

## Vaginal Birth After Cesarean Section (VBAC)

This is a review of information concerning VBAC which you should be aware of in your current pregnancy. It is not meant to be extensive or all-inclusive, but rather to highlight major points that will help you make decisions regarding your delivery options.

- There are no randomized trials to prove that maternal or neonatal outcomes are better with VBAC than repeat C-section.
- VBAC is associated with a small but significant risk of uterine rupture with a poor outcome for both mother and infant.
- Reports also indicate that maternal and infant complications are associated with an unsuccessful trial of labor after previous C-section.
- VBAC success rates are approximately 60-80% in selected populations.
- Risk of uterine rupture increases with the number of previous uterine incisions.
- Neither repeat C-section nor trial of labor is risk-free.

### Advantages of Successful VBAC

- Fewer blood transfusions
- Fewer postpartum infections
- Fewer thromboembolic events (blood clots)
- Shorter hospital stays
- Usually no increased perinatal morbidity

### Risks of Unsuccessful VBAC

- Increased risk of infection for mother and infant.
- Increased risk of uterine rupture, hysterectomy and/or operative injuries.
- Rupture of uterine scar can be life-threatening for both mother and infant. When catastrophic uterine rupture occurs, some patients will require a hysterectomy and some infants will die or could be neurologically impaired (a study of 2000 patients with 1% rupture rate had a 1/3 infant mortality)
- Occurrence of rupture for one prior low transverse incision is 0.2-1.5%.

### Risks of Repeat C-Section

- Operative complications
- Increased risk of placental abnormalities in subsequent pregnancies which may result in blood transfusion, hysterectomy, operative complication and/or preterm delivery.
- Although the absolute risk of maternal mortality is low, an elective C-section has risk of death 2.8 times more than that of a vaginal delivery.

### Candidates for VBAC

- Clinically adequate pelvis.
- No other uterine scars or previous rupture.
- Need for continuous fetal monitoring during labor.
- 24-hour physician and anesthesia availability; in-house physician may need to perform delivery.
- Labor induction must be approached judiciously. Prostaglandin use has been associated with increased risk of uterine rupture; some studies have indicated that high infusion rates of oxytocin place women at a greater risk of uterine rupture.