CHOOSING A VAGINAL BIRTH

Evidence

Is Vaginal Birth after Cesarean or Elective Repeat Cesarean Safer in Women with a Prior Vaginal Delivery?

This article did a retrospective study on women who had had a vaginal delivery in the past, so they knew they could, but then most recently had a cesarean section. They studied the results of about 1,000 women attempting a VBAC and only around 1,000 actually had to end up having a c-section; the rest had successful vaginal births. The results showed that the mother and baby outcomes were better when the woman had a vaginal birth.

Vaginal Birth After Cesarean: New Insights

This article gathered previously published research on the topic. It covered the numbers of VBACs, maternal and infant benefits and harms, as well as the factors influencing each of these results. They only focused on births including a single baby a mother of a healthy gestational age with a prior cesarean section to review the trial of labor or TOL rather than an immediate elective repeat cesarean delivery or ERCD. They found that maternal mortality rates were much higher in ERCD versus TOL showing 13.4 versus 3.8 out of every 100,000 women. Uterine rupture was shown to increase from 3 with ERCD to 4.7 per every 100,000 with TOL. This article concluded that VBAC is a reasonably safe choice for most mothers. More importantly they found that there is an increased risk for serious hard to mother and baby with multiple cesarean sections.

Evidence Cont.

Up to Date concludes that even just a TOL has lower morbidity rates than a cesarean section. Though the instance of uterine rupture is significantly higher when attempting a VBAC, the maternal death rate is not, and the perinatal death rate is only 2.8 percent. As most research shows, they agree that VBACs have a lower rate of postpartum infection than with repeat cesareans. They reviewed why some women chose a ERCD being postpartum sterilization, which is easily performed right after a cesarean delivery, pelvic trauma is mostly avoided with cesareans, convenience of a scheduled repeat cesarean , and fear of a failed TOL. Up to Date also dug into the reasons women chose a VBAC including desiring more children and understanding the risks of multiple cesarean scars on the uterus, a quick return to familial obligations, a desire experience a vaginal birth and wanting their partners to be involved in the birth. The main difference in VBAC delivery versus cesarean is the possible respiratory distress of the infant after cesarean birth because of the lack of sequential compression of the lungs like with vaginal delivery.

Introduction

The VBAC (Vaginal Birth After Cesarean) rate has been increasing over the recent years and is currently at 13.3 %. However, this is still a much lower rate as compared to 1996 when it was roughly 50%. During this time, uterine rupture instances and maternal mortality rates were found to have increased. As a result, facilities overcorrected and stopped offering VBACs as an option. Current research has taught us that VBACs are proven to be safer than elective repeat cesareans, but the education still needs to be passed on to women making this decision.

Purpose

The purpose of this presentation is to help nurses become more encouraging through education of the option of choosing a vaginal birth after a cesarean, when it has been approved by the physician. If the nurse understands the benefits of this option, they will be more comfortable offering it to the patients. The goal of this topic is to support and continue to increase these rates.

Terms

VBAC- Vaginal Birth After Cesarean

TOL- Trail of Labor

ERCD-Elective Repeat Cesarean Delivery

Recommended Practice

Adequate staff must be available to perform an emergent cesarean in the instance of a failed TOL.

Contraindications including a classic incision, a previous uterine rupture, a breech position, a medical complication that prevents a vaginal birth, a pregnancy with more than two babies or more than 3 existing uterine scars.

Hindrances of success including maternal obesity or a previous synthetic induction of labor, macrosomia or a large for gestational age baby, twin gestation, maternal diabetes, and multiple uterine scars.

Qualifications of the patient including a low transverse scar, a singleton pregnancy, a previous vaginal delivery, and the reason for the previous cesarean not pertaining to limited progress being made during labor.

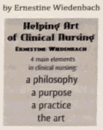
If the decision has been made by the physician that the patient is a candidate prior to beginning labor, education will be presented on the topic to the patient. The patient will then make the informed decision to request or deny a trial of labor in an attempt to achieve a VBAC.

Conclusion

In conclusion, while the rates of VBACs are increasing, they are still lower than they should be. Though the current studies are showing their support for VBACs, not all facilities or providers are even offering them. There is a need for education to expectant mothers on the option of a VBAC versus an ERCD as well as the good that can come from them for mother and baby. More education needs to be done but also more encouragement of VBACs needs to occur across the board, even if it happens one facility at a time.

Theoretical Framework

'The Helping Art of Clinical Nursing Model'
by Ernestine Wiedenbach



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