Birth after previous caesarean

Information for you

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Setting standards to improve women's health

What are my choices for birth after a caesarean delivery?

More than one in five women (20%) in the UK currently give birth by caesarean delivery (a surgical operation where a cut is made in your abdomen and your baby is delivered through that cut). Many women have more than one caesarean delivery.

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

In considering your choices, your obstetrician 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 obstetrician or midwife will consider your chance of a successful vaginal birth, your personal wishes and future fertility plans when making a decision about vaginal birth or caesarean delivery.

What is VBAC?

VBAC stands for 'vaginal birth after caesarean'. It is the term used when a woman gives birth vaginally, having had a caesarean delivery in the past. Vaginal birth includes birth assisted by forceps or ventouse (see RCOG Patient Information **Assisted birth (operative vaginal delivery): information for you**).

What is an elective repeat caesarean delivery?

An elective caesarean means a planned caesarean. The date is usually planned in advance at your hospital antenatal visit. The caesarean delivery usually happens in the seven days before your due date, unless there is a reason why you or your baby need an earlier delivery.

What are the advantages 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
- less abdominal pain after birth
- not having surgery.

When is VBAC likely to be successful?

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

Most women with two previous caesarean deliveries will have their next baby by caesarean delivery. However, should you go into labour your chance of a successful vaginal birth is slightly less than this (between 70% and 75%).

What are my chances of a successful VBAC?

A number of factors (risk factors) make the chance of a successful vaginal birth less likely. These are when you:

- have never had a vaginal birth
- need to be induced
- did not make progress in labour and needed a caesarean delivery (usually owing to the position of the baby)
- are overweight – a body mass index (BMI) over 30 at booking.

What are the disadvantages of VBAC?

The disadvantages of VBAC include:

- **Emergency caesarean delivery**
  There is a chance you will need to have an emergency caesarean delivery during your labour. This happens in 25 out of 100 women (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 women (20%). The usual reasons for an emergency caesarean delivery are labour slowing or if there is a concern for the wellbeing of the baby.
- **Blood transfusion and infection in the uterus**
  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 0.5%). Being induced increases the chance of this happening. If there are signs of these complications, your baby will be delivered by emergency caesarean delivery.
- **Risks to your baby**
  The risk of your baby dying or being brain damaged if you undergo VBAC is very small (two in 1000 women or 0.2%). This is no higher than if you were labouring for the first time, but it is higher than if you have an elective repeat caesarean delivery (one in 1000 or 0.1%). However, this has to be balanced against the risks to you if you have a caesarean delivery (see below).

These disadvantages are more likely in women who attempt VBAC and are unsuccessful.

When is VBAC not advisable?

There are very few occasions when VBAC is not advisable 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.

What are the advantages of elective repeat caesarean delivery?

The advantages of elective repeat caesarean delivery include:

- virtually no risk of uterine scar rupture
- it avoids the risks of labour and particularly the risk of possible brain damage or stillbirth from lack of oxygen during labour (one in 1000 or 0.1%)
- knowledge of the date of delivery.

However, since caesarean delivery is planned for seven days before the due date, there is a chance that you will go into labour before the date of your caesarean delivery. One in ten women (10%) go into labour before this date.

What are the disadvantages of elective repeat caesarean delivery?

The disadvantages of elective repeat caesarean delivery include:

- **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. There are rare reports of accidental cutting of the baby at caesarean delivery.
- **Chance of a blood clot (thrombosis)**
  A blood clot that occurs in the lung is called a pulmonary embolus. A pulmonary embolus can be life threatening (death occurs in less than one in 1000 caesarean deliveries). See RCOG Patient Information Venous thrombosis in pregnancy and after birth: information for you.
- **There is a longer recovery period**
  You may need extra help at home and will be unable to drive for about six weeks after delivery (check with your insurance company).
- **Breathing problems for your baby**
  Breathing problems are quite common after caesarean delivery and usually do not last long. Occasionally, the baby will need to go to the special care baby unit. Between three to four in 100 babies (3–4%) born by planned caesarean delivery have breathing problems compared with two to three in 100 (2–3%) following VBAC. Waiting until seven days before the due date minimises this problem.

- **A need for elective caesarean delivery in future pregnancies**
  More scar tissue occurs with each caesarean delivery. This increases the possibility of the placenta growing into the scar making it difficult to remove at caesarean (placenta accreta or percreta). This can result in bleeding and may require a hysterectomy. All serious risks increase with every caesarean delivery you have.

What happens if I go into labour when I'm planning VBAC?

You will be advised to deliver in hospital so that an emergency caesarean delivery can be carried out if necessary. Contact the hospital as soon as you think you have gone into labour or if your waters break.

Once you are in labour, you and your baby's heartbeat should be monitored continuously. You can have an epidural if you choose.

What happens if I do not go into labour when planning a VBAC?

If labour does not start by 41 weeks, different options will be discussed with you by your obstetrician. These are:

- continue to wait for labour
- induction of labour. 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 elective caesarean delivery rather than induction of labour.

What happens if I have an elective caesarean planned and I go into labour?

Telephone the hospital to let them know what is happening. It is likely that an emergency caesarean will be performed once labour is confirmed. If labour is very advanced, or if the labour is early (before 37 weeks), then VBAC may be more suitable. Your obstetrician will discuss this with you.

A glossary of all medical terms is available on the RCOG website at www.rcog.org.uk/index.asp?PageID=1107.

Sources and acknowledgements

This information is based on the Royal College of Obstetricians and Gynaecologists (RCOG) guideline *Birth After Previous Caesarean Birth* (published by the RCOG in February 2007). This information will also be reviewed, and updated if necessary, once the guideline has been reviewed. The guideline contains a full list of the sources of evidence we have used. You can find it online at: **www.rcog.org.uk/resources/Public/pdf/green_top45_birthafter.pdf**

Clinical guidelines are intended to improve care for patients. They are drawn up by teams of medical professionals and consumer representatives who look at the best research evidence available and make recommendations based on this evidence.

This information has been developed by the Patient Information Subgroup of the RCOG Guidelines and Audit Committee, with input from the Consumers' Forum and the authors of the clinical guideline. It has been reviewed before publication by women attending clinics in Burton on Trent, London and Oxford. The final version is the responsibility of the Guidelines and Audit Committee of the RCOG. The RCOG consents to the reproduction of this document providing that full acknowledgement is made.

A final note

The Royal College of Obstetricians and Gynaecologists produces patient information for the public. This is based on guidelines which present recognised methods and techniques of clinical practice, based on published evidence. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of the clinical data presented and the diagnostic and treatment options available.

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