



VBAC (Vaginal Birth After Cesarean)

The likelihood of having a vaginal birth at home with a midwife after a previous birth by cesarean-section surgery (C-section) is good, provided certain guidelines are followed. Rates for successful VBAC range upwards from 60 percent, depending in part upon the knowledge and attitudes of the pregnant woman and the supportiveness of her healthcare providers. VBAC at home, often called HBAC, is often more successful than in the hospital because midwives provide close, one-on-one, supportive care; no medications which may cause fetal distress or uterine stress are used; midwives are trained to immediately and correctly identify uterine tearing; and fetal well-being is carefully monitored.

Strong predictors of VBAC success are:

- One low transverse c-section with double-layer closure
- Prior vaginal delivery, or one or more prior VBACs
- Spontaneous labor with VBAC, with no induction or augmentation
- When the reason for the C-section was a condition that would not be likely to happen again, such as:
 - Breech or other mal-presentation
 - Multiple gestation
 - Placenta previa
 - Maternal age less than 40
- Natural drug-free birth, ability to move freely
- Favorable cervical factors; soft, ripe, thinning cervix towards the end of pregnancy
- Strong maternal desire for vaginal birth.

Factors associated with a decreased likelihood of successful VBAC:

- More than one prior C-section
- C-section done by classical incision (up and down through front of uterus)
- C-section sutured with a single-layer closure
- Maternal age greater than 40
- Labor induction or augmentation
- Epidural anesthesia
- Continual fetal monitoring which prohibits maternal movement
- Obesity or poor nutritional health
- History of bone-deforming disease such as rickets
- Fetal macrosomia (large baby) >4 Kilograms (8 lbs 14oz)

Benefits of VBAC

Numerous studies documenting the safety of VBAC have appeared in the medical literature over the past thirty years. C-section is considered to be major abdominal surgery, with 8 times the risk of death and 33 times the risk of harm to mother or baby, compared to normal vaginal birth. Some of the risks of c-section occur immediately, such as infection, hemorrhage, and decreased bonding with baby. Some of the risks become apparent in the future, especially in subsequent pregnancies. These include abnormal attachment of the placenta which may cause bleeding during pregnancy or hemorrhage at birth; increased thinning of the uterine wall at the site of the incision causing greater likelihood of uterine rupture during pregnancy or birth; risks from general or epidural anesthesia; and decreased childbearing capabilities.

Below is a list of potential benefits that may occur by avoiding C-section:

- Lower rate of maternal morbidity (such as postpartum infection) and mortality;
 - Maternal death rate for C-section is 4 deaths in 10,000
 - Maternal death rate for normal vaginal delivery is 0.5 in 10,000
- Lower rate of death and injury to baby, lower rate of premature babies
- Lower average blood loss for mother, less postpartum discomfort, and faster recovery
- Lower rate of babies born with breathing problems, and need for resuscitation or NICU
- Less separation of baby from family, shorter hospital stays for mother and baby
- Significantly reduces the cost of health care, including reduction in use of NICU
- Increased maternal feeling of control in decision making process and maternal satisfaction
- Decreased likelihood of future C-section surgeries.

Risks of VBAC

While the safety of VBAC is well documented, risks of VBAC include uterine rupture, abnormal detachment of the placenta from the uterus, and fetal distress or death. If the uterus is too damaged or the bleeding too great, a c-section may need to be done to deliver the baby and/or hysterectomy may need to be performed immediately following the birth.

The risk of potential uterine rupture is the main reason given for concern with VBAC. Massive uterine rupture, potentially causing death of the baby and hysterectomy, is rare, with the reported rate of true catastrophic uterine rupture in the VBAC literature ranging from 1 in 900 to 1 in 125 attempted VBACs. One statistic of symptomatic uterine rupture with VBAC "trial of labor" is 2.7 per 1,000 attempted VBACs. These statistics include VBACs attempted after one, two or more c-sections and women with low to high-risk health status. A client with one previous low transverse c-section has a risk of uterine rupture of less than 1%.

However, it is very important to know that these statistics are derived primarily from VBACs attempted in hospitals where induction and/or augmentation of labor with strong uterine stimulants such as Pitocin, Cytotec and prostaglandin gel are commonplace, even among women with a uterine scar. Induction and augmentation of labor should NEVER be done during VBAC because it increases stress on the uterine scar, inhibits the normal, physiological ability of the uterus to adapt to fetal distress, causes strong, uncontrollable contractions, and reduces the mother's ability to feel pain (because she has also received an epidural) and communicate this with her provider.

Over half of all uterine ruptures occur in women who have not had a prior C-section. This is very important to know as it speaks directly to the risks associated with induction and augmentation of labor. Factors associated with a decreased risk of uterine rupture during VBAC are:

- Double layer closure of the uterus during prior C-section
- Low transverse incision
- Greater than 18-24 months since the prior C-section
- Normal progression of labor, drug-free
- Close monitoring of labor, contractions, and reports of abdominal pain.

Uterine scar separation (dehiscence) occurs when the scar thins and/or opens, leaving only the outside lining of the uterus intact. Dehiscence is usually not a problem in labor unless the opening becomes large enough to allow fetal parts to escape through it. In most cases this type of rupture is not an emergency and is not accompanied by fetal distress or maternal bleeding, and usually heals spontaneously without surgery. These pseudo-ruptures are included in the statistics with true ruptures, increasing the appearance of VBAC risk.

The possibility of other unforeseen events (unrelated to VBAC) requiring emergency transport to the hospital is approximately 2%. While the risk of uterine rupture is present, it is important to consider it in the context of overall risks inherent in birth. As stated in the Midwives' Association of Washington State's position statement on VBAC:

“MAWS does support women's right to engage in a shared decision making process centering around the fact that both elective repeat cesarean section and VBAC carry risks for mother and baby”.

Considerations for choice of birth place

Past obstetrical / surgical history: Women with any of the following conditions may still be candidates for VBAC, but should be advised that they have additional risk factors that they must consider when making their decisions:

- History of prior C-section before 26 weeks gestation
- History of single layer closure when suturing the uterine incision
- History of uterine infection or impaired uterine scar healing
- Current birth spaced less than 24 months from C-section delivery
- Scar thinning or separation seen on ultrasound done at term for current birth.

Current health considerations: Several situations may arise toward the end of pregnancy or during birth that would necessitate the transfer of your care from the midwife to the doctor at the hospital. These may include:

- Fetal positioning at the end of pregnancy or during labor
- Long or abnormal active part of labor or pushing stage
- Abnormal detachment of the placenta and/or increased bleeding after the baby is born.

Time and distance: Morbidity and mortality rates increase when C-section is delayed with a true uterine rupture. Ideally the nearest hospital with emergency C-section capability should be less than 20 minutes from planned birth site. In the unlikely event of a catastrophic uterine rupture, an emergency C-section delivery within this time frame will not guarantee a healthy outcome for mother and especially for the baby. Traffic, road, and weather conditions (especially related to the time of year) are factors to consider when thinking about planning a VBAC in an out-of-hospital setting.

Legal liability issues: Your midwife does not have malpractice insurance coverage for VBACs. Your insurance policy may not reimburse providers for VBAC, so you may be liable for the entire fee; this can be determined in advance.

By initialing the Informed Choice for this document, you agree to the following:

I have reviewed my operative report and obstetrical records with my midwives. I have read and understand the information regarding potential risks and benefits involved with vaginal birth after cesarean section, and have done my own related research. I understand that there is no malpractice insurance coverage for circumstances arising from, or in conjunction with, my decision for VBAC. I have discussed this with my care providers and have had all my questions answered and I choose to plan for an out-of-hospital VBAC.