Vaginal Birth After Cesarean section (VBAC)

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In an interesting case report, Nassozi J et al., describe a gravida 5, para 4, with 4 Cesarean sections, arriving in the second stage of labor and delivering a healthy term baby without any complication for the mother and newborn. Given the perinatal risks for mother and baby, she would surely have been advised a cesarean section (CS) by most colleagues as the risk for serious morbidity and mortality is increasing with every CS. She was lucky, and a wise decision was taken to have a tubal ligation postpartum. As rightfully stated by the authors, Cesarean delivery is one of the commonest surgical procedures and can be lifesaving for both mother and baby when indicated. However, CS rates are rising worldwide from 12% of all births in 2010 to 21% in 2015, mainly in women without medical indication and repeat CS. Overall, overuse of CS has not shown benefits and can create harm for mother and baby. Vaginal birth after cesarean section (VBAC) has been shown to be a safe technique lowering the CS rates. Hence, women with a previous CS should be offered a VBAC assuming there are no other conditions that would normally require a cesarean delivery. The VBAC success rates are between 40 and 75% and surely worth trying.

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The VBAC option should be offered and clearly explained to the pregnant women, with the pros and cons of cesarean section for the health of the woman and the baby. Planning the delivery route for the woman who has had a previous cesarean delivery should be addressed early in pregnancy. There is a consensus amongst recognized bodies that a spontaneous VBAC is a clinically safe choice for the majority of women with a single previous lower segment cesarean delivery. The Royal College of Obstetricians and Gynaecologists (RCOG) further suggests that a woman with two prior low transverse uterine incisions, or a woman with a twin pregnancy with one prior CS with no contraindication to vaginal birth, may also be considered candidates for VBAC with appropriate counseling, and will require consultant-led care. The encouragement of VBAC should be discussed at intervals throughout pregnancy. However, many women are not well informed, not offered a choice, or too late in pregnancy. From the perspective of the Obstetrician-Gynecologist, an elective CS is often considered easier, less time-consuming, and better to plan than taking the patient through the VBAC information and counseling process and providing a consultant-led team to take care of her birth process. However, a vaginal birth remains the best for mother and baby, and VBAC should be promoted and offered as an option to pregnant women with no other conditions requiring a cesarean delivery.