

## **Great Valley Ob/Gyn**

### **Vaginal Birth after Cesarean**

If you have had a prior delivery by Cesarean section and are thinking about having a trial of labor in an attempt to have a vaginal birth (VBAC), we would like you to consider the following information to help make your decision.

Of those patients attempting VBAC, approximately 60-80% will be successful. In other words, 20-40% of patients attempting to have a vaginal delivery will need to be delivered by repeat Cesarean section during labor. Continuous fetal monitoring is recommended. You may have an epidural if desired. Pitocin may be given to help increase the strength and frequency of your contractions. Patients carrying twins may attempt VBAC if the first twin is head down.

The advantages of a successful VBAC include fewer short-term maternal complications than repeat C-sections and a decreased risk of complications in future pregnancies. However, there is ongoing debate regarding long-term complications related to vaginal delivery, which may include urinary and/or fecal incontinence, or prolapse of the pelvic organs.

Factors that make a trial of labor *more* likely to be successful include having had a prior vaginal delivery and going into labor spontaneously. It is also more likely to be successful if the reason for the prior C-section is something that is unlikely to recur (such as breech presentation).

Factors that make a trial of labor *less* likely to be successful include the need for induction, especially if your cervix has not already dilated and effaced (thinned out) on its own. Another negative factor is having had a prior C-section for failure either to dilate to ten centimeters or to push the baby out. This is particularly likely to be a recurrent problem if the baby's weight is thought to be the same or greater than the prior pregnancy. The shorter the time from the last C-section, the greater the age of the pregnancy (especially if over 40 weeks) and the larger the baby, the less likely VBAC is to occur. Older maternal age and higher body mass index are also parameters that make VBAC less likely.

The risks of having a baby regardless of the method include maternal hemorrhage that may require transfusion or even hysterectomy (removal of the uterus resulting in permanent sterilization), infection, injury (to vagina, urethra, bladder, and rectum if vaginal and to internal organs if C-section), blood clot formation and even death. All of these risks except lower genital tears are more likely with Cesarean delivery than with vaginal delivery. However, compared with successful VBAC attempts and scheduled C-sections, the risks are greatest for patients who attempt VBAC but ultimately need to be delivered by C-section.

The most serious potential complication of attempting VBAC is uterine rupture at the site of prior surgery. This risk increases as the number of Cesarean deliveries increases, and rupture has been known to occur even before the onset of labor. Uterine rupture is usually sudden and can be catastrophic. The frequency of uterine rupture varies from study to study but is roughly 1% after one prior C-section, 2% after two prior C-sections, and up to 4% after three or more C-sections. Uterine rupture may result in excessive bleeding requiring transfusion and the need for surgery to repair or remove the uterus. Uterine rupture often results in a decreased delivery of oxygen to the baby, requiring delivery by emergency C-section under general anesthesia.

At times, even when delivery can be accomplished quickly, brain damage or death of the newborn cannot be prevented. If dense scar tissue is present as a result of healing from a prior Cesarean, a quick delivery may not be possible.

Some patients have risk factors that are contraindications to attempting VBAC. For instance, a prior Cesarean involving a uterine incision that is up-and-down rather than side-to-side increases the risk of uterine rupture to an unacceptable level. The uterine incision is completely unrelated to the skin incision so the only way to know the type of uterine incision is to review the operative note dictated by the surgeon. Having had other surgery on the uterus (e.g. removal of large fibroids) may also be a contraindication to VBAC. Patients who have had a prior uterine rupture with a previously attempted VBAC should not have another trial of labor.

The alternative to attempting VBAC is to schedule a repeat C-section, usually performed under spinal anesthesia. There is a very small risk of death after surgery in the United States, but it is 4-7 times more likely after C-section than after vaginal delivery. It is about nine times more likely for an abnormal blood clot to form after C-section. The risks to the baby include scalpel laceration during C-section, as well as a greater likelihood that the baby will need more time to transition from the intrauterine environment. Temporary breathing problems like transient tachypnea (rapid and sometimes labored breathing) are more likely. Delivery by Cesarean also adds risks to future pregnancies. In addition to uterine rupture, the risk of abnormal placental attachment and possible bleeding problems in subsequent pregnancies is increased by approximately 25%. That risk increases with each additional C-section. Finally, the recuperation after surgery is typically, though not always, longer and more difficult than after vaginal delivery.

The American College of Obstetrics and Gynecology does not consider it to be too unsafe to undergo induction of labor after a prior C-section or to attempt VBAC after two prior sections. However, the use of prostaglandins for induction greatly increases the risk of uterine rupture and is strongly discouraged. The physicians at Great Valley Ob/Gyn agree that the best candidates for VBAC are patients who have had only one prior C-section and go into labor spontaneously before 41 weeks gestation. Those are the patients most likely to successfully have a vaginal delivery and least likely to have a major complication. Please talk to us about all of your concerns and preferences.