

## **Ob-Gyns Issue Less Restrictive VBAC Guidelines**

**Washington, DC** -- Attempting a vaginal birth after cesarean (VBAC) is a safe and appropriate choice for most women who have had a prior cesarean delivery, including for some women who have had two previous cesareans, according to guidelines released today by The American College of Obstetricians and Gynecologists.

The cesarean delivery rate in the US increased dramatically over the past four decades, from 5% in 1970 to over 31% in 2007. Before 1970, the standard practice was to perform a repeat cesarean after a prior cesarean birth. During the 1970s, as women achieved successful VBACs, it became viewed as a reasonable option for some women. Over time, the VBAC rate increased from just over 5% in 1985 to 28% by 1996, but then began a steady decline. By 2006, the VBAC rate fell to 8.5%, a decrease that reflects the restrictions that some hospitals and insurers placed on trial of labor after cesarean (TOLAC) as well as decisions by patients when presented with the risks and benefits.

"The current cesarean rate is undeniably high and absolutely concerns us as ob-gyns," said Richard N. Waldman, MD, president of The College. "These VBAC guidelines emphasize the need for thorough counseling of benefits and risks, shared patient-doctor decision making, and the importance of patient autonomy. Moving forward, we need to work collaboratively with our patients and our colleagues, hospitals, and insurers to swing the pendulum back to fewer cesareans and a more reasonable VBAC rate."

In keeping with past recommendations, most women with one previous cesarean delivery with a low-transverse incision are candidates for and should be counseled about VBAC and offered a TOLAC. In addition, "The College guidelines now clearly say that women with two previous low-transverse cesarean incisions, women carrying twins, and women with an unknown type of uterine scar are considered appropriate candidates for a TOLAC," said Jeffrey L. Ecker, MD, from Massachusetts General Hospital in Boston and immediate past vice chair of the Committee on Practice Bulletins-Obstetrics who co-wrote the document with William A. Grobman, MD, from Northwestern University in Chicago.

### **VBAC Counseling on Benefits and Risks**

"In making plans for delivery, physicians and patients should consider a woman's chance of a successful VBAC as well as the risk of complications from a trial of labor, all viewed in the context of her future reproductive plans," said Dr. Ecker. Approximately 60-80% of appropriate candidates who attempt VBAC will be successful. A VBAC avoids major abdominal surgery, lowers a woman's risk of hemorrhage and infection, and shortens postpartum recovery. It may also help women avoid the possible future risks of having multiple cesareans such as hysterectomy, bowel and bladder injury, transfusion, infection, and abnormal placenta conditions (placenta previa and placenta accreta).

Both repeat cesarean and a TOLAC carry risks including maternal hemorrhage, infection, operative injury, blood clots, hysterectomy, and death. Most maternal injury that occurs during a TOLAC happens when a repeat cesarean becomes necessary after the TOLAC fails. A successful VBAC has fewer complications than an elective repeat cesarean while a failed TOLAC has more complications than an elective repeat cesarean.

### **Uterine Rupture**

The risk of uterine rupture during a TOLAC is low—between 0.5% and 0.9%—but if it occurs, it is an emergency situation. A uterine rupture can cause serious injury to a mother and her baby. The College maintains that a TOLAC is most safely undertaken where staff can immediately provide an emergency cesarean, but recognizes that such resources may not be universally available.

"Given the onerous medical liability climate for ob-gyns, interpretation of The College's earlier guidelines led many hospitals to refuse allowing VBACs altogether," said Dr. Waldman. "Our primary goal is to promote the safest environment for labor and delivery, not to restrict women's access to VBAC."

Women and their physicians may still make a plan for a TOLAC in situations where there may not be "immediately available" staff to handle emergencies, but it requires a thorough discussion of the local health care system, the available resources, and the potential for incremental risk. "It is absolutely critical that a woman and her physician discuss VBAC early in the prenatal care period so that logistical plans can be made well in advance," said Dr. Grobman. And those hospitals that lack "immediately available" staff should develop a clear process for gathering them quickly and all hospitals should have a plan in place for managing emergency uterine ruptures, however rarely they may occur, Dr. Grobman added.

The College says that restrictive VBAC policies should not be used to force women to undergo a repeat cesarean delivery against their will if, for example, a woman in labor presents for care and declines a repeat cesarean delivery at a center that does not support TOLAC. On the other hand, if, during prenatal care, a physician is uncomfortable with a patient's desire to undergo VBAC, it is appropriate to refer her to another physician or center.

Practice Bulletin #115, "Vaginal Birth after Previous Cesarean Delivery," is published in the August 2010 issue of *Obstetrics & Gynecology*.

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