13 Myths About VBAC

http://vbacfacts.com
Many women believe that the only safe choice after a cesarean is another cesarean. Social pressure plays a huge role in a woman's decision making process and the prevailing American conventional wisdom is greatly influenced by persistent and pervasive myths about vaginal birth after cesarean (VBAC). The result is a 86% repeat cesarean rate in America among women with one prior cesarean (1) despite the fact that most women are candidates for VBAC and most VBACs are successful. Let's draw a clear line between myth and fact.

According to the National Institutes of Health (NIH), "VBAC is a reasonable and safe choice for the majority of women with prior cesarean." (2) The American College of Obstetricians & Gynecologists (ACOG) concurred when they said "most" women with one prior cesarean and "some" women with two prior cesareans are candidates for VBAC. (3)

Myth: VBAC after one cesarean has a 60-70% risk of uterine rupture.
The risk of uterine rupture after one low transverse (bikini) cut cesarean is about 0.5% – 1% depending on factors. (2) (Keep in mind that this refers to the incision on the uterus, not on the abdomen.) First time moms are at risk for complications that are equally serious to uterine rupture and occur at a similar rate such as placental abruption, (4) cord prolapse, (5) and shoulder dystocia. (6)

Myth: Hospitals ban VBAC because it's such a serious and unusual complication that they cannot manage it appropriately.
Hospitals with labor and delivery units have protocols in place to respond to obstetrical emergencies. The guidelines used to manage the complications from first time moms and repeat cesarean moms are also used to address uterine rupture in VBAC moms.

Myth: To expedite an emergency cesarean, epidurals are required in VBAC moms. VBAC moms can't have epidurals because it will obscure the pain of uterine rupture.
Per ACOG, epidurals may be used in a VBAC (3) and evidence suggests that

epidurals do not mask uterine rupture-related pain. (7, 8) Additionally, only 26% of women who experience a uterine rupture report abdominal pain, so it is an inconsistent and unreliable symptom. (9)

Myth: There is a 25% chance that either baby or mom will die during a VBAC.

The risk of maternal mortality is very low whether a woman plans a TOLAC (0.0038%) or an elective repeat cesarean (0.0134%). (2) Limited evidence suggests that there is a 2.8 – 6.2% risk of infant mortality after a uterine rupture with many factors contributing to this range. (2, 10)

The most serious cesarean-related complications become more likely as an individual woman has more cesareans. (11) These complications include placental abnormalities such as placenta accreta which carries an up to 7% maternal mortality rate (12) and a 71% hysterectomy rate. (13) After two cesareans, the risk of accreta is 0.57%, (11) similar to the risk of uterine rupture after one cesarean.

Myth: I can't have a VBAC in my state because it's illegal.

VBAC is legal throughout America and in some states, it's legal for a midwife to attend an out-of-hospital VBAC.

Farah Diaz-Tello of the National Advocates for Pregnant Women clarifies, "I have never heard of a situation in which a physician has lost their license for adhering to a woman's wishes after providing them will full informed consent, and attending them in a manner that is consistent with the standard of care. Even physicians who have been found liable for medical malpractice do not automatically lose their license."

Myth: VBACs can't, or shouldn't, be induced.

When a mom or baby develops a complication that requires the baby be born sooner rather than later, but not necessarily in the next ten minutes, induction can make the difference between a VBAC and a repeat cesarean. This is why ACOG maintains that medically indicated Pitocin and/or Foley catheter induction "remains an option" during a VBAC. (3, 14)

Myth: Hospitals ban VBAC because they can't meet ACOG's "immediately available" requirement.

Some hospitals interpret ACOG's "immediately available" recommendation to be a mandate that an anesthesiologist must be in the hospital 24/7. Some hospitals that cannot provide that level of coverage have banned VBAC.

However, “immediately available” does not have a standard definition and various hospitals implement the guideline in different ways. (15)

Myth: Hospitals that do not have 24/7 anesthesia coverage ban VBAC.
There are motivated hospitals that offer VBAC without 24/7 anesthesia. The rural hospitals that serve the Navajo Nation in New Mexico are an example and they report a 38% VBAC rate. (16) The American VBAC rate after one cesarean is 14%. That drops down to 4% after two or more cesareans. (1)

Myth: The evidence shows that 24/7 anesthesia coverage creates a safer environment for VBAC.
ACOG confirms that the data is not available: “Although there is reason to think that more rapid availability of cesarean delivery may provide an incremental benefit in safety, comparative data … are not available.” (3, 15) In the absence of empirical evidence, the “immediately available” recommendation is based on the lowest level of evidence which is “consensus opinion.” (3) Hospitals without 24/7 anesthesia implement a variety of policies to make VBAC safer including fire drills and cesarean under local anesthesia. (15)

Myth: If your hospital doesn’t offer VBAC, you have to have a repeat cesarean.
As Howard Minkoff MD said at the 2010 NIH VBAC Conference, “Autonomy is an unrestricted negative right which means a woman, a person, anybody, has a right to refuse any surgery at any time.” (16) ACOG affirms that “restrictive VBAC policies should not be used to force women to undergo a repeat cesarean delivery against their will.” (3)
There are real risks and benefits to VBAC and elective repeat cesarean section. Make the right decision for yourself: understand your options, discern truth from fiction, know your legal rights, and get down to the facts.

References

1. Curtin, S. C., Gregory, K. D., Korst, L. M., & Uddin, S. F. (2015). Maternal Morbidity for Vaginal and Cesarean Deliveries, According to Previous Cesarean History: New Data From the Birth Certificate, 2013. *National Vital Statistics Reports*, 64(4). Retrieved from http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_04.pdf
2. Guise, J.-M.; Eden, K.; Emeis, C.; Denman, M. A.; Marshall, N.; Fu, R. (.; Janik, R.; Nygren, P.; Walker, M.; McDonagh, M. *Vaginal Birth After Cesarean: New Insights;* Agency for Healthcare Research and Quality (US): Rockville (MD), 2010. http://www.ncbi.nlm.nih.gov/books/NBK44571/
3. American College of Obstetricians and Gynecologists. Practice Bulletin No. 115: Vaginal Birth After Previous Cesarean Delivery. *Obstetrics and Gynecology* 2010**,** *116* (2), 450-463, http://www.acog.org/Resources_And_Publications/Practice_Bulletins/Committee_on_Practice_Bulletins_–_Obstetrics/Vaginal_Birth_After_Previous_Cesarean_Delivery.

4. Deering, S. H.; Smith, C. V. Abruptio Placentae, 2013. Medscape. http://emedicine.medscape.com/article/252810-overview#a0199.
5. Beall, M. H.; Chelmow, D. Umbilical Cord Complications, 2012. Medscape. http://emedicine.medscape.com/article/262470-overview#a30.
6. Allen, R. H.; Chelmow, D. Shoulder Dystocia, 2011. Medscape. http://emedicine.medscape.com/article/1602970-overview#a03.
7. Johnson, C.; Oriol, N. The role of epidural anesthesia in trial of labor. *Reg Anesth.,* Nov-Dec 1990, 304-308.
8. Kamel, J. Can you feel a uterine rupture with an epidural?, 2012. VBAC Facts. http://vbacfacts.com/2012/06/22/can-you-feel-a-uterine-rupture-with-an-epidural/.
9. Nahum, G. G. Uterine Rupture in Pregnancy , 2012. Medscape Reference. http://emedicine.medscape.com/article/275854-overview#aw2aab6b6.
10. Kamel, J. Confusing fact: Only 6% of uterine rutpures are catastrophic, 2012. VBAC Facts. http://vbacfacts.com/2012/04/03/confusing-fact-only-6-of-uterine-ruptures-are-catastrophic/.
11. Silver, R. M.; Landon, M. B.; Rouse, D. J.; Leveno, K. J. Maternal Morbidity Associated with Multiple Repeat Cesarean Deliveries. *Obstetrics & Gynecology* 2006**,** *107,* 1226-1232. http://journals.lww.com/greenjournal/fulltext/2006/06000/maternal_morbidity_associated_with_multiple_repeat.4.aspx
12. American College of Obstetricians and Gynecologists. Placenta accreta. Committee Opinion No. 529. *Obstet Gynecol* **2012,** 201-211. http://www.acog.org/~/media/Committee%20Opinions/Committee%20on%20Obstetric%20Practice/co529.pdf?dmc=1&ts=20120623T1523006523
13. Shellhaas, C. S.; Gilbert, S.; Landon, M. B.; Varner, M. W.; Leveno, K. J.; Hauth, J. C.; Spong, C. Y.; Caritis, S. N.; Wapner, R. J.; Sorokin, Y.; Miodovnik, M.; O'Sullivan, M. J.; Sibai, B. M.; Langer, O.; Gabbe, S. The frequency and complication rates of hysterectomy accompanying cesarean delivery. *Obstet Gynecol* 2009**,** *114* (2, Part 1), 224-229. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2771379/
14. Kamel, J. Myth: VBACs should never be induced, 2012. VBAC Facts. http://vbacfacts.com/2012/05/27/myth-vbacs-should-never-be-induced/.
15. Birnbach, D. J. Impact of Anesthesiologists on the Incidence of Vaginal Birth After Cesarean in the United States: Role of Anesthesia Availability, Productivity, Guidelines, and Patient Safety (video), 2010. Vimeo. http://vimeo.com/10808838.
16. National Institutes of Health. NIH VBAC Conference, Day 2, #04 – Discussion, 2010. Vimeo. http://vimeo.com/10898005.
17. Office of Statewide Health Planning and Development. Utilization Rates* for Selected Medical Procedures in California Hospitals, 2011. http://oshpd.ca.gov/HID/Products/PatDischargeData/ResearchReports/Hospipqualind/vol-util_indicatorsrpt/ (accessed June 12, 2013).