Centre intégré de santé et de services sociaux
de la Montérégie-Ouest

Vaginal birth after caesarean (VBAC)

WHAT YOU NEED TO KNOW

This pamphlet contains a wealth of information to help you make an informed decision when it comes to having a vaginal birth after caesarean.

What are my chances of a successful VBAC?

Several factors can influence your chances of a successful VBAC, such as why you needed your previous caesarean and how your current pregnancy is progressing. Thanks to medical advances, VBAC is a safe choice for women and their babies when there are no complications involved. In these cases, the success rate is 75%.

Note that the information in this pamphlet is not a substitute for a detailed discussion with your doctor or midwife. During your pregnancy, you will have opportunities to discuss and consent to the best delivery method for you.

Acronyms

TOLAC: Trial of labour after caesarean (process leading to a VBAC).

VBAC: Vaginal birth after caesarean.

Definitions

Electronic fetal monitoring (EFM): Method of assessing uterine contractions and monitoring the baby's heart rate, using a monitor connected to the mother with two sensors.

Episiotomy: An incision in the perineum made just before the baby comes out. It can be performed when there is a need to deliver the baby faster. The incision is repaired with stitches, under local anesthesia.

Intermittent auscultation (IA): Monitoring technique that measures the baby's heart rate at set intervals.

Planned caesarean: Scheduled surgery at the end of pregnancy, a few days before the expected delivery date. A caesarean involves delivery through an incision in the lower abdomen and uterus when the mother's or baby's condition is not conducive to a vaginal delivery. The procedure is performed under anesthesia.

Uterine rupture: Occurs when the scar from the previous caesarean tears open.

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My chances will be higher if:

- I'm determined and well informed;
- I trust my doctor or midwife;
- I have given birth vaginally in the past;
- My cervix is in good condition;
- My baby is ideally positioned;
- I go into labour spontaneously (not induced);
- I have good support during my labour;
- I change positions often during my labour and when pushing.

My chances will be lower if:

- I am induced and my cervix is not in good condition;
- I needed a caesarean because my cervix stopped dilating or the baby stopped descending;
- The time elapsed between my previous caesarean and the trial of labour after caesarean (TOLAC) is less than 24 months;
- My baby weighs more than 4,000 g (4 kg);
- I am significantly overweight (BMI of 30 or more);
- I am over 35;
- I have a pregnancy-related health problem (hypertension, diabetes, kidney disease, pre-eclampsia);
- I go into labour spontaneously after 40 weeks.

What happens if I choose a TOLAC?

If you choose a TOLAC, this means you will be attempting a vaginal birth. Your condition and your baby's condition will be closely monitored throughout your labour and delivery. A monitor on your stomach will track your contractions and your baby's heart rate. It will alert the medical team to any suspicious activity. If necessary, a caesarean can be performed.

The benefits of a VBAC

- Provides a sense of accomplishment at having delivered vaginally;
- Reduces your time in hospital;
- Allows immediate, sustained contact with your baby;
- Increases your chances of successfully breastfeeding;
- Boosts the baby's immune system;
- Lowers your risk of depression;
- Reduces the risk associated with surgery (caesarean);
- Reduces the risk of complications with future pregnancies;
- Reduces postpartum pain and need for medication;
- Faster recovery and better mobility postpartum;
- Reduces complications with future pregnancies, associated with the placenta covering the cervix or growing too deeply into the wall of your uterus (less than 1%).

Risks and drawbacks of a TOLAC/VBAC

- Ultimately needing a caesarean (emergency or elective);
- Having an assisted delivery (forceps or suction);
- Risk of injury from assisted delivery;
- Risk of postpartum perineal pain;
- Risk of temporary urinary incontinence;
- Painful intercourse due to perineal tearing;
- **Risk of uterine rupture** and associated complications (less than 1%).

What is a uterine rupture?

A uterine rupture is when the old caesarean scar in the uterine wall spontaneously tears open during labour. This rare but serious complication requires emergency surgery. The incidence of uterine rupture is 0.3% to 0.5%.

Risks for the mother

- Bleeding that may require blood transfusions;
- Surgical removal of the uterus (hysterectomy);
- Organ damage (bladder, cervix, vagina).

Risks for the baby

- **26.3%** of babies will lack oxygen to the brain;
- **3.7 to 9.0%** of babies will die if the mother's uterus ruptures.

Absolute contraindications to VBAC

- Classical (vertical) or inverted-T caesarean or any unknown type of caesarean scar;
- Previous uterine or uterine wall surgery;
- Previous uterine rupture;
- Presence of contraindications during labour;
- Patient who refuses to attempt a TOLAC or who refuses to follow the hospital's protocol or the recommendations/ decisions of her doctor or midwife;
- Surgical report from the previous caesarean unavailable.

Factors that increase the risk of uterine rupture

- Previous caesarean less than 18 months ago;
- Characteristics of the uterine scar;
- Labour induced with medication;
- Mechanical difficulties during labour;
- More than one previous caesarean.

Note
A risk factor is not an absolute contraindication to a TOLAC. Your doctor or midwife will be able to assess the risks based on your situation.

Choosing a scheduled caesarean

You will have a surgery to deliver your baby. The procedure will be performed under anesthesia (epidural or spinal). In some cases, general anesthesia may be needed.

The benefits of a scheduled caesarean

- Avoids labour pain and prolonged labour;
- Avoids a failed VBAC;
- Reduces the risk of emergency caesarean;
- Avoids postpartum perineal pain (tearing);
- Avoids complications associated with the use of suction or forceps (injuries, incontinence);
- Reduces the risk of uterine rupture and associated complications (less than 1%).

Risks and drawbacks of a scheduled caesarean

- Risk of separation from your baby;
- Risk of cardiorespiratory complications for the baby;
- Increased risk of bleeding and infection for the mother;
- Postpartum surgical pain;
- Risk of injury to the mother and baby (related to the surgery);
- Slow postpartum motor recovery;
- Reduced success with breastfeeding (delayed milk supply);
- Increased risk of complications during future pregnancies;
- Risk of severe complications for the mother (bowel obstruction, hysterectomy, pulmonary embolism, transfusion, death) (less than 1%).

Services de sage-femme de la Vallée: information depending on birth location

The midwives offer their patients a choice of where to give birth (at home or in hospital). This also applies to women planning a VBAC; however, they must meet specific criteria. A discussion with your midwife will allow you to make informed decisions about your scheduled VBAC and where you will give birth.

If you choose to **give birth outside the hospital**, it is important to understand the **low but significant** risk of a uterine rupture. If this happens, there may be a delay before you can access hospital services. Any delay in surgery (caesarean) can have serious short- or long-term consequences for the mother and the baby.

The incidence of women attempting a VBAC at home or at a birthing centre who are transferred to a hospital varies from 21% to 44%. Most transfers are done for preventive reasons (INESSS). It should be noted that the rate of successful VBACs completed out of hospital has increased.

However, this could be related to the specific cases followed by midwives. But it is important to point out that the following points can contribute to a higher VBAC success rate:

- The woman's mobility;
- No induction with medication or speeding up labour with oxytocin (Pitocin);
- No anesthesia;
- Constant care and follow-up;
- Respect for the physiology of labour.

Intermittent auscultation (IA) of the baby's heart / Electronic fetal monitoring (EFM)

If you choose to give birth outside the hospital (e.g., at home), EFM may not be available. In that case, stricter IA will be performed. It is recommended that the midwife perform IA of the baby's heart every 15 minutes during active labour and every 5 minutes during the second stage.

Note that EFM is the best indicator of uterine rupture; however, it lowers the success rate of a vaginal delivery.

Significant abnormalities in the baby's heart rate often occur in the hour before a uterine rupture. A caesarean may be considered to prevent a significant deceleration in the baby's heart rate.

The Association of Ontario Midwives reports that the only findings that differentiated cases of uterine rupture from completed VBACs were the increased periods of decelerations in the baby's heart rate detected during EFM during the first and second stages of labour. The use of IA can delay the detection of abnormal fetal heart rate patterns, since the monitoring is not continuous.

Ask my doctor or midwife for information

- Why do I want a TOLAC?
- Do I realize that attempting a TOLAC does not guarantee that I will have a successful VBAC?
- Do I still have fears about my choice of delivery method?
- Do I still have questions about my delivery method?

Notes (questions, concerns) to discuss with my doctor or midwife

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