagnosed with G2P1A0 Pregnant 38 weeks Inpartu Stage 1 Prolonged Latent Phase With PROM 18 Hours with failed VBAC and history of SC 1 time Single Fetus Live Cephalic.

**Keywords:** adhesiolysis; premature rupture of membrane; stage 1 prolonged latent phase

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**INTRODUCTION**

Basically, the first stage of labor, namely the latent phase and the active phase, have different times. The latent phase is the initial phase which is characterized by regular contractions, the cervix dilates from 0 to 3 cm (Pillitteri,2009) The latent phase can last between 8-10 hours in primiparas and 6 to 8 hours in nulliparas. with cervical dilatation from 4cm to 10cm dilatation. The prolonged latent phase is the presence of this phase for more than 20 hours in nulliparas and 14 hours in multiparous women. Several things that affect the duration of the latent phase include deteriorating cervical conditions (eg thick, not flattening or not opening), and false labor. The diagnosis can also be determined by assessing cervical dilatation not exceeding 4 cm after 8 hours of labor with regular hysteria. whereas in the first stage the active phase normally runs for 6 hours, if within 6 hours the opening is not complete then it can be said that the labor process is slowing down (Chuma,2014).

Premature rupture of membranes (PROM) is the rupture of the amniotic membranes before delivery. In term pregnancies or pregnancies of more than 37 weeks, as many as 8-10% of pregnant women will experience PROM (Prawirohardjo,2016). Premature rupture of membranes can occur in preterm pregnancies or pregnancies less than 37 weeks with an incidence of as much as 1% of pregnant women will experience KPD. Premature rupture of membranes can lead to infection where this infection can increase the mortality of both mother and child. As for the complications, namely infections during childbirth, puerperal infections, prolonged labor, postpartum hemorrhage, I. while the complications that most often occur in the fetus are prematurity, descent of the umbilical cord, hypoxia and asphyxia, fetal deformity syndrome, and increased perinatal morbidity and mortality (Sumadi, 2013). The risk factors that can increase the incidence of premature rupture of membranes include maternal age, parity, gestational age, birth weight, gemelli/twins, abnormal location and method of delivery (Legawati R, 2013).

Adhesiolysis is the process of cutting or removing internal scar tissue (adhesions) which generally forms after trauma, infection, inflammation or surgery. Adhesiolysis is performed to restore normal function and relieve pain associated with adhesion formation (Maingot, 2019). Adhesions are abnormal fibrous (connective tissue) adhesions between two tissues or organs. Intraperitoneal adhesions (Abdominal Adhesions) are adhesions between two adjacent peritoneal surfaces, either between the visceral peritoneum, or between the visceral and parietal peritoneum (Liakakos, T et al. 2011). One of the most common risk factors for adhesions is the presence of scar tissue after Sectio Caesaria or gynecological surgery. The surgical process causes trauma to the peritoneum, which will then trigger the release of various cytokines, resulting in an inflammatory response in the peritoneum. The next stage, after the inflammatory process has passed and concomitant with the healing process of the peritoneum, fibrinous adhesions will form and eventually become permanent adhesions. Other risk factors for adhesions include age, parity, prolonged or obstructed labor, instrument-assisted delivery, and use of drugs for induction or augmentation of labor (Diamond, M. 2019). Vaginal Birth After Cesarean (VBAC) is a normal delivery process for mothers with a history of Sectio Caesaria (SC). The conditions for VBAC are one history of low transverse cesarean delivery, adequate pelvis, no uterine rupture, easy to contact doctors, availability of anesthesia and facilities for emergency CS. uterine rupture > 1% and multiple uterine injuries. The most common complication of VBAC is uterine rupture (ACOG, 2014). The purpose of this study was to determine the risk factors that could occur in the case of a former cesarean section.

## **METHOD**

This research is case report. The subject of this study were female patient, aged 27 years G2P1A0, 38 weeks gestational age with Premature rupture of membrane (PROM) 18 hours and adhesiolysis. Primary data was obtained from anamnesis, physical examination, and laboratory investigations. Evaluation and examination were carried out on October 5, 2021 to October 9, 2021.

## **RESULTS**

In this case, the patient was diagnosed as G2P1A0 38 weeks pregnant in part 1 prolonged latent phase with PROM < 18 hours and adhesiolysis history of CS 1 time single live fetus with cephalic presentation. The basis of this patient's diagnosis is history and physical examination. From the anamnesis, the patient said the date of HPHT was January 2021. This pregnancy was the patient's second pregnancy. The patient had no history of abortion. The

patient came to the referral hospital from Puri Betik Hati Hospital with complaints of discharge from the genitals without being accompanied by pain and blood mixed with mucus. From the obstetric physical examination, it was found that the height of the uterine fundus was 3 fingers below the xyphoid process (32 cm), the longitudinal position of the left back gave the impression of PUKI, a decrease of 2/5, His (+). On internal examination, it was found soft, medial, 25% effisment, 3 cm opening, membranes (-), the bottom of the head.

Management of this patient is appropriate. The patient was managed definitively with abdominal delivery after 8 hours of observation with no progress in labor. The patient's VBAC score was 4 (58%). According to the National Institutes of Health (NIH), 60 to 80 percent of women who attempt vaginal birth after cesarean section (VBAC) are successful (National Institutes of Health, 2010). However, there are some contraindications for VBAC, namely previous uterine rupture, history of classical CS, contraindications to vaginal birth regardless of history of CS e.g. placenta previa (Queensland Clinical Guidelines, 2020). Initially the mother was planning to undergo vaginal delivery but the opening did not increase after being induced and was observed for 8 hours. Long labor is a latent phase of more than 8 hours with labor having a duration of 12 hours or more for the unborn baby, marked by cervical dilatation to the right of the alert line in the active phase of labor (Prawirhardjo, 2016).

A prolonged latent phase occurs if it is more than 20 hours in nulliparas and 14 hours in multiparous mothers. Several things that affect the duration of the latent phase include deteriorating cervical conditions (eg thick, not flaring or not opening), and false labor. The diagnosis can also be determined by assessing cervical dilatation not exceeding 4 cm after 8 hours of labor with regular hystera. whereas in the first stage, the active phase normally runs for 6 hours, if within 6 hours the opening is not complete, it can be said that the labor process is slowing down. This is in line with the examination carried out, namely the opening did not increase and remained 3 cm after 8 hours of observation (Nugroho, 2012).

This patient was observed for FHR and maternal vital signs. This is done in order to determine the condition of the fetus and also the condition of the mother. The FHR is monitored to find out if there is any fetal distress that could threaten the fetus. Morbidity and mortality in PROM include fetal distress that can occur due to compression of the placenta due to oligohydramnios, intra uterine fetal death (1-2% of cases). Monitoring the mother's vital signs to determine the mother's condition or conditions that can threaten the mother's life such as infection. Maternal infection characterized by temperature  $>38$  o C, 2 or more signs of uterine pain, contractions, amniotic odor, increased leukocytes and positive culture values. In this patient, FHR 180 x/minute showed signs of fetal distress. Fetal distress is fetal heart rate (FHR) less than 100 per minute or more than 180 per minute (Nugroho, 2012). Fetal distress occurs when the fetus does not receive sufficient O<sub>2</sub>, so it will experience hypoxia. Prolonged labor can result in decreased oxygen in the blood and decreased blood flow to the placenta so that the oxygen available to the fetus decreases, which in turn can cause fetal hypoxia so that it can cause asphyxia in the newborn. which can result in uterine relaxation insufficient to provide adequate filling of the placenta; Infections caused by rupture of the membranes in prolonged labor can also harm the mother and fetus, because bacteria in the amnion penetrate the amnion and invade the decidua and chorionic vessels, resulting in bacteremia and sepsis in the mother and fetus (Rukiyah,A; Yulianti, L.2010).

Antibiotic therapy in this case was appropriate, namely in the form of injection of Ceftriazone 1 gr/12 hours which serves as prophylaxis to reduce the risk of chorioamnionitis. Premature rupture of membranes (PROM) experienced by patients can be caused by increased intra uterine pressure in OUI such as incompetent cervix, twin pregnancies, hydramnios, increased myometrial contractions, DKP, PAH, malposition, can also be caused by infection, age > 35 years, multiparity and others include: low socioeconomic, nutritional and vitamin C deficiencies, smoking, heredity, and history of trauma and previous history of KPD (August, F et al. 2016). Based on the history taken, the patient said that in the first pregnancy the patient also had the same history as the current pregnancy. The pathogenesis of PROM in a nutshell is the result of a decrease in collagen content in the membrane, thus triggering premature rupture of membranes (Nugroho, 2010). Experienced KPD before, due to the composition of the membrane which becomes easily brittle and the collagen content decreases in subsequent pregnancies.

The factor causing adhesions or adhesions in this case is a previous history of CS. The surgical process causes trauma to the peritoneum, which will then trigger the release of various cytokines resulting in an inflammatory response in the peritoneum. The next stage, after the inflammatory process has passed and along with the healing process of the peritoneum, fibrinous adhesions will form and eventually become permanent adhesions (Diamond, M. 2019). according to Awonuga A., et al. 2011, adhesions occur as a result of a response to hypoxia in an injured tissue, where the body tries to rebuild the supply of oxygen and nutrients to the tissue due to previous surgery or pathology (Awonuga A., et al. 2011).

## CONCLUSION

A 27-year-old patient with G2P1A0 pregnant 38 weeks in labor during 1st stage of prolonged latency with PROM <18 hours and adhesiolysis history of SC 1 time single live fetus with cephalic presentation. Abdominal post partum patients with Adhesiolysis, babies born at NCB SMK with male gender, birth weight 3700 grams, baby birth length 50 cm, complete placenta born. so that the patient was diagnosed as P2A0 post SC with a history of PROM <18 hours and adhesiolysis. The patient has been managed according to indications.

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