

The VBAC dilemma

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Vaginal birth after cesarean (VBAC) has been a contentious and controversial issue for fifty years. Once a woman is delivered by cesarean, her options in a subsequent pregnancy are either a planned trial of labor or a planned elective repeat cesarean. There are no randomized trials comparing the two choices to definitively guide patients and physicians. Complicating the VBAC issue is the rising primary cesarean rate, viewed by many as too high, at a time when VBAC rates are decreasing. Thus, any discussion of VBAC must begin with a discussion of primary cesarean. The U.S. cesarean rate of 5.5% in 1970 to 32.9% in 2009 represents a 598% increase. Almost one in 3 nulliparous women now deliver by cesarean. New Jersey has the highest primary cesarean rate (38.2%), Utah has the lowest (22.2%) and Iowa has a rate of 29.4%. If the primary and secondary cesarean rates continue at the same pace as in recent years, the overall cesarean rate is projected to be 56.2% by 2020. Measures proven to lower cesarean rates are likely to be unpopular with physicians.

The VBAC rate peaked at 28.3% in 1996 and has progressively declined to about 7.5% in 2006. Non-medical factors such as financial incentives and medical legal disincentives have had a major effect on these trends. The 2010 National Institutes of Child Health and Human Development (NICHD) Conference of VBAC, after a detailed analysis of benefits compared to risks, recommended that measures should be taken to assure women that VBAC is available to them. However, this is not as simple as it might seem. ACOG responded by stating that a trial of labor after cesarean (TOLAC) is a safe

and appropriate choice for most women who have had a previous cesarean. It reaffirmed the view that TOLAC is most safely undertaken where staff can immediately provide an emergency cesarean, but it also recognized that such resources are not universally available.

Multiple studies have shown that of those women attempting TOLAC, 60-80% will result in successful vaginal births. A number of prediction scoring systems for VBAC have been created, but none are reliable enough to use for an individual patient. The fact remains that VBAC is largely a uterine rupture issue. Most studies on VBAC have been conducted in University or tertiary centers under ideal conditions. Yet the majority of women in the U.S. are delivered in community hospitals where obstetricians and anesthesiologists may not be available in-house on nights and weekends. These manpower constraints present a dilemma for many physicians and hospitals. Rupture of the uterine scar occurs in <1.0% of women with one prior cesarean, but it carries with it the possibility of fetal death or long-term neurologic disability for the child if the patient is not delivered promptly.

Overcoming obstacles to VBAC takes commitment and hard work. To provide a safe and successful outcome with TOLAC, a specific management plan should be formulated for each patient after careful evaluation, assessment of the local setting and prelabor counseling. Checklists, practical coverage arrangements, and simulation drills are important components of labor management. This requires an organized and collaborative effort on the part of patients, physicians and hospitals.

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