VBAC – What is it and why choose it? With a patient's perspective

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VBAC stands for 'vaginal birth after caesarean'. It is the term used when a woman gives birth vaginally (including births assisted by forceps or ventouse), having had a caesarean delivery in the past. Currently in the UK, approximately 20% of deliveries are by Caesarean section. Of these women, it is estimated that 90% are suitable candidates for VBAC. All women who have experienced a prior caesarean birth should be counselled about the maternal and perinatal risks and benefits of planned VBAC and ERCS when deciding the mode of birth.

The risks and benefits should be discussed in the context of the woman's individual circumstances, including her personal motivation and preferences to achieve vaginal birth or ERCS, her attitudes towards the risk of rare but serious adverse outcomes, her plans for future pregnancies and her chance of a successful VBAC (principally whether she has previously had a vaginal birth). In addition, where possible, there should be review of the operative notes of the previous caesarean to identify the indication, type of uterine incision and any perioperative complications.

The advantages of a successful VBAC include: a vaginal birth (which might include an assisted birth), a greater chance of an uncomplicated normal birth in future pregnancies, a shorter recovery and a shorter stay in hospital, less abdominal pain after birth, and not having to undergo surgery.

Overall, about 75% with a straightforward pregnancy who go into labour give birth vaginally following one caesarean delivery. If ladies have had a vaginal birth, either before or after caesarean delivery, 90% have a vaginal birth. Most women with two previous caesarean deliveries will have their next baby by caesarean delivery. Regardless, if women with >1 caesarean section go into labour, their chance of a successful vaginal birth is slightly less than this, but still at about 70%. Factors that DECREASE the likelihood of a successful VBAC include: BMI of >30 at time of booking, failure to progress previously owing to position of the baby, needing to be induced, and having never had a vaginal birth.

There are of course risks to VBAC; the principal risk is that of **uterine rupture**. Rupture at the site of the prior caesarean scar is the most feared complication of trial of labour in women with a prior caesarean delivery. While rare, its consequences to mother and baby are serious. Evidence provided by two articles, one by Fitzpatrick and colleagues in the UK, and the second by Crowther and colleagues in Australia report that, in women eligible for VBAC, it was estimated that the incidence of uterine rupture was approximately **1 in 500** women planning VBAC and **1 in 1,000** women planning an elective repeat caesarean.

The disadvantages of VBAC include: emergency caesarean delivery, which happens in 25% of women . This is only slightly higher than if labouring for the first time, when the chance of an emergency caesarean delivery 20%. The usual reasons for an emergency caesarean delivery are labour slowing or if there is a concern for the wellbeing of the baby. Women choosing VBAC also have 1% higher chance of needing a blood transfusion or having an infection in the uterus compared with women who choose a planned caesarean delivery. The risk of neonatal mortality or brain damage in VBAC is very small (0.2%), which is is no higher than primiparous women. However it IS higher than if you have an elective repeat caesarean delivery(0.1%).

Sometimes, despite women's dearest wishes to deliver vaginally after caesarean section, it is sometimes simply not advisable. The following circumstances are absolute contraindications to VBAC: firstly, when ladies have had three or more previous caesarean deliveries; the uterus has ruptured during a previous labour; the scar is a high 'classical' caesarean scar (conversely, 'bikini scars' are said to fare very well as the part of the uterus scarred is not as actively involved in the 'heavy duty' of labour and delivery), or if there are maternal medical or surgical complications that means it is safer to deliver by caesarean.

CASE REPORT

Mrs YM is a 34-year old gravida 2, para 1+0 who attended UCLH labour ward on the evening of 17/05/12, and delivered vaginally at 11am on 18/05/12.

YM's first pregnancy was unremarkable, and she was very keen to give birth vaginally; unfortunately after over 90 minutes of 'pushing' the midwife noted that there were variable decelerations on the CTG and evidence of meconium passage. Therefore the decision was taken to perform an emergency lower segment Caesarean section, of which the result was delivery of a healthy female infant.

I was with YM and her midwife throughout the 30 minutes prior to establishment of the 2nd stage, and then subsequent 3rd stage of her labour, and her transfer to the post-natal ward. During this time, I chatted to YM and asked her to offer up her own experiences of VBAC. Her principal fear, as validated by much of the current literature on this topic, was of uterine rupture. She attempted to overcome this with the support of her midwife and Obstetrician mid-way through her 2nd stage of labour, when she gave what she describes as 'trial pushes' to test the tenacity of her uterine scar. YM felt comforted by the presence of more than one professional during this time, and reports that it gave her the 'final bit of confidence needed' to try for a successful vaginal birth.

The birth itself was reasonably straightforward; YM was understandably anxious and, after 40 minutes of pushing and still no baby, she was incredibly worried. The midwife reassured her , explaining that, even though it was her second pregnancy, as it was her first attempt at a vaginal delivery, YM could expect to push for as long as a primiparous lady.

Ten minutes later, the midwife made a decision to perform a right-sided mediolateral episiotomy. This, in hindsight, was perhaps not the best time, as it was another 6 minutes before her healthy baby was delivered. By this time, YM had lost an estimated 600mls of blood, and was going into hypovolemic shock. Whilst I delivered fluids to YM and took obs, the midwife took 45 minutes to complete sutures on YM; YM was kept fully informed at all times as to what was happening, and also what could be expected post-natally regarding pain, follow-up clinics etc, which YM particularly mentioned made her feel much more relaxed.

Four hours post-delivery, YM, her husband, and baby F were transferred to the post-natal ward. It was here that I asked YM, **'if you had to do it all again, would you choose Caesarean section or a vaginal delivery?'** Almost without hesitation, she said, **'vaginal, every time.'**

Her reasons were:

1. She had always dreamt of giving birth vaginally, as it felt like a 'proper' end to the pregnancy.

2. She had planned, right to the point of delivery, to give birth vaginally to baby 1, and whilst she fully understood the reasons for taking her to theatre, she was very keen for subsequent pregnancies to deliver vaginally.
3. She felt **'educated, informed, prepared and supported'** for a VBAC by her midwife and obstetrician.
4. She felt able to care for her second baby much quicker than baby 1, reporting that after her caesarean section she **'wasn't her usual active self for 3 weeks.'**

I was thrilled to be a part of YM's labour and delivery, and was fascinated to talk through with her her positive experience of a VBAC. Whilst there are undeniably figures that suggest VBAC carries risk, what I feel having read the literature, and what YM confirmed, is that, for mothers who wish to have more than one pregnancy following a first Caesarean section and provided there are no absolute contraidications, it **is safe, possible and beneficial** for both mother and infant to enter VBAC with a positive attitude, and to expect healthy, uneventful vaginal delivery for second and subsequent deliveries.

REFERENCES:

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