

VBAC

VAGINAL BIRTH AFTER CESAREAN SECTION

Benefits to VBAC

Successful, uncomplicated Vaginal Birth After Cesarean (VBAC) theoretically carries a lower risk to mother and baby as compared to a repeat cesarean delivery. The reported success rate in the medical literature for those attempting vaginal delivery after a previous cesarean is about 50-80%.

Risks to Repeat Cesarean Sections

Elective repeat cesarean delivery (the alternative to VBAC) carries associated risks. Cesarean delivery is a major operation and, in some cases, there can be injuries to the mother's bladder or bowel or other serious complications. Cesarean delivery is associated with a higher risk of blood transfusion, infection and hysterectomy than that of a vaginal delivery. For these reasons, cesarean delivery carries a very small, but increased risk of maternal death. Infants have a greater risk of developing breathing problems and may require breathing support and close observation. In rare cases, this condition becomes life threatening for the infant.

Risks to VBAC

Risks of VBAC include damage to the maternal bladder and bowel. The most serious complication is uterine rupture. In the case of uterine rupture, internal and/or external bleeding may occur and may also require transfusions and/or hysterectomy. Fetal injury or death may also occur if the uterus ruptures during the trial of labor.

Patients who have had more than one cesarean delivery will not be discouraged from attempting a vaginal birth if they request to. However, there is an increased risk of uterine rupture in this group. In addition, there is a slightly higher risk of the above complications occurring if it is necessary to perform a cesarean delivery after you have gone into active labor and failed to have a successful vaginal delivery.

The dictum "once a caesarean, always a caesarean" had been the standard of practice in the United States for about fifty years. However, in the last ten years vaginal birth after a caesarean section (VBAC) is becoming a practical and feasible alternative to elective repeat C-section. In fact, some insurance companies will not pay for an elective repeat C-section except in certain circumstances where a trial of labor is medically contraindicated. For that reason, and—more important—because C-sections involve maternal trauma and possible neonatal respiratory problems interest has grown in encouraging patients with prior low transverse C-sections to attempt a vaginal delivery.

Numerous large studies of outcome following a trial of labor have reported a successful vaginal delivery about 66% of the time. A lower success rate is reported for women undergoing a C-section for "CPD" (baby too large for pelvis) or failure to progress, with success only 55% of the time. Women undergoing C-section for other indications (such

as bleeding, fetal distress, breech presentation, etc.) had a higher success rate of about 80%.

One of the major concerns in allowing a trial of labor is the fear of uterine scar separation. Many studies have shown that the risk of uterine rupture is slightly less than 1%. Clearly, the most important factor in rupture is the type of incision, with the classical up-and-down uterine incision carrying a 3-4 times greater risk compared to the low transverse incision. The low transverse incision carries a risk of approximately .8% chance of rupture prior to labor and a 1.2% chance of rupture during labor. The direction of the skin incision has nothing to do with the type of incision made in the uterus. Operative records often need to be obtained to verify if the uterine incision is compatible with attempting labor.

Rupture of the lower transverse scar has not been documented to cause an increase in either perinatal or maternal mortality. There has been no reported maternal death from rupture of lower segment scars in the English literature for the past 30 years. In a review of over 3200 VBACs, three fetal deaths were noted (a rate of 93%). Two of these, however, occurred in patients with the classical uterine incision who should have undergone a repeat C-section. In addition, the incidence of wound infection, bladder injury, blood transfusion and uterine infection is 2-3 times greater in patients undergoing repeat C-section.

In summary, a trial of labor after previous low transverse C-section is relatively safe for mother and fetus. The chief medical benefit for the mother is the avoidance of surgery and the risks thereof. The benefit for the infant is the prevention of prematurity from an ill-timed elective procedure. Psychologically, there is the satisfaction of having attempted vaginal birth, a quicker recovery and the avoidance of prolonged hospitalization.

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