



Does vaginal birth after cesarean have a future?

📌 VBAC is destined to fade out of practice and memory unless we accurately, and individually, assess the risks it poses to patients and babies

Once again, vaginal birth after cesarean, or VBAC—sometimes referred to as a trial of labor after cesarean, or TOLAC—has arisen as a topic of interest in obstetrics, as demonstrated in this issue of OBG MANAGEMENT.¹ I say “once again” because, frankly, I thought that the matter had become irrelevant—reminiscent of a debate over vaginal breech delivery in the 1970s and 1980s now largely resolved in the United States, thanks to evidence-based randomized clinical trials.

I thought the issue was closed when, in 2005, the chair of ACOG’s Committee on Obstetric Practice was quoted in *USA Today*: “... the VBAC rupture rate may seem quite low but it’s damn high if you’re the one.” And later in the same article: “I think VBAC is dead.”

And I considered VBAC finished when I compared the target VBAC rate established in the US Department of Health and Human Services’s *Healthy People 2010* report against the astounding data that we see reported today:

- In 1998, the US **primary cesarean delivery rate** was 18%; the *Healthy People 2010* target was 15%. **Today, that rate exceeds 25%.**
- In 1998, the **repeat cesarean delivery rate** was 72%; again, the *Healthy People 2010* target was 63%. In 2003, however, the repeat cesarean rate had climbed to 88.7%—and **today, that rate exceeds 90%.**

Called “reasonable” for many women

Yet, in a recent report, a consensus panel convened by The National Institutes of Health declares that VBAC is a “reasonable option” for many pregnant women. The panel encourages physicians to incorporate evidence-based data into the counseling they provide to patients.²

But even our own College admits to a paucity of high-quality evidence about VBAC. A 2009 ACOG Practice Bulletin says that “despite thousands of citations in the world’s literature there are currently no randomized trials comparing maternal or neonatal outcomes for both repeat cesarean delivery and VBAC.”³

So the question remains: How can medical science help patients and physicians make the best decisions about VBAC? Let me try to

provide an answer here. Some of the ideas I draw on are discussed by Dr. Aviva Lee-Parritz in her article beginning on page 17.

What are the risks?

The true risks of VBAC are unknown. However, we do know—all the data are in agreement—that elective repeat cesarean delivery, performed at the appropriate gestational age, is safer for fetus and newborn than a trial of labor.⁴

We also know that most mothers accept a greater burden of risk for themselves if there is potential benefit for their newborn. (An example is expectant management of severe preeclampsia remote from term, when a delay in delivery offers no maternal benefit but does offer potential benefit to the newborn.) With VBAC, mothers must be willing to accept the risks of the procedure; better ways to assess that risk have been proposed to help them make a decision.⁵

What are the chances of success?

It amazes me when the quoted VBAC success rate at a given hospital exceeds the likelihood there of successful vaginal delivery of a nullipara. I see such data reported often.

Be certain that your patients know the hospital-specific cesarean delivery rate and VBAC

Where does VBAC fit in your practice?

Take the **Instant Quiz** on page 8

CONTINUED ON PAGE 7

success rate—and if you don't have those data, then tell the patient that you don't. It doesn't make sense to quote an 85% VBAC success rate if your institution's primary cesarean delivery rate is 25%.

What does VBAC cost?

The data with which to answer this question are hard to obtain cleanly; ultimately, however, the choices we make should be based on proper medical decision-making, not cost. That said, I remain unconvinced that VBAC overall offers significant savings over repeat cesarean delivery when *total cost* (not just the cost of postpartum care or the cost of post-delivery length of stay) is examined.

Furthermore, the expense of settling malpractice claims of "VBACs gone awry" is never included in estimates of the cost of care.

How are VBACs reimbursed?

The current structure of reimbursement for health care doesn't favor VBAC. In most regions of the country, **1)** physicians' reimbursement for performing a VBAC is either the same as, or lower than, it is for cesarean delivery and **2)** most hospitals enjoy a greater margin on the

hospital stay postcesarean than after a vaginal delivery.

Given the increased time involved in managing a VBAC, a change in reimbursement to recognize the greater effort and exposure to liability would be a reasonable step for payers—if there is true interest in reversing the trend away from VBAC that we're seeing.

How great are concerns over liability?

In every data set that I have reviewed, perinatal morbidity and mortality are clearly higher in the VBAC group than in the repeat cesarean group. In essence, **the central issue with VBAC is uterine rupture** and all the complications that can flow from that event.⁶

A problem for small hospitals. ACOG has already issued guidelines for what care should be "readily available" in a hospital that offers VBAC. For the College to retreat from these recommendations in an effort to increase acceptance of VBAC among smaller community hospitals—many of which are without students, residents, fellows, or myriad other support personnel—would, I think, be disingenuous and

ill-advised. Add to this recent data suggesting that peripartum hysterectomy (for which VBAC patients are at increased risk) is best done in a high-volume hospital setting⁷ and you further reduce the likelihood that smaller community hospitals will ever embrace VBAC.

How well do patients accept VBAC?

It's tough to sell a product that people don't want. My anecdotal experience (meaning that my conclusions are unencumbered by data) is that informed health care personnel who themselves have had a cesarean delivery almost uniformly select cesarean delivery subsequently. They know the data and they're aware of the risks. Often, they aren't planning on having more than two children, so the problem of placenta accreta in the future doesn't apply.

These observations suggest, to me, that *maybe 1)* we need to do a better job counseling patients or **2)** our society's value system overwhelmingly favors predictability of delivery and safety of the newborn at the expense of even a slight increase in risk to the mother.

CONTINUED ON PAGE 8

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Alas, common sense is the most difficult thing to legislate VBAC was, and is, a good idea. It's based on sound principles and good intentions.

Recall that, in 1970, our dictum was "once a section always a section." The cesarean delivery rate in the United States was 5%, and we didn't need to worry about VBAC.

VBAC became popular only as the primary cesarean rate began to rise above 15%; at that time, strict rules accompanied the procedure: no oxytocin or epidural anesthesia, and, in many institutions, x-ray pelvimetry was required to document "adequacy" of the pelvis.

Now, we've moved to the other end of the spectrum: It seems we offer VBAC to anyone who wants it, regardless of comorbidities.

Can we compromise?

I support a middle-of-the-road position that strongly *encourages* VBAC for women who:

- have no comorbidities
- have had a prior VBAC or previous vaginal delivery of a term baby and
- who have had no more than one prior cesarean delivery.

On the other hand, VBAC should be *discouraged* for women who:

- have a body mass index >40
- are post-term
- present at term with premature rupture of the membranes, an unengaged vertex, or an unfavorable cervix or
- have any other condition that might make emergency cesarean delivery more difficult and, therefore, best avoided.

Such risk assessment approaches have already been proposed.⁵

Applying common sense to the matter, we might be able to agree

on a solution that makes VBAC attractive and, more important, safe for our patients and for us. Furthermore, we must diligently keep track of our own data on maternal and neonatal outcomes so that we can most appropriately counsel our patients.

It's up to us to determine whether VBAC should stay or go

I estimate that we have a window of opportunity of 5 to 10 years to resolve whether VBAC remains part of practice. If we don't take that opportunity, we'll be left with a generation of physicians who have little or no experience performing the procedure. VBAC will **disappear**, in a self-fulfilling prophecy—which, when you think about what happened with vaginal breech delivery, may not be a bad thing. 



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References

1. Lee-Parritz A. When is VBAC appropriate? *OBG Manage.* 2010;22(7):17-24.
2. National Institutes of Health Consensus Development conference statement: vaginal birth after cesarean: new insights March 8-10, 2010. *Obstet Gynecol.* 2010;115(6):1279-1295.
3. Vaginal birth after previous cesarean. ACOG Practice Bulletin #54. *Obstet Gynecol.* 2004;104(1):203-212.
4. Guise JM, Denman MA, Emeis C, et al. Vaginal birth after cesarean; new insights on maternal and neonatal outcomes. *Obstet Gynecol.* 2010;115(6):1267-1278.
5. Grobman WA, Lai Y, Landon MB, et al. Can a prediction model for vaginal birth after cesarean also predict the probability of morbidity related to a trial of labor? *Am J Obstet Gynecol.* 2009;200(1):56.e1-e6.
6. Scott JR. Solving the vaginal birth after cesarean dilemma. *Obstet Gynecol.* 2010;115(6):1112-1113.
7. Wright J, Herzog T, Shah M, et al. Regionalization of care for obstetric hemorrhage and its effect on maternal mortality. *Obstet Gynecol.* 2010;115(6):1194-1200.

Instant Poll

Your opinions about VBAC, please

With regard to VBAC, which one of these positions do you most favor?

- VBAC should no longer be encouraged
- VBAC should be encouraged, but it should be offered only in high-volume tertiary or quaternary medical centers
- VBAC should be encouraged and offered in all obstetric facilities
- VBAC should be actively discouraged

Which one statement expresses your thinking? "I would be more likely to encourage VBAC if..."

- ...I was reimbursed at a higher rate than I am for cesarean deliveries
- ...I felt better protected from litigation involving the known risks of VBAC
- ...I could count on the conditions in both "a" and "b" answers
- Forget it! Nothing can convince me to encourage VBAC

File your responses at www.obgmanagement.com. Then, see how closely your opinions match those of your colleagues, when Instant Poll results are reported in an upcoming issue of OBG MANAGEMENT.