13 Myths About Vaginal Birth After Cesarean

By Jennifer Kamel | Director of VBACFacts.com

Many women believe that the only safe choice after a cesarean is another cesarean. Social pressure plays a huge role in a woman's decision making process. The prevailing conventional wisdom in the United States is greatly influenced by persistent and pervasive myths about VBAC, or Vaginal Birth after Cesarean. The result is a 92% repeat cesarean rate in America, despite the fact that most women are candidates for a VBAC and most VBACs are successful. To make an informed choice about your birth, you need to know the myths and truths about VBAC.

MYTH: Once a cesarean, always a cesarean.

According to the National Institutes of Health (NIH), "VBAC is a reasonable and safe choice for the majority of women with prior cesarean." The American College of Obstetricians & Gynecologists (ACOG) concurred when they said "most" women with one prior cesarean and "some" women with two prior cesareans are candidates for VBAC.

MYTH: A VBAC after one cesarean has a 60-70% risk of uterine rupture.

The risk of uterine rupture after one low transverse (bikini) cut cesarean is about 0.5% – 1% depending on various factors. First time moms delivering vaginally are at risk for complications that are equally serious to uterine rupture and occur at a similar rate such as placental abruption, cord prolapse, and shoulder dystocia.

MYTH: Hospitals ban VBAC because it's such a serious and unusual complication that they cannot manage it appropriately.

Hospitals with labor and delivery units have protocols in place to respond to obstetrical emergencies. The guidelines used to manage the complications from first time moms and repeat cesarean moms are also used to address uterine rupture in VBAC moms.

MYTH: VBAC moms can't have epidurals because it will obscure the pain of uterine rupture.

Per ACOG, epidurals may be used in a VBAC and evidence suggests that epidurals do not mask uterine rupture-related pain. However, only 26% of women who experience a uterine rupture report abdominal pain, so it is an inconsistent and unreliable symptom.

MYTH: There is a 25% chance that either baby or mom will die during a VBAC.

The risk of maternal mortality is very low whether a woman plans a VBAC (0.0038%) or an elective repeat cesarean (0.0134%). Limited evidence suggests that there is a 2.8 – 6.2% risk of infant death after a rare uterine rupture.

MYTH: There are no risks associated with cesareans other than surgery.

The most serious cesarean-related complications become more likely as an individual woman has more cesareans. These complications include placental

abnormalities such as placenta accreta, which carries a 7% maternal mortality rate and a 71% hysterectomy rate. After two cesareans, the risk of accreta is 0.57%, similar to the risk of uterine rupture after one cesarean.

MYTH: I can't have a VBAC in my state because it's illegal.

VBAC is legal throughout America, and in some states, it is legal for a midwife to attend an out-of-hospital VBAC.

MYTH: My doctor will lose his/her medical license if I have a uterine rupture.

Farah Diaz-Tello of the National Advocates of Pregnant Women clarifies, "I have never heard of a situation in which a physician has lost their license for adhering to a woman's wishes after providing them with fully informed consent, and attending them in a manner that is consistent with the standard of care. Even physicians who have been found liable for medical malpractice do not automatically lose their license."

MYTH: VBACs can't, or shouldn't, be induced.

When a mom or baby develops a complication that requires the baby be born sooner rather than later, but not necessarily in the next ten minutes, induction can make the difference between a VBAC and a repeat cesarean. This is why ACOG maintains that medically indicated Pitocin and/or Foley catheter induction "remains an option" during a VBAC.

MYTH: Hospitals ban VBAC because they can't meet ACOG's "immediately available" requirement.

Some hospitals interpret ACOG's "immediately available" recommendation to be a mandate that an anesthesiologist must be in the hospital 24/7. Some hospitals that cannot provide that level of coverage have banned VBAC. However, "immediately available" does not have a standard definition, and various hospitals implement the guideline in different ways.

MYTH: Hospitals that do not have 24/7 anesthesia coverage ban VBAC.

There are motivated hospitals that offer VBAC without 24/7 anesthesia. The rural hospitals that serve the Navajo Nation are an example, and they report a 38% VBAC rate. The VBAC rate in LA County is 7.9%.

MYTH: The evidence shows that 24/7 anesthesia coverage creates a safer environment for VBAC.

ACOG confirms that the data is not available: "Although there is reason to think that more rapid availability of cesarean delivery may provide an incremental benefit in safety, comparative data … are not available." Thus the "immediately available" recommendation is based on the lowest level of evidence which is "consensus opinion." Hospitals without 24/7 anesthesia implement a variety of policies to make VBAC safer, including fire drills and cesarean under local anesthesia.

MYTH: If your hospital doesn't offer VBAC, you have to have a repeat cesarean.

As Howard Minkoff, MD said at the 2010 NIH VBAC Conference, "Autonomy is an unrestricted negative right which means a woman, a person, anybody, has a right to refuse any surgery at any time." ACOG affirms that "restrictive VBAC policies should not be used to force women to undergo a repeat cesarean delivery against their will."

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13 Myths About Vaginal Birth After Cesarean (Con't)

There are real risks and benefits to VBAC and elective repeat cesarean section. Make the right decision for yourself: understand your options, discern truth from fiction, know your legal rights, and get down to the facts. Citations available at http://vbacfacts.com/13-myths-about-vbac/

Jennifer Kamel is the Founder & Executive Director of VBAC Facts whose mission is to make hard-to-find, interesting, and pertinent information relative to post-cesarean birth options easily accessible to the people who seek it. She presents her class "The Truth About VBAC: History, Politics, & Stats" to parents, providers, and advocates throughout the United States.

Understanding Stretch Marks (Con't)

The most important thing to remember about stretch marks is that you should never feel embarrassed or ashamed by them – they're just a small reminder of the amazing feat your body performed in growing and nurturing a new life. Focus on the connection between yourself and your baby, and love the skin you're in!

Kim Walls is an internationally recognized skincare expert focused on optimizing health through skincare. Leading child health advocacy groups and national media rely on Kim's clinical expertise to help parents navigate the often confusing world of natural skincare.

Group B-Strep (Con't)

- Avoid processed foods, sugar, saturated fats and man-made chemicals, as these will not help your gut flora to stay healthy.

HYGIENE

- Wear cotton underwear
- AVOID thong underwear (it is like a wick from the anus to your meatus)
- Women…always, always, always wipe front to back after urination or a

BM

- After a BM use a wet wipe…and wipe front to back until clean

STRESS RELEASE

- Exercise
- Meditation
- Yoga
- Massage

Even if you are GBS positive, there are many simple and effective ways to prevent transmission to your baby. Understanding this process is important to reduce fear and stress before, during and after labor and birth.

Davi Kaur Khalsa, Certified Nurse Midwife and Nurse Practitioner, has over 25 years experience working with women, pregnancy and childbirth. She is certified by the American College of Nurse Midwives, and works closely with several prominent OBGYN doctors in Los Angeles, Beverly Hills, Santa Monica and across the greater Los Angeles area.