The Rosie Hospital

Vaginal birth after previous caesarean (VBAC)

This leaflet contains information and evidence that you may find helpful in making decisions about giving birth vaginally following a previous caesarean section.

If you do not understand any of the words or phrases used in this leaflet ask your midwife or doctor to explain them to you clearly. You can bring someone with you to your appointments if you think you might need some support in understanding what is said or in making decisions.

What are my choices for birth after caesarean delivery?

If you have had one or more caesarean deliveries, you may be thinking about how to give birth next time. Whether you have a vaginal birth or a caesarean delivery in a future pregnancy, either way is safe with different risks and benefits. Overall, both are safe choices with only very small risks.

In considering your care, your midwife or doctor will ask you about your medical history and about your previous pregnancies. They will want to know about:

- The reason you had the caesarean delivery and what happened – was it an emergency?
- The type of cut that was made in your uterus (womb)
- How you felt about your previous birth. Do you have any concerns?
- Whether your current pregnancy has been straightforward or have there been any problems or complications?

You and your midwife or doctor will consider your chances of a successful vaginal birth, your wishes and future fertility plans when making a decision about vaginal birth or caesarean delivery (RCOG, 2015).

What is VBAC?

This is known as vaginal birth after caesarean section ‘VBAC.’ Most women who have had a previous caesarean section can safely have a vaginal birth in a subsequent pregnancy.

What are the benefits of a successful VBAC?

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
When is a VBAC likely to be successful?

Overall, about three out of four women (75%) with a straightforward pregnancy who go into labour spontaneously give birth vaginally following one previous caesarean delivery.

If you have had a vaginal birth, either before or after your caesarean delivery, about nine out of ten women (90%) have a vaginal birth. Women who have had two previous caesarean delivery can choose to have a vaginal birth and can have a discussion with either a consultant obstetrician or a consultant midwife to plan care. However, should you go into labour yourself the chance of a successful vaginal birth is 70 to 75%.

What reduces my chances of a successful VBAC?

There are a number of factors (risk factors) that make the chance of a VBAC less successful. These are when you:

- have never had a vaginal birth
- have less than 12 months since your caesarean section
- need to be induced
- are over 40 years old
- did not make progress in labour and needed a caesarean delivery, possibly due to the position of the baby
- are overweight – a body mass index (BMI) over 30 at booking
- previous baby weighing over 4.5kg

What are the risk factors associated with having a VBAC?

These include:

**Emergency caesarean delivery**

There is a chance you will need to have an emergency caesarean delivery during your labour. This happens in about 25 out of 100 (25%). This is only slightly higher than if you were labouring for the first time, when the chance of an emergency caesarean delivery is 20 in 100 (20%). The usual reasons for an emergency caesarean delivery are labour slowing or if there is a concern for the well-being of the baby.

**Blood transfusion and infection in the uterus (womb)**

Women choosing VBAC have a one in 100 (1%) higher chance of needing a blood transfusion or having an infection in the uterus compared with women who choose a planned caesarean delivery.

**Scar weakening or scar rupture**

There is a chance that the scar on your uterus will weaken and open. If the scar opens completely (scar rupture) this may have serious consequences for you and your baby. This occurs only in two to eight women in 1000 (about 0.2%-0.5%).
Being induced is associated with a 2-3 fold increased chance of this happening. If there are signs of these complications, your baby will be delivered by emergency caesarean delivery.

**Risk to your baby**
The risk of your baby dying or being brain damaged if you undergo VBAC is very low two in 1000 (or 0.2%). This is no higher than if you were labouring for the first time.

The risk of your baby dying with a repeat caesarean section is extremely low, but there is a small increase in respiratory problems when a repeat emergency caesarean section is performed before 39+0 weeks of gestation. The risk of respiratory problems can be reduced with a preoperative course of antenatal corticosteroids.

**When is a VBAC not advisable?**
There are very few occasions when VBAC is not suitable and repeat caesarean delivery is a safer choice. These are when:
- you have had three or more previous caesarean deliveries
- the uterus has ruptured during a previous labour
- you have a high uterine incision (classical caesarean)
- you have other pregnancy complications that require a caesarean delivery

A detailed discussion with an obstetrician in all these situations is important.

**What are the disadvantages of having a repeat elective caesarean?**

A longer and possibly more difficult operation
A repeat caesarean delivery usually takes longer than the first operation because of scar tissue. Scar tissue may also make the operation more difficult and can result in damage to the bowel or bladder and a higher risk of haemorrhage. There are rare reports of accidental cutting of the baby at caesarean delivery.

There is a longer recovery period
Some women choose an elective caesarean to avoid the pain of labour, but of course they will have an abdominal wound with a slower recovery, longer in hospital. An average stay is usually two days. You will also need extra help at home and will be unable to drive for about six weeks depending on your insurance cover. There are risks associated with surgery and these include, the risk of infection requiring antibiotic treatment is 8% and the risk of significant bleeding is 4%.

**Chance of a blood clot (Thrombosis)**
A blood clot that occurs in the lung called a pulmonary embolus. A pulmonary embolus can be life threatening (death occurs in less than one in 1000 caesarean deliveries) and is more common in pregnancy and after caesarean delivery.

**Breathing problems for your baby**
An elective caesarean can occasionally result in breathing difficulties for your baby as the process of labour helps prepare babies for breathing once they are born. This may mean admission to the special care baby unit (SCBU) and artificial help with breathing.
To make this less likely we do not perform elective caesareans (where there is no medical reason for the operation) before 39 weeks. The risk is then reduced to approximately 1%. Caesarean delivery does not entirely protect against trauma to the baby, for example the risk of a laceration (superficial cut) is 2%.

**A need for elective caesarean delivery in future pregnancies**

Having another caesarean can make problems with your placenta more likely in a future pregnancy – for example placenta praevia (where the placenta is low and there is a risk of bleeding) and placental abruption (bleeding from under the placenta) could both result in the need for a hysterectomy at the time. Ectopic pregnancy (where the embryo develops in one of the fallopian tubes, instead of the womb), is also more likely.

Many of the complications associated with caesarean section increase with every further operation. Research shows that women who have caesareans tend to have longer gaps between children and have fewer living children.

**Is there anything I can do to increase my chances of a vaginal birth?**

**Support**

Good support in labour is one of the most important factors in helping women cope with the pain of labour and have a normal birth. It may also affect the length of labour and what sort of birth you have.

**Active birth session for women who plan for a VBAC**

This class has been established as many women ask for information regarding how to maximise their chance of having a successful vaginal birth. The class is facilitated by a physiotherapist who is also a NCT teacher and expected to be an hour and a half long.

The class equips you with practical skills for labour and is specially designed for expectant parents who have had a previous caesarean section and would now like to prepare for a vaginal birth. You can book this session by contacting the Rosie main reception extension: 3617.

**Where to give birth?**

**It is advised that all women who have had a caesarean before have a hospital birth in the delivery unit where there are facilities for an immediate caesarean section should it be necessary.**

**Can I have a home birth?**

There is no evidence on the safety of home birth for women who have had a caesarean before. At home monitoring of the baby’s heart rate is undertaken intermittently with a handheld device, as it not possible to monitor the baby’s heart rate continuously.

While there is no evidence to suggest that this is less effective at detecting problems with the baby’s heart rate in low risk pregnancies, it may not be possible to pick up early warning signs of scar problems as quickly compared to continuous electronic monitoring.
Home birth means a delay in receiving treatment should the need for a caesarean arise.

We would still continue to provide midwifery care if you do decide to have a home birth after a full discussion of the potential risks and benefits with the consultant obstetrician, consultant midwife or senior midwife. An individual birth plan is then written based on your choices.

**Water birth**

Monitoring equipment, which is waterproof, enables continuous monitoring of your baby heart rate is available on delivery unit should you wish to have a pool birth.

**When to come into hospital**

Many women come into hospital very early in labour. This is not necessary and may increase the likelihood of your labour being considered slow. If you come to hospital very early you may be less mobile and are more likely to have an epidural, as you may feel you have used up your own resources to help you cope with the pain.

For most women we recommend waiting until the contractions are in a regular pattern coming every three minutes and lasting for a whole minute, before they come to hospital if they are otherwise coping with the pain.

Of course there are some situations when you would be advised to come to hospital before this point, for example:

- if you have any vaginal loss
- if your waters break and the fluid is green or brown coloured
- if you have abdominal pain that is not related to your contractions
- if you have any worries about your baby

**Are there any differences in how I am cared for in labour?**

**Electronic monitoring**

Once you are in established labour (with strong, frequent and regular contractions) your baby’s heart rate will be monitored continuously with an electronic monitor. This will help us to detect any changes in your baby’s heart rate that could be related to problems with the scar on the uterus. We have wireless (telemetry) monitoring available which enables greater mobility.

**Intravenous access**

We recommend that you have a venflon put into a vein in the back of your hand or forearm, so that if you should need a caesarean we can quickly attach a ‘drip’ (intravenous infusion). A blood sample for your blood group and a full blood count would be taken at the same time.

**Progress of labour**

Women often worry that they will have another long labour, but we would expect you to make good progress once in established labour.

There is no need to stay in hospital any longer than usual if you have a vaginal birth this time.
What happens if I do not go into labour when planning a VBAC?

All women planning a VBAC should have an appointment with an obstetrician at 38-39 weeks to make a plan for birth if the baby is not born by 40 weeks, an appointment will be made in antenatal clinic where different options will be discussed with you by an obstetrician. These are:

- Continue to wait for labour to begin.
- Induction of labour booked. This increases the risk of scar weakening and lowers the chance of a successful VBAC.
- Repeat elective caesarean delivery. Some women choose to aim for VBAC if they labour spontaneously but opt for a repeat caesarean delivery rather than induction of labour.

Useful information

Royal College of Midwives Position Statement – www.rcm.org.uk


We are now a smoke-free site: smoking will not be allowed anywhere on the hospital site. For advice and support in quitting, contact your GP or the free NHS stop smoking helpline on 0800 169 0 169.

Other formats:

If you would like this information in another language, large print or audio, please ask the department where you are being treated, to contact the patient information team: patient.information@addenbrookes.nhs.uk. Please note: We do not currently hold many leaflets in other languages; written translation requests are funded and agreed by the department who has authored the leaflet.

Document history

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Contact number: 01223 245151
Publish/Review date: July 2017/July 2020
File name: Vaginal_birth_after_previous_caesarean_(VBAC).doc
Version number/Ref: 7/PIN1578/Doc ref 12026