Childbirth Connection

 Childbirth Connection, formerly Maternity Center Association, is a national not-for-profit organization that has been a leader in maternity care quality improvement since 1918. Our mission is to promote safe, effective and satisfying maternity care for all women and their families through research, education and advocacy. Most recent page update: **4/5/2006**

Options: VBAC or Repeat C-Section

Which is safer for my baby: planning a *VBAC* or a repeat c-section?

The choice between *vaginal birth after cesarean* (*VBAC*, "vee-back") and repeat c-section is sometimes presented in black and white, with some holding the opinion that another cesarean is safest for your baby. It is true that the c-section scar can give way (*uterine rupture*) during labor and that this is, on rare occasions, life-threatening for the baby. The decision is not so simple, however, as a c-section also poses risks to babies. This website can help you consider the full range of risks involved when making your decision. You can find detailed information about these risks in Best Evidence: VBAC or Repeat C-Section and Best Evidence: C-Section.

Which is safer for me: planning a VBAC or a repeat c-section?

Both vaginal birth after cesarean and repeat c-section involve some increased risks to mothers. However, without a clear, compelling and well-supported need for c-section in the present pregnancy, **planned vaginal birth is safer overall** for you than a planned repeat c-section. With supportive care, 75 or more out of 100 women who plan VBAC give birth vaginally. The others go on to have another cesarean, primarily for reasons that are unrelated to the scar.

A planned cesarean offers certain advantages over a cesarean that takes place after labor is underway: a planned cesarean is less likely to involve injury to other organs during surgery, to lead to infection after surgery, and to take an emotional toll. Nonetheless, whether planned or unplanned, cesarean sections are major surgery and involve pain, a post-operative recovery period, and greater risk for mothers in many areas. You can find detailed information about these risks in Best Evidence: VBAC or Repeat C-Section and Best Evidence: C-Section.

Which will be safer for me and my babies in any future pregnancies: planning a VBAC or a repeat c-section in this pregnancy?

A VBAC in your current pregnancy is the far safer choice for any future pregnancies you may have. Each additional cesarean operation increases the amount of internal scarring (*adhesions*) and the number of uterine scars. The accumulating scar tissue makes it more and more difficult for the egg to make its proper way from the ovary into the uterus and for the placenta that nourishes the baby to grow and attach normally. These problems can pose life-threatening risks to babies and mothers. The scarring can also pose challenges for future surgical procedures, cesarean or other.

A VBAC this time around has other advantages in future pregnancies. If a woman who has a VBAC has more children, she almost always gives birth vaginally and her *uterine scar* almost never gives way during future labors.

Why is it important to keep options open for VBAC or repeat c-section?

Dozens of studies involving tens of thousands of women have concluded that planned VBAC is a reasonable choice in nearly all cases. Unfortunately, other factors have come into play on this issue. These include changing cultural views of c-section, VBAC and vaginal birth in general, and fears of legal claims and lawsuits. Many discussions of this matter fail to recognize the full range of risks involved with surgical birth. For these reasons, caregivers and hospitals that offer VBAC are becoming ever more difficult to find. Nonetheless, every woman should have the opportunity to carefully weigh the benefits and potential hazards of planned c-section versus planned VBAC and make the decision she feels is right for her, her baby, and her family.

How does my right to "informed consent" or "informed refusal" relate to my decision about VBAC vs. repeat c-section?

Informed consent is a process to help you decide what will and will not be done to you and your body. In the case of maternity care, informed consent also gives you authority to decide about care that affects your baby. The purpose of informed consent is to respect your right to self-determination. It empowers you with the authority to decide what options are in the best interest of you and your baby. Your rights to autonomy, to the truth (as best as it can be known at the time), and to keep yourself and your children safe and free of harm are basic human rights. As the person receiving care and mother of your baby, you are in the best position to decide what risks are important to you.

Whether you wish to plan a VBAC or a repeat c-section, it is important to make this decision on the basis of complete, accurate, unbiased information. In practice, you

will not always have access to your choice, as providers, hospitals and birth centers also have rights and may choose not to offer some types of care. However, others in your community or surrounding communities may offer the type of birth you want, including emotional support that addresses fears or anxieties that you may have.

How can I learn more about my specific situation?

It is essential that you seek information beyond what is provided here. Your caregivers are an important source of this information. If your caregiver proposes a repeat cesarean or a VBAC, ask:

- What is involved in this particular course of action?
- Are there any special considerations for my specific situation?
- What benefits do you believe the recommended care offers?
- What potential problems or disadvantages could there be?
- What are the pros and cons of the alternative route?

Your decision affects the likelihood that you, your baby, and any future babies will experience dozens of risks. You can learn about these in **Best Evidence: VBAC or Repeat C-Section and Best Evidence: C-Section**. Your caregiver can help answer questions about this information.

Especially if you decide to plan vaginal birth when the chances of the scar causing problems are greater than usual, you may wish to choose a hospital capable of handling an urgent cesarean at any time. To do this, the hospital must have obstetricians, anesthesiologists, and pediatricians immediately available around the clock and a blood bank that is open at all times.

What if a cesarean is recommended for a new problem that is a not an urgent matter?

In many cases, where some caregivers would recommend a cesarean, others would disagree that a cesarean is necessary. When the situation is not urgent, you have time to discuss the advantages and disadvantages of a cesarean with your caregiver. You can consult this website's separate Pregnancy Topic on **Cesarean Section**.

What are some special scar-related situations when a planned c-section might be recommended, but research has not found any extra risk of having problems with the scar?

- **type of uterine scar not known:** Many years ago, studies showed that a side-to-side cut on the lower part of the uterus (*low transverse incision*)

produced a much stronger scar than the previously used vertical (*"classical"*) incision. As a result, virtually all women who had a previous cesarean and are pregnant now have a scar that goes from side to side. Exceptions may be a past cesarean for: *placenta previa* (placenta overlays the cervix), an emergency situation, premature (*preterm*) birth, or *breech* (baby in feet- or buttocks-first position).

- **previous cesarean for premature (preterm) birth:** The lower portion of the uterus may not have developed enough at the time of the past cesarean to permit a cut that goes from side to side (*transverse incision*). For this reason, doctors may make an up-and-down incision at the bottom of the uterus (*low vertical uterine incision*). However, the *low vertical incision* appears to be just as strong as a *transverse incision*.
- **baby expected to be larger than average:** Some have thought that babies expected to weigh more than 8 pounds, 13 ounces (4,000 grams), so-called *macrosomic* or "big bodied" babies, would put extra pressure on the scar. However, studies don't show this to be the case.
- **pregnancy goes beyond the due date:** Studies do not show an increase in problems with the scar in pregnancies going beyond 40 weeks.
- **twin pregnancy:** Studies haven't shown an increase in problems with the scar during labor with twins compared with one baby. However, limited information on VBAC labors with twins is available at this time.
- **baby is in a buttocks- or feet-first (*breech*) position:** Few care providers will agree to vaginal breech birth even when the mother has no cesarean scar, so the question here is whether it is it safe to have a procedure in which the care provider uses hand maneuvers on the belly to try to turn the baby into a head-first position (*external cephalic version*). As with twins, we have little research on this point, but what little we have has not found extra problems.

Are there any factors that *do* increase my risk of having problems with the scar?

Overall, fewer than 1 in 100 women who labor after a cesarean experiences the scar giving way during labor, which generally leads to an urgent c-section. Researchers have found that some factors increase this likelihood. None of these factors raises this risk higher than 4 out of 100, and most do not raise it higher than 2 out of 100. In other words, 96 to 98 out of 100 women who have these factors will labor without any problem with the scar.

In VBAC labors, loss of the baby occurs much less frequently than scar separation and urgent c-section. A recent major government report found that, on **average, over 7,100 planned repeat cesareans (and their associated risks) are required to prevent the death of 1 baby as a result of problems with the scar.**

The following situations have been shown to increase risk for scar-related problems:

- more than one prior cesarean
- uterine infection following the previous cesarean
- mother aged 30 or older
- due date less than 18 months after the previous cesarean.

Are there any situations where the risk of the scar giving way (*uterine rupture*) is so high that labor should not be attempted?

In some rare situations, it is thought that substantially more women 8 to 12 out of 100 or so will have the scar give way. Almost all care providers, including those who usually encourage VBAC, would strongly recommend planned cesarean in the following situations:

- **certain uterine scars from a cesarean that aren't the usual horizontal cut made at the bottom of the uterus (*low transverse scar*):** In these rare situations, the concern is that the scar on the uterus may be weaker and more likely to give way (*rupture*) and cause serious problems than the usual cesarean scar.
  - **a high cesarean scar that runs up-and-down (*vertical* or *"classical" uterine incision*):** a vertical incision may have been used if you had a placenta that grew over the opening to your uterus (*placenta previa*), for some urgent cesareans, or in some cases previous baby was in a buttocks- or feet-first (*breech*) position. (It is possible to have a low horizontal scar on your skin but a vertical cut on your uterus.)
  - **inverted T- or J-shaped incision**
- **mother had previous uterine surgery** for gynecologic problems, such as for removal of fibroid tumors
- **uterine scar opened *and* caused problems in a prior labor:** The key point here is that the scar has caused problems before. Many times, scar openings are small, harmless "windows" (*dehiscences*). These windows are not thought to have any ill effects in future labors.
- **uterus does not have the usual pear shape:** Examples of this are a heart-shaped (*bi-cornate*) uterus or a uterus that is partly divided down the middle (*septate* uterus).
- **ultrasound in late pregnancy finds that the area of the scarred uterus is unusually thin:** There may be a concern if the scar is 2.5 millimeters thick (about the height of 2 stacked dimes) or less.

Does starting labor artificially (*induction*) affect the likelihood of *uterine rupture*?

Agents used to soften and shorten the *cervix* (the opening to the uterus) may increase the likelihood that the scar will open and lead to problems in labor (some

studies find a relationship, and others do not). Some researchers think these agents may soften the uterine scar as well. They belong to a family of hormone-like substances called *prostaglandins*. They may be put in a woman's vagina or, less commonly, given by mouth. Brand names include Cytotec, Cervidil and Prepidil. **Please note:** although a recent independent review concluded that evidence is unclear at this time, the manufacturer of Cytotec includes a warning on the official Food and Drug Administration (FDA) "label" that use of this product for labor *induction* increases risk for *uterine rupture*, which is higher for women with a previous cesarean (see references for Searle and for Guise, McDonagh and colleagues.).

Using synthetic *oxytocin* (Pitocin or "Pit") by itself to try to start (*induce*) labor may also increase the likelihood that the scar will give way. In this case, at most 2 women in 100 experience this problem compared to the rate of less than 1 in 100 in women not being induced. Giving *oxytocin* early in labor to strengthen contractions (labor *augmentation* or *stimulation*) may also increase the risk of scar problems.

Given the increasingly casual use of labor induction in the U.S., many women have the option of waiting for labor to begin on its own, or at least waiting to induce labor until changes in the cervix signal that it is ready to open. If your caregiver recommends *induction* to you, it is important to consider together the risks and benefits of waiting for labor to begin on its own, inducing labor, or scheduling a cesarean section.

Are there any situations where the risk of the scar giving way (*uterine rupture*) is somewhat lower than average?

If you have given birth vaginally in the past, your chances of having scar problems with a VBAC labors appear to be reduced.

What factors increase my chances of having a vaginal birth if I prefer VBAC?

If you have already had a vaginal birth (in addition to your c-section), you are more likely to reach a goal of VBAC than a woman who has not had a vaginal birth. See Tips & Tools: VBAC or Repeat C-Section for things you can do in pregnancy and during labor to increase your likelihood of having a vaginal birth this time around.

Though I prefer VBAC, would it ever be wise to plan repeat c-section due to a situation with very low chances of having a vaginal birth?

VBAC is associated with risks and trade-offs, so deciding whether to give birth vaginally after c-section is a choice that only you can make. It may help you to know, though, that some doctors developed a scoring system to try to identify the

likelihood that a woman would end up having a vaginal birth, from 0 (least likely) to 10 (most likely). As expected, almost all women scoring 8 to 10 had vaginal births, but half the group scoring 0 to 2 still gave birth vaginally. Studies that have looked at such factors as suspected big baby, slow or stalled labor as the reason for the previous cesarean, going past the due date, more than one previous cesarean and others have found that despite these disadvantages half or more of women who planned VBAC achieved their goals.

What can I do if fear of repeating another difficult labor is holding me back from considering VBAC?

- If you can identify what elements of your labor distressed you, you may be able to avoid repeating the problem. Here are some ideas:

- **If you feel that you didn't have good supportive care from your caregivers**, you may wish to choose a different caregiver, birth setting, or both.

- **If you feel that you didn't get the support you needed from your partner or others who were with you**, hire a *doula* (trained labor support companion) or invite a friend or relative to assist you and your partner.

- **If the problem is the frustration of long, non-productive hours in labor or pushing**, you can:

    - know that your next labor may proceed very differently; the first is usually the longest.

    - learn about factors that can interfere with labor progress and gather ideas on how to help labor progress more smoothly. This is another reason to hire a *doula* as she will know these things.

    - decide ahead of time on reasonable limits for the cervix to dilate fully and then for you to push the baby out. Knowing you have an end point can help you feel less anxious and more in control. If you reach this point, you can choose whether to go beyond it. Keep in mind when setting limits that women with prior cesareans tend to labor more like first-time mothers than women who have given birth vaginally.

- **If your concerns are with the pain of labor**, become informed about epidurals, which tend to offer effective pain relief, and consider planning to have one. Epidurals and spinal analgesia have a particular drawback for VBAC labors that you should be aware of: they can slow the baby's heart rate and may create a "false alarm" that the scar has ruptured. Nonetheless, some women value feeling in control of pain relief in this way. A *doula* can also help with many measures for comfort and calming in labor.

What if deep fear of labor is holding me back from considering VBAC?

Although many pregnant women have moments of apprehension about labor, some experience continuing deep-seated fear of labor. If you find yourself in this situation, a series of counseling or psychotherapy sessions during pregnancy may help you overcome these fears and keep your options open. If you decide to seek counseling, be sure to get help from a trained individual who has both good counseling skills and an understanding of maternity issues. With this help, about one-half of women who previously requested planned c-section change their minds. Continuous support during labor by a trained labor support companion (*doula*) may also be of special value in this situation. If you still have deep fears of childbirth despite counseling, cesarean birth may be your best option. Should this be your choice, Tips & Tools: VBAC or Repeat C-Section can help you have a safer and more satisfying cesarean birth.

I've gotten the information, and I'm feeling torn: how can I decide?

Pay attention to the feelings that arise as you consider these questions:

- If you decided on VBAC and it ended with another cesarean, would you feel better for having tried or worse because you went through labor only to have another c-section?
- If you scheduled a cesarean, would you feel relieved that you wouldn't have to labor again or upset because now you would never know what would have happened if you had chosen a VBAC?
- If you planned a VBAC and had one, what would that mean to you?

Best Evidence: VBAC or Repeat C-Section

Most recent page update: 4/5/2006

http://www.childbirthconnection.org/article.asp?ck=10211

VBAC Consent Form for California Article 3.5, Sec. 1379.19

_____ LM #____
Address _____
_____
( ) ____-_____ ( ) ____-_____

I, _____ read the attached Childbirth Connection (formerly Maternity Center Association) document entitled **"Options: VBAC or Repeat C-Section",** 04/05/06 edition, **and I believe it to have answered my questions about my VBAC status and to have provided the necessary information to accompany my informed refusal of a planned vaginal birth after CS in the hospital and my informed consent for planned home birth under the care of a California licensed midwife.**

I am also familiar with the document entitled "**Article 3.5 Midwifery Practice**", which enumerates the following informed consent requirements for California licensed midwives relative to providing community-based care for VBAC.

I have been provided with the required documents, information and I consent to the following:

- **ACOG Practice Bulletin N0. 5, July 1999** entitled "Vaginal Birth After Cesarean Delivery" (client initials _____)
- Description of the **LM's level of clinical experience** and **history in providing care to VBAC clients** and **any advanced training** or education in the clinical management of VBACs (_____)
- A list of **educational material provided** to the client, including this document and Childbirth Connections' document on "Informed Decision Making Informed ~ Consent or Refusal" (_____)
- Client's **agreement to provide a copy of the dictated operative report** regarding the prior C-section (_____)
- Client's **permission to use increased monitoring** during labor (_____)
- Client's **agreement**, if requested by the midwife, **to transfer to a hospital** at any time or if labor does not unfold in a normal manner (_____)
- Detained **description of the material risks and benefits** of VBAC and of elective Cesarean section (CC's **"Options: VBAC or Repeat C-Section",** 04/05/06 edition _____)

Client Name _____ Date ____ Signature _____

Partner Name_____ Date ____ Signature _____

_____LM Date ____ Signature _____