VAGINAL BIRTH AFTER CESAREAN (VBAC)  
Guidelines for Decision-Making

Cesarean births now account for approximately 31% of all births nationwide. As the number of women undergoing cesarean increases, so does the number of women seeking a vaginal birth after a prior cesarean. In 2004, the American College of Obstetricians and Gynecologists issued guidelines for management of Vaginal Birth after Cesarean (VBAC). These guidelines shape much of the decision-making that occurs today in the hospital setting as women undergo a Trial of Labor After Cesarean (TOLAC). If you are desiring a VBAC, you will want to consider the following information.

VBAC Success Rates

**FACT:** For women with one prior cesarean, the chance of a vaginal birth is about 60 per cent if the cesarean was done because of incomplete dilation or because of inability to push out the baby. The chance is about 80 per cent if the cesarean was done for other reasons.

**FACT:** For women with two prior cesareans, the chance of a vaginal birth is about 50 per cent if both cesareans were done following a failed trial of labor. The chance is 75 per cent if one of the cesareans was done before or during early labor.

Women who are most likely to have a successful VBAC meet one or more of the following conditions:

- have had only one prior cesarean
- had a low transverse uterine incision that was closed in two layers
- had a vertical incision within the lower uterine segment that did not extend into the fundus
- had a cesarean for reasons other than lack of progress or lack of fetal descent in labor
- already have had a successful VBAC

Women who are least likely to have a successful VBAC meet one or more of the following conditions:
- have had more than one prior cesarean
- have a large baby
- require labor induction or augmentation
- are obese
- there is less than 19 months between the prior cesarean birth and current delivery

**Complication Rates**

**FACT:** Women who have vaginal birth after cesarean have better outcomes than women who have scheduled repeat cesareans.

**FACT:** Women who attempt a VBAC but deliver by cesarean have worse outcomes than women who have scheduled repeat cesareans.

A serious but rare complication related to VBAC is uterine rupture. This occurs when the uterine scar separates. Uterine rupture occurs in about 5 of every 1,000 women who have had one prior cesarean, and in about 15 of every 1,000 women who have had two previous cesareans. Usually a uterine rupture results in no harm to the mother or baby. It can be life-threatening, however, and both mothers and babies have died from uterine rupture.

There are other complications associated with both planning a VBAC and scheduling a repeat cesarean. The following table compares outcomes for both options.

<table>
<thead>
<tr>
<th>Complication</th>
<th>Trial of labor*</th>
<th>Repeat cesarean delivery*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mothers with fever after delivery</td>
<td>43</td>
<td>54</td>
</tr>
<tr>
<td>Mothers needing a blood transfusion</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td>Mothers who have a hysterectomy</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Mothers in whom the uterus ruptures</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Death of the baby</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Babies with serious infection</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Babies with low Apgar scores</td>
<td>22</td>
<td>9</td>
</tr>
<tr>
<td>Babies with breathing problems</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Babies with jaundice</td>
<td>20</td>
<td>60</td>
</tr>
</tbody>
</table>

*Numbers reflect incidence per 1,000 women.*
It is strongly advised that women have a scheduled repeat cesarean if there exists:

- a new obstetrical reason for having a cesarean
- a history of any uterine incision that extended into the contractile portion of the uterus
- a previous uterine rupture
- the presence of additional uterine scars (e.g., myomectomy)

**Decision-Making**

The decision about whether or not to labor with a uterine scar should be made with careful consideration of risks and benefits and in consultation with a midwife or physician. Every woman is unique and the counsel she receives should take into consideration her individual history, present condition and desires. Ultimately, the decision of whether or not to labor is left to the woman.

**VBAC Management at Group Health Cooperative in Seattle**

Group Health Cooperative in Seattle has the lowest cesarean rate in the greater Seattle area. Its commitment to evidence-based healthcare results in policies which are quite supportive of VBAC.

Midwives who attend births at Group Health often care for women planning a VBAC. It is required that women planning VBAC at Group Health attend a one-hour, OB-led VBAC class. The midwife then continues primary care through labor and birth, consulting with the Group Health obstetrician only if concerns or complications develop.

In the rare case of uterine rupture, the midwife will want to recognize this immediately and be able to promptly intervene. For this reason, continuous electronic fetal monitoring is used throughout labor. The monitors are external and may be used under water, permitting the client to labor in the tub. To ensure a prompt ability to intervene, IV access is established upon admission. A heparin lock is placed, which is the beginning of an IV. It does not need to be connected to IV lines or bags of fluid and allows freedom of movement.

Since prostaglandins have been shown to significantly increase the rate of uterine rupture, these are not used at Group Health to induce labor in women with a uterine scar. However, studies suggest that pitocin may safely be used to augment labor once it has started. Women who begin labor spontaneously (without induction) have a higher chance of successful VBAC.
Epidurals may be safely used in women choosing VBAC. Since they may prolong the pushing stage of labor and may result in more need for pitocin, however, women may want to consider alternative ways of coping with labor pain. In some women, epidurals do help labor progress by promoting relaxation.

Both uterine rupture and surgical complications are more likely to occur if a woman attempting a VBAC is experiencing no progress in active labor with adequate contractions. Every attempt will be made to safely encourage progress with both natural and medical methods. However, in an effort to avoid serious operative injury and uterine rupture, the midwife and consulting obstetrician would recommend a cesarean if cervical dilation were persistently stalled.

In the event of any labor complications, the midwife and obstetrician discuss risks, benefits and recommendations with the client. The laboring woman is a crucial part of the decision-making team and her thoughts and concerns are respected.

Resources


www.ican-online.org International Cesarean Awareness Network, Inc. is a non-profit organization that has the goal of preventing unnecessary cesareans. Local chapters offer meetings and support groups.

www.maternitywise.org Provides women and health professionals evidence-based information about pregnancy and birth.

www.vbac.com This site is hosted by Nicette Jukelevics, MA, ICCE, a childbirth educator, speaker and author on cesarean and VBAC issues.

The statistics cited in this paper were derived from the practice bulletins cited above, as well as the Group Health Cooperative Guidance for Discussions, revised 2004.

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