FMCC Fertility & Midwifery Care Center

Once a Cesarean, Always a Cesarean?

Vaginal birth after cesarean section

One of the most common reasons a woman undergoes a cesarean section is due to a previous cesarean section. That is, her physician subscribes to the "once a cesarean always a cesarean" philosophy. Yet many women have successful vaginal deliveries after a prior cesarean section. What is the right answer? What does the research tell us? What is best for you and your baby?

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There was a time in the early 1990's when the thinking was that everyone and anyone could attempt a vaginal birth after cesarean section (VBAC). There were even some areas in the country where insurance companies required patients to have a so-called trial of vaginal labor before they would allow a repeat cesarean section. However, over time reports surfaced of poor, even catastrophic outcomes from women attempting VBAC. As a result, physicians and hospitals in some areas stopped VBAC programs altogether and our national cesarean section rates have increased dramatically as a result. More recently, thanks to new research and policy statements from national medical organizations, VBAC is on the comeback. Yet change comes slowly in medical practice and – despite new recommendations – VBAC remains unobtainable for far too many women.

What drives many physicians and hospitals away from VBAC? The problem lies with the potential for the scar in the uterus from the previous cesarean section to separate or rupture during labor. If this happens, the result can be truly catastrophic with severe injury and even death of the baby with similarly devastating consequences for the mother. The research data is challenging to interpret when it comes to the likelihood of VBAC complications. It is difficult if not impossible to predict when and to whom a complication may occur. To make matters worse, there has been and will likely always remain an intense fear of litigation resulting from a VBAC complication. As a result, the default position of many physicians and some hospitals has been to perform repeat cesarean sections in hopes of avoiding VBAC complications. However, an important detail to remember is that **repeat cesarean sections also contain significant risks**. A cesarean section is a major abdominal surgery and that comes with risks; risks that too often are not discussed or even considered. These include bleeding, infection, injury to other pelvic structures, the need for blood transfusion, deep vein thrombosis leading to potentially fatal pulmonary embolism.

One of the greatest risks of repeat cesarean section rarely discussed is known as "**placenta accreta spectrum** (PAS)," a condition in which the placenta abnormally attaches to the uterus requiring interventions including

hysterectomy, among others. ACOG reports the incidence of PAS has dramatically increased from 1 in 4,000 in the 1980s, to 1 in 272 in 2016. This is a devastating condition directly related to the number of cesarean sections performed. So, a woman having a repeat cesarean section greatly increases her subsequent risk of PAS in future pregnancies. Sadly, this is rarely, if ever discussed with patients.

The critical point to understand is there are no zero-risk alternatives; both repeat cesarean section and VBAC have risks.

So what is one to do? There are risks to having a repeat cesarean section and risks to attempting VBAC. How do you choose which set of risks to accept? Sadly, many patients and physicians alike underestimate the risks of repeat cesarean section while overestimating the risks of VBAC. From a physician's perspective, this makes sense because the risks of repeat cesarean section are considered "acceptable risks of surgery" (a terrible phrase) – they can and do occur with any major surgical procedure. The reason that many doctors prefer repeated c-sections is simply the fact that obstetricians themselves usually feel more comfortable accepting surgical risks as compared to the VBAC risks. When VBAC complications occur, obstetricians may feel out of control, being only able to react to what has occurred. Most obstetricians don't like that feeling of vulnerability. This, coupled with the very real risk that the obstetrician will face litigation if a VBAC complication occurs, leads to many physicians opting out of VBAC or being "tolerant" but not "supportive" of women's desire for VBAC.

The approach to VBAC at FMCC involves an effort to understand and describe the risks of both alternatives and to work with women to determine what is best for them on an individual basis. This is informed consent. We respect a woman's right to make the decision that is best for her, most consistent with her values. We believe many of the problems encountered in the past have resulted from policy makers attempting to force a given decision on all women and their physicians. Instead, this is a decision that should be based on an individual women's comfort with the various risks in close consultation with her obstetrician. Should obstetricians be forced to participate in VBAC? Absolutely not. Rather, if uncomfortable with VBAC, they should refer a woman to another physician who is trained and comfortable with all things VBAC.

Is there an ideal candidate for VBAC? Research data says probably not, though this too is unclear. We like to think of potential VBAC candidates along a continuum from "ideal" on the one extreme, to "not-so-ideal" on the other.

The ideal candidate is probably a woman who has experienced one or more successful vaginal births, but in a subsequent pregnancy, underwent cesarean section for what one might think of as "bad luck." Meaning that something occurred which is not necessarily likely to reoccur in the present pregnancy. Examples include a baby in the breech (bottom first) presentation, the prolapse of a baby's hand through the cervix, or the prolapse of the baby's umbilical cord through the cervix. Each of these problems require a cesarean section, but they are not

likely to reoccur in subsequent pregnancies. A patient in this situation – who is very motivated to have a VBAC and understands the risks – is an ideal VBAC candidate.

What type of patient is not-so-ideal for VBAC? In discussing this with patients, we describe a woman who – in a previous pregnancy – labored and her cervix became fully dilated. Then she pushed for several hours, yet was not able to deliver despite an adequate trial (and "adequate" can have several definitions). This patient is probably a less-than-ideal candidate. This does not mean such a patient cannot or should not attempt VBAC, however.

Another example in this category is a woman who knows in advance that induction of labor will be required because of some other underlying condition. Chronic hypertension, for example. In the woman who has not had a previous vaginal birth who will require induction of labor is probably not "ideal," but she should not be excluded altogether. Patients with similar past experiences like these interested in VBAC should discuss with their physician, ideally in advance of pregnancy.

Is there a patient who simply should not attempt VBAC? The data here is clearer. A woman who has undergone uterine surgery for the removal of fibroids and that surgery involved the full thickness of the uterine wall should not attempt VBAC. There is general agreement that a woman who has experienced a uterine rupture in the past should not attempt VBAC. A woman who has had a prior cesarean section, is now pregnant and her baby's weight is estimated to be greater than 4,500 grams (or approximately 9 lbs.) may not be an ideal candidate, but this is less clear and not an absolute contradiction to VBAC.

A word about our experience FMCC. At FMCC, our overall VBAC success rate is approximately 83%. That means, in those patients with a history of prior cesarean section, our c-section rate is only 17%, which is considerably lower than the national average for patients who have not undergone a prior cesarean section, yet only slightly higher than our cesarean section rate for pregnant women in their first pregnancy. Our VBAC success rate for those patients who had one prior cesarean is 87%. For patients with a history of two prior cesareans it is 67%.

- We take VBAC seriously, as do our patients. We strongly suggest to our patients they attend the childbirth preparation class offered by our friends at Birth Matters (www.birthmatters.com). When you are tired and the pregnancy is approaching its tenth month, the negative forces will attack you. Well-meaning friends will suggest there is something wrong because you're not in labor; poorly informed co-workers will suggest it is safer to have a repeat c-section than to attempt VBAC; concerned parents will suggest you should ask to be induced, and the list goes on. It's at this time that you need the confidence acquired from the professional childbirth instruction provided by Birth Matters. The greatest resource available to women considering VBAC is the web site www.vbacfacts.com. We strongly suggest visiting that site and if possible supporting their work financially.

- Labor is an athletic event and any such event requires training and conditioning. We encourage our patients to aggressively manage their weight gain during pregnancy and to do all they can to maximize their fitness and flexibility in preparation for labor. This can and should involve exercise and aerobic fitness, resistance training, and chiropractic therapy.

- Avoid unnecessary induction of labor, that is, when it is not medically indicated. While it can be tempting to consider inducing labor, particularly when you watch your due date pass, unnecessary induction will only increase the probability of the very thing you are trying to avoid: a cesarean section. Our community has an alarmingly high induction of labor rate such that it can seem normal when discussing it with friends and relatives. Nowhere is non-indicated or "social" induction of labor more harmful than with VBAC.

While all births are exciting and beautiful, there is something particularly magical when a woman who has undergone a cesarean section and, in many cases, has been told vaginal birth was not an option for her, goes on to deliver vaginally. "I did it!" is a common cheer at those moments. Many women carry with them deep emotional scars and unanswered questions from their prior cesarean births. They question what they might have done differently to prevent the surgery. They frequently question the decisions, interventions, and motivations of their healthcare providers in retrospect. The beauty of successful VBAC is real and so is the birth trauma that many experience from previous experiences.

In summary, the most important take-away message when it comes to VBAC is the need for a detailed, transparent discussions with your obstetrical provider about the complexities and uncertainties related to VBAC as they relate to your specific set of circumstances. It is critical that you understand the issues outlined above – and how they relate to your specific set of circumstances – so that you can discuss them in a meaningful way with your provider. In this way, the two of you can come to a decision that is right for you and your baby.

If you are interested in reading more about VBAC, we suggest the American College of Obstetricians and Gynecologists (ACOG) Practice Bulletin #205, Vaginal Birth After Cesarean Delivery, February 2019. This publication can be found at https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2019/02/vaginal-birth-after-cesarean-delivery. Another important resource is ACOG Obstetric Care Consensus #7, Placenta Accreta Spectrum, December 2018. This can be found at https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2018/12/placenta-accreta-spectrum

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