National Association of
Specialist Obstetricians & Gynaecologists

INFORMATION SHEET

Vaginal Birth After Caesarean (VBAC)

expert care for women

After a caesarean section women may want to experience a vaginal birth and others may feel more comfortable having another caesarean and knowing what to expect. It is possible for most women to have a vaginal birth after a caesarean section for a previous birth, depending on the reasons for the caesarean.

Your doctor can discuss the specific reasons you needed a caesarean section and if it will also impact future births. They can advise you on the medical pros and cons of each option and discuss your specific risk factors. You need to consider the risks in the current pregnancy; plans for further children and the likelihood of achieving a vaginal delivery. The decision is a personal one for you and your family to make in consultation with your obstetrician.

What are the advantages of a VBAC

There are a number of advantages for vaginal birth after caesarean including less post partum pain, less analgesia and earlier skin on skin contact with baby. Birth can take place outside of an operating theatre and may feel more relaxed and natural.

What are the risks for the mother of a VBAC?

The scar in the uterus from the previous caesarean section is a site of potential weakness, particularly during the contractions of labour. This potential weakness may result in a uterine rupture, which is when the uterus tears and bleeding results. The risk of a uterine rupture is approximately 0.5%. There is also a 0.05% risk that an emergency hysterectomy will be needed.

What are the risks for the baby of a VBAC?

There is a greater risk of a baby dying during a VBAC compared to a planned caesarean delivery. This risk is approximately 0.18%. This is partly due to the increased risk of delivering a baby vaginally after 39 weeks gestation, compared to before 39 weeks with a planned caesarean.

Are there any factors that make a VBAC more risky?

The risks associated with a VBAC are increased if:

1. labour is induced;
2. there is less than 18 months from the last birth;
3. there has been more than one previous caesarean section
4. induction or augmentation of labour
5. the baby is estiated to weigh more than 4000g, and
6. the mother is obese.

It is also worth noting a previous vaginal birth reduces the risk of a uterine scar rupture.

Are there risks in having another planned caesarean section?

All surgical procedures, no matter how routine, do have inherent risks. A caesarean section is a major surgery and does carry risks associated with anaesthesia, infection, blood loss, respiratory complications and for the baby there may be injury and complications with anaesthesia. Your doctor can discuss these risks

It may be important for you to consider how many children you would like to have, as there can be increased risks of a complication known as placenta accreta and placenta praevia with ongoing caesarean sections.

Placenta praevia occurs when the placenta covers the cervix, which obstructs normal birth and causes significant bleeding..

Placenta accreta occurs when the placenta binds to the previous uterine scar and does not separate after the birth. It has been reported that placenta accreta increases with each caesarean section birth for example: 0.24 per cent for the first birth;

0.31 per cent for the second;
0.57 per cent, for the third;
2.1 per cent for the fourth;
2.3 per cent for the fifth and
6.7 per cent for the sixth birth.

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What are the chances of a successful vaginal birth after a caesarean section?

Most studies show there is a 60 to 80 per cent chance of having a successful vaginal birth after a single previous caesarean section.

Can I have baby in any hospital?

All women electing to labour after a previous caesarean section should deliver at a hospital where there is ready access to the range of obstetric and neonatal services; your doctor can discuss which hospital is appropriate.

Are any special precautions needed during labour?

It is recommended the baby's heart is closely monitored during labour with an electronic fetal monitor to detect any signs of distress.

It is also recommended you have an intravenous line inserted and ready to be used in case of an emergency during the labour. Blood can be taken from the line for an antibody screen and to determine your blood group. You should not eat and only drink clear fluids during the labour, in case an emergency caesarean section under general anaesthesia is required.

Inducing labour with a drip of syntocinon should be used with caution. While good evidence is lacking, mechanical methods of cervical ripening may be preferable to pharmacological methods.

There is little evidence that an epidural is harmful during a VBAC and this should be readily available in the absence of contraindications.

Careful assessment of progress in labour is needed with vaginal examinations at least four-hourly in the active phase of labour and more frequently as full dilatation approaches. The cervix should dilate at least at 1cm per hour in the active phase of labour and second stage should not exceed an hour in duration, unless birth is imminent.

What is the best decision?

This decision is best made by the woman and her family in consultation with her obstetrician. Each woman will have different risk factors and will view the risks associated with a VBAC differently. Some women may view the risks to the baby to be too great and some may see the risks as acceptable.

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