VBAC or ERCS: Making an Informed Choice

One of the biggest decisions a pregnant parent with a history of cesarean makes is to plan a vaginal birth after cesarean (VBAC) or schedule a cesarean before labor begins, called an elective repeat cesarean section (ERCS).

At VBAC Facts, we give parents a lot of evidence about different aspects of choosing a VBAC, but the first step is deciding between VBAC or ERCS. In this handout, we summarize some of the things you may want to consider when determining how to have your baby.

Current Recommendations

One recent large study looked at worldwide guidelines for VBAC vs. ERCS and found that only a few mention a previous cesarean as an indication for a repeat cesarean and none recommend to routinely offer ERCS.[1] In certain situations, the guidelines explicitly say parents and providers should discuss the benefits vs. risks of VBAC or ERCS. In a few circumstances, guidelines do recommend an ERCS. Let's look at what some major obstetric organizations say about VBAC or ERCS.

Recommendations for VBAC

The three largest obstetric organizations in Canada, the United Kingdom (UK), and the United States (US) agree that providers should offer a VBAC to everyone who has a history of one previous cesarean if they have a lower uterine scar and are pregnant with one baby.[1,2,3,4] This recommendation has strong evidence to support it. Additionally, Canadian guidelines also say that everyone without a medical reason to avoid labor, anyone who has had a previous vaginal birth, and anyone who arrives at the hospital or birth center already in labor should VBAC if that is what the birthing parent wants.[2]

Recommendations for a discussion on VBAC or ERCS

People with specific histories or conditions can decide how they will birth after discussing risks and benefits. Some providers will say that some situations make VBAC too risky, but that does not align with professional guidelines. Canadian guidelines say people with multiple previous cesareans, breech presentations, multiples, or a short time between their last birth and this one, should still be offered VBAC.[2] Guidelines out of the UK also recommend deciding on a case by case basis, including for people with complicated uterine scars, multiple prior cesareans, factors that might increase the risk of rupture, and arriving at the hospital already in labor.[3]

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Due to lack of evidence, UK guidelines recommend a "cautious approach" to VBAC for post-dates, pregnancy with twins, abnormally large babies, birthing parents over 40 years old, who have had a stillbirth, or who have J or T shaped incisions.[3] US guidelines say multiple prior cesareans, twins, big babies, short birth intervals, or an unknown scar do not rule out VBAC unless there is a "high suspicion" that the scar is a high classical.[4] Canadian guidelines recommend against using uterine

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scar thickness to make a recommendation, citing insufficient evidence,[2] and US guidelines does not mention scar thickness at all.[4]

It's important to remember that you always have the right to make your own medical decisions even if that is different from what your provider recommends. Guidelines help us understand the evidence and recommendations, but you still make the ultimate decision.

Recommendations for ERCS

Canadian and US guidelines recommend ERCS with a history of a classical or T incision or extensive uterine surgery in the upper part of the uterus such as surgery to remove uterine fibroids.[2,4] At the same time, UK guidelines recommends against planned VBAC for people with classical cesarean scars but considers T incisions a maybe.[3] All organizations recommend ERCS for people who have other reasons not to birth vaginally, such as placenta previa or a history of uterine rupture.[2,3,4] UK and US guidelines say ERCS should not be scheduled before 39 weeks.[3,4]

Additional Options

Epidurals are still an option during planned VBAC as they do not mask the signs of uterine rupture.[3,4] Additionally, labor induction is also possible during a planned VBAC when a medical indication presents.[2,3,4] Multiple studies have shown that, if your baby is not head down, external cephalic version - when the provider manually turns baby head down - is safe in people with cesarean history.[5,6,7,8] Further, new research shows that vaginal breech birth with a cesarean history is as safe as vaginal breech birth among first-time parents for babies and parents alike.[9]

Risks vs. Benefits

It's important to say this: both VBAC and ERCS are reasonable options. Both have risks, and both have a small chance of a negative outcome. To the right are the known risks, using the research available for the past 10-20 years of planned VBAC vs. ERCS. It is important to note that there is a low overall risk of any significant complications listed.

Will I have a VBAC?

One of the most critical factors in deciding if you will plan a VBAC or ERCS is how likely you think it is you will have a VBAC. Suppose you have individual factors that decrease your VBAC odds. In that case, you have a higher risk of complications and needing a repeat, unplanned cesarean.[2] Although planned VBACs have the lowest risks, unplanned cesareans have the highest risks.[3,4] People who have had prior vaginal deliveries or a prior cesarean for breech tend to have the highest VBAC odds.[12,15] This decision has to be up to you. Your providers can help you know what to consider, and you can do your homework, but there is not one clear answer.

There are VBAC calculators and similar tools out there that attempt to predict who will and will not have a VBAC. Still,

Relative risks and benefits of planned VBAC vs. ERCS

- High likelihood of having a VBAC, up to 95% without risk factors and with a supportive environment[3]
- Moderate likelihood of having a VBAC, up to 40%, even with risk factors[3]
- VBAC has the lowest maternal complication rates[10]
- Repeat cesarean during a planned VBAC has the highest maternal complication rates[10]
- Lower risk of blood clots[4]
- Lower risk of infection[4]
- Lower risk of sexual problems such as pain during sex and reduced lubrication[11]
- Lower risks associated with multiple cesareans such as surgical injury, hysterectomies, infection, and placenta abnormalities like previa or accreta[4]
- Lower risk of bleeding too much[4]
- Higher risk of uterine rupture, but risk is low at 0.2% - 0.7%, and decreases after the first VBAC[2,3,4,12]
- Higher risk of fetal or newborn death, but the risk is low and comparable to first births[2,3,4]
- Higher risk of birth-related fetal or newborn death, but the risk is very low[2,3,4]

Relative risks and benefits of planned ERCS vs. VBAC

- Planned delivery date
- Reduced short term risk of pelvic organ prolapse and incontinence[3]
- Longer recovery[3]
- Difficulty in finding someone to attend a VBAC after multiple cesareans
- Increased risk of needing future cesarean[3]
- Greater than 3x higher risk of maternal death, though the risk remains very, very low[2,3,4]
- Increased risk of placenta previa and accreta in future pregnancies[2,3,4]
- Increased risk of pelvic adhesions complicating any future abdominopelvic surgery[3,13]
- Increased newborn respiratory problems such as breathing too fast, but the risk is low[3]
- Associated with baby having autism, ADHD, obsessive-compulsive disorder, eating disorders, and intellectual delay in future[14]

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many of them are based on flawed evidence and show clear bias.[16] Recent research shows that these decision-making tools aren't accurate, and they don't change who has a VBAC or reduce risk.[17,18,19] Further, they favor white parents and give Black and Latinx parents less chance, with no evidence to support this.[20] In other words, providers cannot predict whether your medical or personal risk factors will influence your birth.

What does seem to directly contribute to VBACs vs. ERCS is whether or not there is a "VBAC culture" where you intend to birth. Providers and clients in places with high VBAC rates and good outcomes assume vaginal birth is the first choice, and VBACs are a normal part of pregnancy care.[21] In places where technology is overused, there tend to be higher rates of ERCS. For example, continuous fetal heart rate monitoring is the standard of care in many hospitals, despite no evidence supporting its use and the fact that it does not improve outcomes but does increase cesareans.[22] Midwifery care and collaborative care between midwives and physicians increase VBACs.[23,24]

A VBAC friendly culture, where providers and pregnant people know VBAC benefits compared with ERCS and use a shared decision-making process, improves VBAC rates without increasing risk.[25] To explore the importance of a VBAC friendly culture, look at our handouts "VBAC Community Birth - What Do We Know About Risk" and "VBAC Community Birth - Choosing Place and Provider." To learn more about the VBAC evidence, check out our parents' class: "The Truth About VBAC for Families."

RESOURCES:

1. Coates, D., Homer, C., Wilson, A., Deady, L., Mason, E., Foureur, M., & Henry, A. (2020). Indications for, and timing of, planned caesarean section: A systematic analysis of clinical guidelines. Women and Birth, 33(1), 22-34. https://doi.org/10.1016/j.wombi.2019.06.011
2. Dy, J., DeMeester, S., Lipworth, H., & Barrett, J. (2019). No. 382-trial of labour after caesarean. Journal of Obstetrics and Gynaecology Canada, 41(7), 992-1011.https://doi.org/10.1016/j.jogc.2018.11.008
3. Royal College of Obstetricians & Gynaecologists. (2015). Birth after previous caesarean birth. Green-top Guideline No. 45. 2015.https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg45/
4. American College of Obstetricians and Gynecologists. (2019). Practice Bulletin No. 205: Vaginal Birth After Cesarean Delivery. Obstetrics & Gynecology, 133 (2), e110. https://doi.org/10.1097/aog.0000000000003078
5. Abenhaim, H. A., Varin, J., & Boucher, M. (2009). External cephalic version among women with a previous cesarean delivery: report on 36 cases and review of the literature. Journal of Perinatal Medicine, 37(2), 156-160. https://doi.org/10.1515/JPM.2009.006
6. Burgos, J., Cobos, P., Rodríguez, L., Osuna, C., Centeno, M. M., Martínez Astorquiza, T., & Fernández Llebrez, L. (2013). Is external cephalic version at term contraindicated in previous caesarean section? A prospective comparative cohort study. BJOG: An International Journal of Obstetrics & Gynaecology, 121(2), 230-235. https://doi.org/10.1111/1471-0528.12487
7. Keepanasseril, A., Anand, K., & Soundara Raghavan, S. (2017). Matched cohort study of external cephalic version in women with previous cesarean delivery. International Journal of Gynecology & Obstetrics, 138(1), 79-83. https://doi.org/10.1002/ijgo.12169
8. Sela, H. Y., Fiegenberg, T., Ben-Meir, A., Elchalal, U., & Ezra, Y. (2009). Safety and efficacy of external cephalic version for women with a previous cesarean delivery. European Journal of Obstetrics & Gynecology and Reproductive Biology, 142(2), 111-114. https://doi.org/10.1016/j.ejogrb.2008.08.012
9. Paul, B., Möllmann, C. J., Kielland-Kaisen, U., Schulze, S., Schaarschmidt, W., Bock, N., ... & FRABAT FRAnkfurt Breech at Term Study Group. (2020). Maternal and neonatal outcome after vaginal breech delivery at term after cesarean section–a prospective cohort study of the Frankfurt breech at term cohort (FRABAT). European Journal of Obstetrics & Gynecology and Reproductive Biology. https://doi.org/10.1016/j.ejogrb.2020.04.030
10. Landon, M. B., Hauth, J. C., Leveno, K. J., Spong, C. Y., Leindecker, M. S., Varner, M. W., . . . Miodovnik, M. (2004). Maternal and perinatal outcomes associated with a trial of labor after prior cesarean delivery. New England Journal of Medicine, 351, 2581-2589. https://doi.org/10.1056/NEJMoa040405
11. Hjorth, S., Kirkegaard, H., Olsen, J., Thornton, J. G., & Nohr, E. A. (2019). Mode of birth and long-term sexual health: a follow-up study of mothers in the Danish National Birth Cohort. BMJ Open, 9(11). https://dx.doi.org/10.1136%2Fbmjopen-2019-029517
12. Mercer, B. M., Gilbert, S., Landon, M. B., & Spong, C. Y. (2008). Labor outcomes with increasing number of prior vaginal births after cesarean delivery. Obstetrics & Gynecology, 11, 285-91. http://doi.org/10.1097/AOG.0b013e31816102b9
13. Silver, R. M., Landon, M. B., Rouse, D. J., Leveno, K. J., Spong, C. Y., Thom, E. A., . . . Mercer, B. (2006). Maternal morbidity associated with multiple repeat cesarean deliveries. Obstetrics & Gynecology, 107(6), 1226-1232. https://doi.org/10.1097/01.AOG.0000219750.79480.84
14. Zhang, T., Sidorchuk, A., Sevilla-Cermeño, L., Vilaplana-Pérez, A., Chang, Z., Larsson, H., ... & de la Cruz, L. F. (2019). Association of Cesarean Delivery With Risk of Neurodevelopmental and Psychiatric Disorders in the Offspring: A Systematic Review and Meta-analysis. JAMA Network Open, 2(8), e1910236-e1910236. https://doi.org/10.1001/jamanetworkopen.2019.10236
15. Landon, M. B., Leindecker, S., Spong, C., Hauth, J., Bloom, S., Varner, M., & Moawad, A. (2005). The MFMU Cesarean Registry: Factors affecting the success of trial of labor after previous cesarean delivery. American Journal of Obstetrics & Gynecology, 193(3), 1016-1023. https://doi.org/10.1016/j.ajog.2005.05.066
16. Harris, B. S., Heine, P. H., Park, J., et al. (2019). Are prediction models for vaginal birth after cesarean accurate? American Journal of Obstetrics & Gynecology, 220, 492.e1-7. https://www.ncbi.nlm.nih.gov/pubmed/30716285
17. Vankan, E., Schoorel, E., van Kuijk, S., Nijhuis, J., Hermens, R., Scheepers, H., & SIMPLE study group. (2019). The effect of the use of a decision aid with individual risk estimation on the mode of delivery after a caesarean section: A prospective cohort study. PLoS ONE, 14(9), e0222499. https://dx.doi.org/10.1371%2Fjournal.pone.0222499
18. Wise, M. R., Sadler, L., Shorten, B., van der Westhuizen, K., & Shorten, A. (2019). Birth choices for women in a 'Positive Birth after Caesarean' clinic: Randomised trial of alternative shared decision support strategies. Australian and New Zealand Journal of Obstetrics and Gynaecology, 59(5), 684-692. https://doi.org/10.1111/ajo.12955.
19. Denham, S. H., Humphrey, T., deLabrusse, C., & Dougall, N. (2019). Mode of birth after caesarean section: individual prediction scores using Scottish population data. BMC Pregnancy and Childbirth, 19(1), 84. https://doi.org/10.1186/s12884-019-2226-6
20. Nguyen, M. T., Hayes-Bautista, T. M., Hsu, P., Bragg, C., Chopin, I., & Shaw, K. J. (2020). Applying a Prediction Model for Vaginal Birth after Cesarean to a Latina Inner-City Population. American Journal of Perinatology Reports, 10(02), e148-e154. https://dx.doi.org/10.1055%2Fs-0040-1708493
21. Lundgren, I., Morano, S., Nilsson, C., Sinclair, M., & Begley, C. (2019). Cultural perspectives on vaginal birth after previous caesarean section in countries with high and low rates—A hermeneutic study. Women and Birth. [Epub ahead of print]. https://doi.org/10.1016/j.wombi.2019.07.300
22. Sartwalle, T. P., Johnston, J. C., & Arda, B. (2017). A half century of electronic fetal monitoring and bioethics: Silence speaks louder than words. Maternal Health, Neonatology, and Perinatology, 3, 21. https://doi.org/10.1186/s40748-017-0060-2
23. Rutherford, J. N., Asiodu, I. V., & Liese, K. L. (2019). Reintegrating modern birth practice within ancient birth process: What high cesarean rates ignore about physiologic birth. American Journal of Human Biology, 31(2), e23229. https://doi.org/10.1002/ajhb.23229
24. Carlson, N. S. , Neal, J. L. , Tilden, E. L. , Smith, D. C. , Breman, R. B. , Lowe, N. K. , . . . & Phillippi, J. C. (2019). Influence of midwifery presence in United States centers on labor care and outcomes of low risk parous women: A Consortium on Safe Labor study. Birth, 46(3), 487-499. https://doi.org/10.1111/birt.12405
25. Miazga, E., Reed, C., Tunde-Byass, M., Cipolla, A., Shapiro, J., & Shore, E. M. (2020). Decreasing Cesarean Delivery Rates Using a Trial of Labour After Cesarean (TOLAC) Bundle. Journal of Obstetrics and Gynaecology Canada. https://doi.org/10.1016/j.jogc.2020.02.113

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