INTRODUCTION

Caesarean section represents the most significant operative intervention in obstetrics, it's development and application has saved the lives of countless mothers and infants. On the other hand, it' s inappropriate use can be a direct and avoidable cause of maternal mortality and morbidity. For these reasons CS probably represents the largest controversy and debate in modern obstetrics ***(Munro Kerr's, 2007).***

CS rate varies from one country to another it is impossible to determine what an optimal rate for caesarean should be for any population; however there has been a rising rate of CS over the last 25 years in most of the developed countries. This rise has slowed down in some countries although the trend is still upwards ***(Savage, 2000).***

Few studies have examined CS rate in the Arab region, most were based on samples from hospital registers owing perhaps to the lack of reliable administrative records at the national level**.** These studies as well as recent evidence from population- based data suggest that CS rates are increasing in this region ***(Khawaja et al., 2004)***.

There are many theories to explain this rise including fear of litigation, reluctance to implement the active management of labor, a lowering threshold concerning the decision to carry out CS , the increased use of the electronic fetal monitoring, the decrease in use of forceps and the improved safety of caesarean section, also the maternal request by some women as they fear from labor pain ***(Peskin and Reine, 2002).***

There has been an escalating rate of caesarean deliveries in the United States of America (USA) and many European and Latin American

countries. Currently, one out of every 10 American women delivered each year in the United States has a previous caesarean delivery, it seems also that Egypt is following suit ***(Ventura et al., 2000).***

Currently in the United Kingdom (UK) slightly more than one in seven women experiences complication during labour that provides an indication for surgical delivery, these problems can be life threatening for the mother and/or baby (e.g. eclampsia, abruptio placenta) and in approximately 40% of such cases caesarean section provides the safest solution. In the UK more than 21% of all babies are delivered by caesarean section - approximately 120000 babies in the year 2000 ***(Hayman, 2004).***

The indications for CS vary from country to country and from hospital to hospital, nonetheless there are four main indications that account for 60-90% of all CS , these include; repeated CS (35%-40%), dystocia (20%-35%), breech (10%-15%) and fetal distress (10%-15%) ***(Munro Kerr's , 2007).***

When facing cases with prior CS is it safer to allow the patients to have a trial of vaginal delivery or to do a repeated CS ? One of the most controversial issues in obstetrics practice ***(Jeffrey, 2004).***

Attention is increasingly being focused on monitoring and analyzing CS rates to identify ways of reducing the use of CS , population-based studies analyzing the indications for CS have found that several complications contribute to the large number of CS or to the increase in this technique**.** With the current trend of rising CS rates there is an ongoing debate about the long-term effects of CS. The potential risk of pelvic adhesions and subsequent tubal infertility are important considerations for women and their obstetricians ***(Jurdi and Khawaja, 2004).***

Murphy et al. (2002) demonstrated that a history of previous CS was associated with an increased risk of taking more than a year to conceive from the time of planning a pregnancy.

Thomson et al. (2005) concluded that the relationship between CS and sub fertility is complex, because sub fertility may both precede and be a consequence of CS.

The rising incidence of CS worldwide and a concomitant increasing in couples seeking fertility treatment may points to an association between CS and subsequent reproductive failure due to tubal disease which is clinically and socially important. The evidence that support the pathophysiological explanation for impaired fertility following CS remains inconclusive ***(Fenwick et al., 2006).***