PRIOR CESAREAN SECTION COUNSELING

The decision for trial of labor versus repeat cesarean section is an important one. Based on data of the Perinatal Collaborative Study from 2002 the stated likelihood in a patient with one prior cesarean section in the subsequent pregnancy of having an opening of a low transverse uterine incision is described as approximately 1:100 to 1:200. The likelihood of fetus having significant hypoxic ischemic encephalopathy or death as a consequence of this is described at approximately 1:4 to 1:5. Therefore, the overall likelihood of hypoxic ischemic encephalopathy or death in the pregnancy following a primary low transverse cesarean section is in the order of 1:800 to 1:1000. Although this is the data on a population level, the likelihood for a single patient in a single pregnancy is either 0% or 100%.

Changes in the policy of the American College of Obstetricians and Gynecologists related to trial of labor have dramatically affected the availability of Trial of Labor in the U.S.

Prior to the publication of ACOG Practice Bulletin No. 54 dated July 2004, access to trial of labor in America was far broader. Prior to this policy, physicians were required to be readily available to labor and delivery which was commonly interpreted as affording a 30-minute interval from the time diagnosis is made to the time that the actual delivery is affected. With this new ACOG policy, immediate availability in labor and delivery is mandated. Hospitals and physicians have interpreted this policy as to require an obstetrician, appropriate nursing and surgical personnel, and appropriate anesthesia personnel to be in the labor and delivery unit or at least in the hospital on a continuous basis if trial of labor is offered. This has had a chilling effect on the availability of trial of labor to patients with previously scarred uterus.

Based on evolving concerns about the ever increasing Cesarean Section Rate, The National Institutes of Health (NIH) held a Consensus Development Conference on Vaginal Birth After Cesarean in March, 2010.

There are short- and long-term risks and benefits for both the mother and the baby that need to be considered in determining optimal route of delivery. They include — for the mother — risks of uterine rupture, transfusion and hemorrhage, operative risks including injury to the bowel and
bladder, hysterectomy, death, infection, problems with placentation in subsequent pregnancies, risk of stillbirth and ectopic pregnancies. For the baby, the risks include transition problems for the neonate, respiratory distress, neonatal encephalopathy and hypoxic ischemic encephalopathy, death, and brachial plexus injury.

The NIH Consensus Conference recommended that current VBAC guidelines from professional societies be reassessed, particularly the recommendation for "immediate availability" of surgical and anesthesia personnel before a trial of labor can be offered.

According to 2 recent surveys of hospital administrators, 30% of hospitals no longer offer a trial of labor or VBAC services because they could not meet the immediate availability standard suggested by the American College of Obstetricians and Gynecologists and the American Society of Anesthesiologists guidelines. However, the panel found no evidence that outcomes were improved by the immediate availability of surgical and anesthesia personnel. Other recommendations of the panel are that malpractice concerns be addressed and that additional research be performed to better understand the medical and nonmedical factors that affect decision making for women with previous cesarean deliveries.

In August, 2010, the American College of Obstetricians and Gynecologists published revised recommendations for attempting vaginal birth after cesarean delivery. Revised guidelines consider most women with one or two previous low transverse cesarean incisions, women with twin pregnancy, and women with an unknown type of uterine scar to be appropriate candidates for Trial of Labor After Cesarean Section (TOLAC). Patient-specific decisions are recommended based on a woman's chance of a successful VBAC, the risk for complications from TOLAC, her future reproductive plans, and her personal preference.

If candidates for TOLAC are selected appropriately, approximately 60% to 80% will be successful at VBAC. In addition to maternal preference, potential advantages of VBAC for the individual patient include reduced maternal morbidity associated with avoiding major abdominal surgery, particularly a lower risk for hemorrhage and infection and faster postpartum recovery.

VBAC may also help women avoid the possible future risks of having multiple cesarean deliveries, such as hysterectomy, bowel and bladder injury, transfusion, infection, and abnormal placenta conditions (placenta previa and placenta accreta). At the population level, VBAC is also associated with a lower overall rate of cesarean deliveries.

New guidelines point out that because failed TOLAC is associated with increased maternal and perinatal morbidity compared with elective repeat cesarean delivery, it is important to evaluate individual risks and the likelihood of VBAC when deciding whether TOLAC is a feasible option.

The ACOG bulletin states that TOLAC is most safely undertaken where staff can immediately provide an emergency cesarean delivery while acknowledging that such resources may not be universally available.
ACOG's Revised VBAC Guidelines

The practice bulletin makes the following specific recommendations based on good, consistent scientific evidence (level A):

- TOLAC may be appropriate for most women with 1 previous cesarean delivery via a low transverse incision. These women should be counseled about VBAC and offered TOLAC as a delivery option.
- As part of TOLAC, epidural analgesia may be used for labor.
- For women who have undergone previous cesarean delivery or major uterine surgery, misoprostol should not be used for third-trimester cervical ripening or labor induction.

Also included in the statement are the following recommendations based on limited or inconsistent scientific evidence (level B):

- TOLAC may be considered in women with 2 previous low transverse cesarean deliveries.
- TOLAC may be considered in women with 1 previous cesarean delivery via a low transverse incision who are otherwise appropriate candidates for twin vaginal delivery.
- In women with a previous cesarean delivery via a low transverse uterine incision who are at low risk for adverse maternal or neonatal outcomes from external cephalic version and TOLAC, external cephalic version for breech presentation is not contraindicated.
- Planned TOLAC is generally not recommended in women at high risk for complications, such as those with a classic or T-incision; prior uterine rupture; extensive transfundal uterine surgery; and in other women in whom vaginal delivery is contraindicated, such as those with placenta previa.
- In women undergoing TOLAC, it is permissible to induce labor, when appropriate, based on maternal or fetal indications.
- For women with previous cesarean delivery with an unknown uterine scar type, TOLAC is not contraindicated unless there is a high clinical suspicion for a previous classic uterine incision.

Finally, the statement also provides the following recommendations that are based mainly on consensus and expert opinion (level C):

- Women undergoing TOLAC should do so at facilities able to perform emergency deliveries and with staff immediately available to provide emergency care because of unpredictable risks associated with TOLAC.
- When these resources are not available, women should be clearly advised regarding greater risks for TOLAC and management alternatives, and counseling and management plans should be documented in the medical record.

Data for women with multiple previous cesarean sections, women with non-low transverse cesarean sections, women not in the pregnancy following the surgical delivery, women with breech or other
malpresented fetuses, and women with multiple gestations are all special circumstances. These circumstances carry different risks that deserve additional consideration.

Within the Desert Women’s Care hospital network, trial of labor is discouraged at Tempe St. Luke's but it is readily available at Banner Desert Hospital. Differences in these hospitals and in the staffing of these hospitals are discussed with this patient.

Costs of Trial of Labor and Repeat C-section are discussed differentially with the patient as well.

Return to work following trial of labor and return to work following repeat cesarean section are compared and contrasted. Successful VBAC carries with it the most rapid return to normal activities post partum, decreased procedure-related discomfort, decreased blood loss and earlier maternal–neonatal bonding.

Dr. Demir has extensive experience in treating women with prior Cesarean Section, has been an invited speaker on this issue at medical meetings and has published a book chapter on Safe Reduction of Cesarean Section Rates.

DWC presents additional information on our website on Prior Cesarean Section. You are also invited to review outside information on this topic available in libraries, book stores, and on the Internet to formulate specific questions and to return to this office for a thorough discussion of those topics.