
Vaginal Birth After Cesarean (VBAC) Fact Sheet

by Nicette Jukelevics

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Evidence confirming the safety of vaginal birth after cesarean (VBAC) within proper guidelines has been available for more than ten years. However, wide variations in VBAC rates, unjustified by medical factors, still exist between hospitals and physicians. These facts are presented with the hope that more women will be encouraged to avoiding unnecessary cesarean section and supported in their wish to labour and have a VBAC.

- VBAC with appropriate informed consent is the standard, of care for women with one prior low transverse uterine incision. Studies indicate that overall at least 50% and as many as 90% of women who plan a VBAC can delivery vaginally (ICEA VBAC Review 1990).
- The rate of reported uterine rupture in planned VBAC with a low transverse scar has ranged from 09% to .22%. This risk is thirty times lower than any other unpredictable childbirth emergency such as acute fetal distress, premature separation of the placenta and prolapsed umbilical cord. A 1994 study based on 5733 planned labours after one or more cesareans reported a rupture rate of .8% with no maternal deaths related to uterine rupture (Guide to Effective Care in Pregnancy and Childbirth 1992; Obstetric Gynecology 1994).
- Maternal morbidity rates are consistently and substantially lower for women who plan a VBAC - 2%-23% - than for women who have an elective repeat cesarean - 11%-38% (Guide to Effective Care in Pregnancy and Childbirth 1992).
- Any hospital that provides standard obstetric care can also provide care for women who wish to plan a VBAC. A recent study concluded that family physicians can play a major role in promoting VBAC (American Family Physician 1993).
- The National Association of Childbearing Centres of the United States (NACC) indicates that birth centres may encourage VBAC clients to labor and deliver in their facilities provided that emergency care can be initiated within thirty minutes of recognition of a problem (NACC Committee Opinion 1989).
- In the United States, 22.6% of all births in 1992 were by cesarean section. Thirty-eight percent of all cesareans performed were elective repeat operations. The VBAC rate in 1991 was 24.2%. A national health objective for the year 2000 is a cesarean rate of 15% and a VBAC rate of 35% (Unnecessary Cesarean Sections: Curing a National Epidemic 1994).
- In 1988-89. the cesarean rate in Canada was 19.5%. Thirty-eight percent of all cesareans were repeat operations. The VBAC rate for this same period was 15.6%, a fivefold increase since 1979-80.

In the province of Manitoba, the VBAC rate for women younger than twenty was 55.2% (Canada Health Reports 1991).

- A review of twenty-five medical reports concluded that women with two prior low transverse uterine scars who wish to plan a VBAC are not at any greater risk for a uterine rupture. The literature indicates that 60% to 75% of women with two or three prior cesareans gave birth vaginally (British Journal of Obstetrics and Gynecology 1991; American Journal of Obstetrics and Gynecology 1988 and 1989; Obstetrics and Gynecology 1990).
- A low segment vertical uterine incision does not appear to increase the risk of uterine rupture for women who plan a VBAC (American Journal of Obstetrics and Gynecology 1988; Obstetrics and Gynecology 1987 and 1988).
- VBAC is safe for non-diabetic women who are expected to give birth to infants that weigh more than 4000 grams (Obstetrics and Gynecology 1989; Journal of Reproductive Medicine 1984).
- A review of forty-two studies concluded that within appropriate e guidelines. VBAC with a breech presentation is a safe and reasonable option (Journal of Reproductive Medicine 1989; Clinical perinatology 1989; American Journal of Obstetrics and Gynecology 1989).
- External cephalic version (a method of rotating a breech presentation) is a reasonable option for women with a prior low transverse scar who wish to plan a VBAC (American Journal of Obstetrics and Gynecology 1991).
- Prostaglandin E2 in gel can safely be used for cervical ripening for women who plan a VBAC. Its use can lower the risk of a cesarean for failed induction with oxytocin (Acta Obstetrics and Gynecology of Scandinavia; American Journal of Perinatology 1992).
- Although uterine rupture in planned labor after cesarean is a rare event, when it does occur, it is often seen as an acute emergency. The most common indicators of uterine rupture are an abnormal fetal heart rate pattern or prolonged declarations with an arrest of progress in labor. Abdominal pain or vaginal bleeding are not reliable indications (American Journal of Obstetrics and Gynecology 1991, 1993 and 1992; Journal of Clinical Anesthesiology 1991).
- A vertical incision (classical/midline) in the upper segment of the uterus is a contraindication for labor (Canadian Medical Association Journal 1993).
- A Canadian study of sixteen community hospitals revealed that physicians are more likely to offer a trial of labor-38.2%-if an educationally influential opinion leader initiated practice guideline recommendations. than if the hospital audited charts of women with a prior cesarean, held departmental meetings and discussed the audit results-21.4% (Journal of the American Medical Association 1991).



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- Data from North American studies indicate that 30% to 50% of women who are offered a trial of labor based on the medical benefits versus risks approach choose to have a repeat operation. A significant number of women who elect another cesarean had their initial surgery for non-progressive labor (Culture. Medicine and Psychiatry 1987; Journal of Reproductive Medicine- 1993; Women and Health 1989; American Family Physician 1993).
- A European study of over 1000 women with a prior cesarean section concluded that routine examination of the prior scar to detect dehiscence after vaginal delivery is of doubtful value (ACTA Obstetrics and Gynecology, of Scandinavia: Enkin, Kerise and Chaimers 1992).
- X-ray pelvimetry, is an unreliable indicator of the outcome of planned labor after cesarean and should be abandoned (British Journal of Obstetrics and Gynaecology 1993; 1991).
- A five-year American study concluded that nurse midwives attending women in labor with a prior cesarean had an 83% rate of vaginal delivery (Journal of Nurse Midwifery 1989).
- Data from a National Birth Center VBAC Study in progress indicate that 8616 of 189 women had a vaginal birth and 93% of these took place in the birth center setting. Forty-nine infants were "macrosomic" - more than 4000 grams: 82% of them were delivered vaginally (NACC 1994).
- VBAC is a valid option in developing countries. Maternal and fetal outcomes are not compromised when women are attended by midwives in hospitals that do not have the use of electronic fetal monitors and availability of a blood bank. However, an attending physician and a surgical team must be available as needed (International Journal of Gynaecology and Obstetrics 1991; Journal of Reproductive Medicine 1992. Australian and New Zealand Journal of Obstetrics and Gynecology 1988).

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International Childbirth Education Association, PO Box 20048,
Minneapolis, Minnesota 55420 USA
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