

CHOOSING A VAGINAL BIRTH

Evidence

In 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 to show how they could feel their most recent had a cesarean section. They studied the results of about 4,000 women attempting a VBAC and only around 1,000 actually had to end up having a cesarean, 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 or multiple of a healthy gestational age with a prior cesarean section to receive the trial of labor or TOL rather than an immediate elective repeat cesarean delivery or ERCD. They found that the rate of cesarean was more than double in ERCD versus TOL, showing 11.4 versus 5.8 out of every 100,000 women. Cesarean repeat was also more than double from 3 with ERCD to 8.7 per every 100,000 with TOL. This article concluded that VBAC is a reasonable safe choice for most mothers. More importantly they found that there was an increased risk for serious harm 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 cesarean repeat is significantly higher when attempting a VBAC, the maternal death rate is low, 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 morbidity, which is easily performed right after a cesarean delivery pelvic trauma is easily avoided with cesarean, 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 cervix, a quick return to normal 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.

Theoretical Framework

'The Helping Art of Clinical Nursing Model'

by Ernestine Wiedenbach

by Ernestine Wiedenbach

Helping Art of Clinical Nursing

Ernestine Wiedenbach

A nurse's mission is clinical nursing

a philosophy

a purpose

a practice

the art

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 20%. During this time, cesarean repeat rates and maternal mortality rates were found to have increased. As a result, facilities encouraged and stopped offering VBAC 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 patients. The goal of this topic is to support and continue to increase these rates.

Terms

VBAC- Vaginal Birth After Cesarean
TOL- Trial of Labor
ERCD- Elective Repeat Cesarean Delivery

Recommended Practice

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

Contraindications including a classic incision, a previous cesarean repeat, a breech position, a medical complication that prevents a vaginal birth, a pregnancy with more than two babies or more than 7 existing cesarean scars.

Hardware of access including maternal obesity or a previous cesarean, identification of their requirements as to help for gestational age baby, low gestation, maternal diabetes, and multiple cesarean 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 provided on the topic to the patient. The patient will then make the informed decision to repeat or deny a trial of labor as 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 encourage mothers on the option of a VBAC versus an ERCD as well as the goal 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 over facility at a time.

References

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