

VBAC Safety

By momofsix

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A Vaginal Birth After a Cesarean (VBAC) can be hard to come by these days, as lawsuits and malpractice insurance escalate. Many women are told that a VBAC is impossible, citing safety reasons. Uterine Rupture is the most commonly talked about complication that can occur with a VBAC, but evidence has shown that the risks of uterine rupture are small.

In several studies, the uterine rupture rate has been shown to be about 0.6%, or about 6 out of 1,000 women. Most of these ruptures are not catastrophic, but perinatal mortality does occur in about 0.018% of uterine rupture cases. Or, about 18 out of 10,000 VBACs will end in a fatality caused by a rupture of the uterus.

To put this in perspective, we should look at the infant mortality rate for the United States. It stands at about 67 deaths per 10,000 babies born. Many of these deaths are attributed to the rise in elective cesareans, because babies are twice as likely to die after a c-section as those born vaginally. Studies that show a higher rate of perinatal mortality from VBAC's versus cesarean usually do not account for the increased risks that some medical establishments put on VBAC's (induction, electronic fetal monitoring, and frequent cervical checks). Most studies that track VBAC safety do not allow natural births, such as water birth, intermittent monitoring or homebirth. This would be akin to ruling out all cesareans where antibiotics are used; it just doesn't make sense.

Some measures that can be used for a safer VBAC:

Go into labor on your own. Induction drugs can double the incidence of uterine rupture, as well as more commonly lead to cesarean (happens in all births, regardless of prior cesareans), where it can be chalked up to 'another failed VBAC.'

When induction methods are used, the contractions are harder, stronger and longer than normal contractions, which puts added stress on the uterine scar. Most medical institutions now strictly forbid induction of labor, but some do still practice it, regardless of the evidence that clearly shows how dangerous it can be.

There is no clear evidence to suggest that going past your due date is more dangerous than delivering before. Most women are perfectly safe delivering before 42 weeks, though some care providers will prefer non-stress tests and bio-physicals to check the fetal heart tones and amniotic fluid present.

If your care provider wants you to go into labor before 42 weeks, ask them what evidence suggests that delivering before 42 weeks is better?

Allow enough time to pass for birth. Along with induction, many hospitals choose to augment labor that has started on its own. The same drugs that are used to start labor, can be used to strengthen it, and none of them should be used on a scarred uterus.

Instead, natural methods of labor augmentation can be used, like nipple stimulation, walking and squatting.

A first vaginal birth is just like any other first vaginal birth; they take time. Your doctor shouldn't dictate how much time your body needs to go deliver your baby. Many hospitals are interested in emptying beds and turning rooms, so you have to stand up for yourself and your birth, and insist that they **wait**.

Be Healthy. Staying healthy is paramount to any good birthing experience. During pregnancy, you should follow a good nutritional plan, eat plenty of vegetables, proteins and whole grains, and get exercise 3-5 days per week.

Think of labor as a marathon you have to prepare for. For any marathon, you'll need to stay in excellent shape.

And remember that anything you eat yourself, you're feeding your baby. If you wouldn't feed it to your 2 year old, why would you feed it to your unborn child? This includes trans fats, fast food, junk foods of all kinds and alcohol. This will also ensure that *you* get the required nutrients and avoid unhealthy foods.

Labor and Birth in Water. Many midwives insist that a water birth is the best birth for a VBAC. It relieves pain gently, and is a peaceful way to birth the baby.

If you are able, consider birthing in water. It lowers blood pressure and increases amniotic fluid. It can also speed labor along, sometimes cutting in half the duration of the first stage of labor.

Intermittent Fetal Monitoring. Many hospitals insist on electronic fetal monitoring, which are straps placed across the belly that monitor the mother's contractions and the baby's heart rate. This is done for many women, including anyone that has an epidural or Pitocin, but is often mandatory for VBAC's. The problems arise when EFM readouts are used as gospel, and humans aren't interpreting the results. Sometimes the sensor will pick up the mother's (slower) heart rate instead of the baby's, and it will look like fetal distress. Sometimes the baby sleeps, which can also look like distress. EFM can be detrimental to vaginal birth because the laboring mom must stay in bed, usually on her back or side, throughout the labor. This is not only uncomfortable for the mother, it is also a poor position to be in for labor to progress.

Instead of EFM, intermittent fetal monitoring can be used, where a hand-held Doppler device allows the care provider to listen to the heart rate along with a mother's contraction. It is quite obvious when women are having contractions, and a machine doesn't need to announce it.

Intermittent monitoring can be done every 30 minutes throughout labor, and more often as the 2nd stage of labor approaches. Some care providers prefer to listen more often, which is also fine if the mother is comfortable with it.

The important thing to remember is that variations of the baby's heart rate are normal, what is not normal is if the heart rate does not recover in between contractions. This is when fetal distress may be evident.

Labor Naturally. Epidurals are used in more than half of all births these days, but they may also contribute to the high cesarean rate. There is some fear that having an epidural may mask the painful symptoms of a uterine rupture as well.

Epidurals come with their own risk, which include insufficient pain relief, maternal fever, lower heart rate, fetal distress, longer labor and inadequate ability of the mother to push during the 2nd stage of labor.

Natural labor (unmedicated) is often a satisfactory alternative for women. There are many methods for coping with pain during birth, including the Bradley method, Hypnobabies, Hypnobirth and Lamaze. A doula can also be an important component of a natural labor, since they have been shown to lower the cesarean, epidural and instrumental delivery rates. And, more mother's have a positive birth experience if they have a doula at their side.

What makes you a VBAC candidate?

A lower-transverse uterine incision, or a “bikini cut.” The classical, vertical incisions have much higher rupture rates, and are not recommended for VBAC.

Be in **good general health**, without serious medical complications.

What *still* makes you a VBAC candidate?

Post-dates. Just because you hit the 42 week mark does not mean that you need to sign up for a repeat cesarean. It is an option, but waiting for labor to start is also an option.

Macrosomia (big baby). The American College of Obstetricians and Gynecologists do not recommend induction or cesarean for an estimated big baby. First of all, techniques to estimate fetal size are notoriously inaccurate, and fetal size is no predictor of outcomes.

Oligohydramnios (low amniotic fluid). The uterus is not a sealed vessel, and water can be added to it. If oligohydramnios is suspected the mother can drink 80+ ounces of water per day, and then retest. This is just one method of increasing the amount of amniotic fluid in the womb.

Gestational Diabetes. GD can make babies bigger, and more prone to complications, but those can be watched along with maternal blood sugars. GD may make VBAC more difficult to achieve, but it in itself is not an indicator of disqualifying for VBAC.

Homebirth. Giving birth at home is absolutely possible, and often safer, than giving birth in a hospital. Close distance to nearest hospital, competent care provider (or knowledgeable partner if planning unassisted), and suitably clean birthing environment are all that need be present for a successful homebirth after a cesarean (HBAC).

In the end, women must look at the options available to her, the research she finds, and the results she hopes to accomplish. For some, having a VBAC isn't as important as having control over the birth date or maternity leave; in those cases, a VBAC and the safety of it is irrelevant. For others, the implications of a repeat cesarean are daunting, and the relative safe vaginal birth can be very rewarding. In those cases, it should be encouraged.

No birth is without risk. All situations must be evaluated to find the best possible conclusion for both mother and baby.

This is for informational purposes only, and is not meant to replace the advice of a medical professional.

References:

A VBAC Primer

Infant and Neonatal Mortality Rates

Doula information

Fetal Monitoring

Epidural risks

Waterbirth and VBAC

VBAC and induction

Infant mortality

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