Panel questions 'VBAC bans,' advocates expanded delivery options for women

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An independent panel convened this week by the National Institutes of Health confronted a troubling fact that pregnant women currently have limited access to clinicians and facilities able and willing to offer a trial of labor after previous cesarean delivery because of so-called VBAC bans. Many, even those at low risk for complications in a trial of labor, are not offered this option. The panel affirmed that a trial of labor is a reasonable option for many women with a prior cesarean delivery. They also urged that current VBAC guidelines be revisited, malpractice concerns be addressed, and additional research undertaken to better understand the medical and non-medical factors that influence decision making for women with previous cesarean deliveries.

"Declining VBAC rates and increasing cesarean delivery rates over the last 15 years would seem to indicate that planned repeat cesarean delivery is preferable to a trial of labor. But the currently available evidence suggests a very different picture: a trial of labor is worth considering and may be preferable for many women," said Dr. F. Gary Cunningham, panel chair, and chair of obstetrics and gynecology at the University of Texas Southwestern Medical Center at Dallas.

Rigorous research shows that a trial of labor is successful in nearly 75 percent of cases, and maternal mortality is actually lower for women who have a trial of labor, regardless of whether they end up delivering vaginally or by cesarean, though those women who have an unsuccessful trial of labor and undergo a repeat cesarean delivery experience higher morbidity than those who have a successful VBAC.

In light of their assessment of VBAC's relative safety, the panel urged professional societies to revisit existing VBAC guidelines, in particular, the recommendation for "immediate availability" of surgical and anesthesia personnel as prerequisites for offering a trial of labor; two recent surveys of hospital administrators found that 30 percent of hospitals had stopped offering trial of labor or providing VBAC services because they could not meet this standard, creating a serious barrier to that option.

The panel thus advocated for additional research to develop clear, evidence-based risk assessment tools to assist mothers and providers in the decision-making process from early pregnancy through delivery, accounting for individual risk factors, values, and preferences.

The panel also expressed concern that medico-legal considerations exacerbate other barriers to trial of labor for women with a previous cesarean delivery. They strongly recommended that policymakers and providers collaborate in the development and implementation of appropriate strategies to address malpractice concerns and mitigate this problem.

"There's still a lot we don't know about which women will be successful in having a VBAC, but we believe it's essential that women's desires and preferences be respected throughout the decision making process," said Dr. Cunningham.

Safety is the chief concern for women and their providers in deciding whether to attempt a trial of labor or plan a repeat cesarean delivery. Each option carries important benefits and risks for both mother and baby. This poses a profound dilemma because benefits for the woman may come at the price of increased risks for the baby, and vice versa. For example, hysterectomy rates were comparable across both modes of delivery, but uterine rupture was higher in women who have a trial of

labor. Conversely, women who had a VBAC had reduced abnormalities of placental growth and position in subsequent pregnancies. Unfortunately, the lack of high-quality evidence about many medical and non-medical factors prevents precise risk calculations that could inform the decision-making process.

Factors contributing to some women's desire to attempt a trial of labor include desire for their partner's involvement in the delivery, belief that labor and vaginal delivery can be deeply empowering, enhanced opportunity for maternal-infant bonding, greater ease in establishing breast feeding, and easier recovery. Conversely, scheduling convenience, the desire to avoid labor pain, fear of failed trial of labor, avoidance of possible emergency cesarean section, and desire for surgical sterilization at the time of delivery may all contribute to a preference for planned cesarean delivery.

Prior to 1980, VBACs were generally discouraged because of the widely held idea that once a woman had a cesarean delivery, any subsequent pregnancies would also have to be delivered by cesarean. After a 1980 consensus statement questioned routine repeat cesarean delivery, VBAC rates increased steadily until 1996 when rates began to decline again. This panel's deliberations took place in the context of this trend, in which the current overall cesarean delivery rate is 31 percent and the VBAC rate is less than 10 percent compared to 28 percent in 1996.

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