Fact Sheet: Repeat Cesarean and Vaginal Birth After Cesarean

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Choices to be made:
Pregnant women who had a cesarean for a previous birth face the question of whether to plan an Elective Repeat Cesarean Delivery (ERCD), or to plan a Trial of Labor After Cesarean (TOLAC). If a trial of labor is successful, and baby is delivered vaginally, the woman has had a Vaginal Birth After Cesarean. (VBAC) Women make these decisions based on their own personal values and goals for their birth experience combined with medical advice from their doctor or midwife.

Chance of VBAC Success: Who is a Good Candidate for TOLAC/VBAC?
Most women who plan a VBAC, and whose care providers support them in their choice, achieve a vaginal birth (60 - 80 % of the time).

VBAC is more likely if:

- the uterine incision from her previous cesarean is a low transverse scar (most are)
- the reason for her previous cesarean hasn't recurred
- the mother has had a prior vaginal birth, especially a prior VBAC
- labor is allowed to begin on its own, and is not induced or augmented
- the mother is younger than forty and has a BMI (body mass index) below 30 kg/m2

VBAC is less likely if:

- the mother had a uterine infection after her cesarean
- the mother has had multiple prior cesareans (or had one cesarean less than 18 months ago)
- gestation is over forty weeks and baby weighs over 9 pounds

VBAC may not be recommended if:

- her uterine incision was vertical, T- or J-shaped (only used in emergencies or unusual situations)
- she had a uterine rupture in a previous pregnancy that caused problems

Ask your care provider for advice specific to you, based on your medical history. Also ask your care provider: "Of your clients who have had a previous cesarean, what percentage try for a VBAC? Of those, what percentage succeed in having a vaginal birth?" A care provider who strongly and actively supports the idea of VBAC and supports women's choices for their birth will say that over 60% of clients with prior cesareans plan a VBAC, and over 60% of those succeed.

A 2006 study found 45% of women who hoped for a VBAC were denied the option by a care provider who was unwilling to offer VBAC. (DeClercq, 2006) You may need to "shop around" for a supportive caregiver.

What are the Potential Risks of ERCD or TOLAC / VBAC?

- For the mother, generally the lowest risk situation is a TOLAC ending in VBAC, moderate risk is ERCD, and the higher risk is from an unplanned or emergency cesarean that follows a failed TOLAC.
- With a repeat cesarean (whether planned or unplanned), there is an increase in: blood loss, chance of infection, postpartum pain, length of hospital stay, chance of complications from anesthetic. Chance of maternal death is very small, but lower with VBAC than with ERCD. (4 in 100,000 vs. 13 in 100,000)
- For baby, the risks are comparable, except in the rare case of uterine rupture.
    - Uterine rupture is when the scar in the uterus opens up during labor. (Chance of rupture is about 325 in 100,000 for VBAC, and closer to 26 in 100,000 for ERCD) This can be relatively harmless, and can usually be managed with a prompt cesarean.
    - In rare circumstances, rupture can lead to infant death.
    - The chance that a baby will die is 130 per 100,000 for TOLAC compared to 50 per 100,000 for ERCD. (Note, both these rates are fairly similar to those of any mom in labor with her first baby, so not much different than the risk you faced with your first birth.)

How Labor is Managed for Women with Prior Cesareans
Because of the increased risk of uterine rupture, care providers monitor these labors more closely than they monitor a woman who does not have a scarred uterus. These women may be asked to come to the hospital earlier - as soon as they think they are in labor, rather than waiting for active labor to become established. Also, they typically have continuous electronic fetal monitoring throughout the entire labor. (Uterine rupture causes a distinct change in fetal heart rate patterns, so the monitor can quickly detect early signs of rupture. If the heart rate indicates a rupture, a cesarean can be done before baby is harmed.)

Because women with prior cesareans have a greater statistical likelihood of having a cesarean, there may be additional restrictions, such as: no food in labor. Labor induction with prostaglandins significantly increases risk of rupture, and should be avoided. P"itocin increases the risk, and should be used with caution. Women may choose to avoid pain medications, as they can slow labor, which can lead to cesarean.

Women planning a TOLAC may write two birth plans: a VBAC plan to be used if everything goes well, and a Cesarean Birth Plan to be used if cesarean becomes necessary. (see below)

Planning Repeat Cesarean / Preparing a Birth Plan for an Unplanned Repeat Cesarean

Advice on planning the Best Possible Cesarean: www.parenttrust.org/index.php?page=parenting-tips

Trends in Cesarean Rates (nationwide, CDC statistics)

	1996	2001	2006	2007	change 1996 - 2006
Total Cesareans	20.7%	24.4	31.1	31.8%	↑ 50%
Primary Cesarean	14.6%	16.9	20.8	-	↑ 42%
VBAC	28.3%	16.4	7.6	-	↓ 73%

- Primary cesarean rate is the rate for births to women with no previous cesarean.

Recommended Rates: The World Health Organization recommends an overall cesarean rate of less than 15%. "Healthy People 2010", from the Center for Disease Control and the U.S. Health Resources and Services Administration, sets a goal for a cesarean rate of ≤15.5% for low-risk women, and VBAC rate of 37% or more. Current trends continue to distance us from those goals.

There are many complex reasons why VBAC has become less common: As cesareans have become safer surgeries, the barrier against choosing cesarean has become lower. There are liability concerns for doctors, who may use cesareans as "defensive medicine." The American Congress of Obstetricians & Gynecologists (ACOG) recommended in 2004 that VBAC only be done in hospitals where a surgeon and anesthesiologist are "immediately available" in case a cesarean is needed. This created staffing challenges and cost considerations for smaller hospitals. In 2009, one-third of all hospitals no longer offered VBAC. ACOG has recently (August 2010) changed their position, saying VBAC is "a safe and appropriate choice for most women who have had a prior cesarean delivery"; and stated that a hospital cannot deny care or force a repeat cesarean on a woman who presents in labor. The American Academy of Family Physicians (AAFP), and the Society of Obstetricians and Gynaecologists of Canada also support the TOLAC / VBAC option.

Making Your Decision:
After reading this information, and after consulting with your care provider about your unique medical situation, you (and your partner) can consider what your hopes and goals are for this birth, and make the informed choice about what is best for you and your baby.

Sources:

NIH Consensus Development Conference on VBAC, 2010. Final statement: http://consensus.nih.gov/2010/vbacstatement.htm
ACOG Practice Bulletin #115. *Obstetrics/Gynecology 2010. http://www.acog.org/from_home/publications/press_releases/nr07-21-10-1.cfm*
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"What Every Pregnant Woman Should Know About Cesarean" and other materials from the Childbirth Connection. www.childbirthconnection.org
CDC statistics on cesarean trends, www.cdc.gov/nchs/data/nvsr/nvsr57/nvsr57_07.pdf
Landon, M. B. et al. (2004). Maternal and perinatal outcomes associated with a trial of labor after prior cesarean delivery. NEJM, 351 (25).
Agency for Healthcare Research and Quality. (2003) Vaginal Birth After Cesarean (VBAC). Number 71. AHRQ Publication Number 03-E017
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Roberts, R., Deutchman, M., King, V., Fryer, G., Miyoshi, T. (2007) Changing Policies on VBAC: Impact on Access. Birth 34:4: 316-322.