

Is vaginal birth after cesarean risky?

By Henci Goer

"A Risk Is Found in Natural Birth After Cesarean" *New York Times*

"Study: Labor Risky After a Cesarean." *Associated Press*

From the above titles and the articles that followed them, readers would think that a new study published in the prestigious New England Journal of Medicine showed that planned repeat cesarean was safer than vaginal birth after cesarean (VBAC, pronounced "vee-back"). However, the study concluded nothing of the kind. Slanted by quotations from Dr. Michael Greene, an associate editor of the New England Journal who wrote an accompanying editorial, the newspaper, TV and radio reports were actually another salvo in the disinformation campaign to eliminate VBAC. Before we get to why obstetricians want to discredit VBAC, let's look first at what the study really said.

What did the study really say?

Reuters Medical News was perhaps the sole major news outlet to get it right. They ran their piece under: "Prostaglandin-Induced Labor Linked to High Risk of Uterine Rupture after C-Section." The researchers ascertained this by comparing the rate at which the uterine scar gave way in some 20,000 women in Washington State who had a second child after having the first by cesarean. They found that the odds were:

- 1 in 625 with a planned repeat cesarean,
- 1 in 192 with starting labor on their own,
- 1 in 130 with an induction of labor but without using prostaglandin to soften the cervix first,
- 1 in 41 with labor inductions that included prostaglandin.

While potentially serious, the scar giving way, though, is not the crucial issue in determining the safety of VBAC, but rather what happens to the mother and baby as a result. Even when uterine rupture occurred, only one-third of the women experienced a surgical complication during the emergency cesarean that would usually follow. As for irremediable harm, for a woman beginning labor spontaneously, the chance of ending up with a hysterectomy was 1 in 5,000 and of losing the baby was 1 in 3,300. For women being induced without use of prostaglandin, the odds went up only slightly, but when labor induction included prostaglandin, they soared to 1 in 900 for hysterectomy and 1 in 770 for infant death.

In point of fact, this study had nothing to say about the merits of planned cesarean versus VBAC because it only considered uterine rupture. And while VBAC women have a slightly greater risk of this, cesarean section introduces a host of other complications that occur much less often with vaginal birth. To evaluate which is better, you have to compare outcomes between women having a planned repeat cesarean with women planning VBACs. Those studies exist. Among thirty studies comprising 56,300 VBACs, the rate of stillbirths and newborn deaths attributable to uterine rupture was 1 in 3,300, the same as in the Washington State women beginning labor spontaneously. Those odds did not differ significantly from the perinatal mortality rate in 29,900 women having planned cesareans. In other words, *VBAC was no riskier for babies than planned cesarean*.

By contrast, according to a Swiss study of 29,000 women with prior cesareans, women having planned cesareans for a subsequent birth were three times as likely to have hysterectomies as women planning VBACs: 1 in 220 versus 1 in 625. In addition, every time a woman elects a cesarean over a VBAC, she rolls dice that are loaded more and more heavily against her, especially if she desires more children.

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Studies show that accumulating cesareans increase the risk of:

- infertility
- chronic pain and bowel problems
- the embryo implanting outside of the uterus (ectopic pregnancy)
- the placenta overlaying the cervix (placenta previa)
- the placenta detaching before the birth (placental abruption)
- the placenta growing into or through the muscular wall of the uterus (placenta accreta or percreta).

The last three are life-threatening; placenta accreta particularly so. Planned repeat cesarean also puts babies at risk for breathing difficulties. One problem, persistent pulmonary hypertension, can be deadly.

Objective readers of the New England Journal study would conclude neither that VBAC was unduly risky nor even that VBAC women should never be induced.

3 things they would conclude are:

- The first cesarean should be avoided both because of the inherent risks of major surgery and because it introduces risks into future pregnancies.
- Induction of labor should only be done when the risks of awaiting labor outweigh the risks of inducing it -- a situation that occurs far less often than the typical obstetrician thinks it does.
- When induction seems the most prudent course, don't use prostaglandins.

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Are OBs really objective about VBAC? *Obstetric opposition to VBAC isn't about safety.* Obstetricians have been quite open about their motivation to condemn VBAC. In 1996, a prominent obstetrician and the editor of an obstetric trade magazine proposed a prototype of what he called an "informed consent" form. It described the dreadful things that could go wrong with a VBAC but said nothing about the equally dreadful things that could go wrong with a repeat cesarean, let alone the dangers of accumulating scars for future pregnancies. Few women would be brave enough to attempt a VBAC after reading this form. This doctor frankly admitted that the form was intended to forestall lawsuits and that using it would "send your [cesarean] rate soaring." Since then, malpractice insurance companies have widely adopted it and begun recommending that their obstetrician clients use this form or others like it. Many of them have

The obstetricians' professional trade organization, the American College of Obstetricians and Gynecologists, has been equally forthcoming about why it reversed its position on VBAC. Despite no change in the data, it issued new guidelines in 1998 that took a much more negative view of VBAC than the previous guidelines. A stated rationale for the about face was that "adverse events during trial of labor have led to malpractice suits." The desire to avoid malpractice suits doesn't necessarily mean obstetricians don't have a legitimate concern about VBAC. However, the logical discrepancies and inconsistencies that riddle obstetric arguments and pronouncements reveal that they aren't, in fact, expressing genuine interest in promoting safe and effective care. Let me cite some examples.

The new guidelines recommend that hospitals not permit VBAC unless they can perform immediate emergency cesareans. This has had a chilling effect on VBACs, because most community hospitals can't do this, especially at

night or on weekends. But the general hospital population has about the same potential for an emergency in labor as the potential for the scar giving way. If it isn't safe for VBAC labors in hospitals that cannot perform an immediate cesarean, then it isn't safe for any woman to labor there.

Leaving aside that cesareans impose other risks that balance out the risk of uterine rupture during a VBAC, commentators on the Washington State data deemed the 1 in 3,300 chance of losing the baby during a spontaneous VBAC labor was sufficient to mandate planned repeat cesarean. The odds of amniocentesis precipitating a miscarriage fall somewhere between 1 in 200 and 1 in 400, more than ten times the risk of the baby dying from a VBAC-related uterine rupture. Yet obstetricians aren't lobbying for an end to amniocentesis on the grounds that it is too hazardous.

Another tip-off is a willingness to distort data. The 1998 VBAC guidelines cite a single study as the other rationale besides reducing liability for revising the guidelines. The sole study with this finding, it concluded that "major maternal complications" were twice as likely in women laboring compared with women having elective cesareans,. However, as a preeminent VBAC researcher points out, the authors coded wound infections and hemorrhage requiring transfusion as "minor complications," both of which occurred more often in the planned cesarean group. If you make these major complications, as would normally be the case, the difference between the two groups disappears. Even without doing this, he adds, major complication rates were quite low—a bit less than one percent in the planned cesarean group, a bit more than one percent in the labor group.

Dr. Greene, the New England Journal editorialist obstetrician, provides another example of data distortion. He leaps from the limited finding that VBAC, at least barring prostaglandin use, slightly increases the risk of uterine rupture to the sweeping statement that VBAC is more dangerous than repeat cesarean. He treats a risk factor, uterine rupture, as the actual devastating outcome, stillbirth or newborn death. Both are such elementary errors of proper scientific approach for an assistant editor at a prominent medical journal that it strongly suggests he has an axe to grind.

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Even the way in which the Washington study data was presented was biased against VBAC. The article stated that spontaneous VBAC labor increased the risk of rupture 3.3-fold compared with repeat cesarean, a statistic quoted in media articles. This sounds alarming, but the absolute difference was four women per thousand, a miniscule number when you consider that two-thirds of women experiencing uterine rupture will suffer nothing worse than the cesarean they would have had in any case had they not decided on a VBAC. The study purporting to show that VBAC resulted in more major maternal complications, it should be noted, was also published in the New England Journal, as have other equally prejudiced editorials. This leads one to suspect that the obstetricians involved in the editorial process are using the journal to promote their agenda under the guise of journalistic objectivity.

To be fair, not every obstetrician who won't do VBACs is willfully engaging in deception. Some are unconsciously suiting the facts to their beliefs. Some have been convinced by those they take as authorities that repeat cesarean is best. Some are glad to have an excuse to not do what they never wanted to do in the first place. Some have reluctantly bowed to pressure from their malpractice insurance company, hospital policy or colleagues. The result for you, though, is the same: the experts you trust to advise you on what is safest for you and your baby have abandoned that responsibility. With few exceptions, when obstetricians tell you planned repeat cesarean is the better option, they aren't talking about your or your baby's wellbeing; they are talking about their own.

Note: For those of you aware of the dangers of [Cytotec](#) (misoprostol), a prostaglandin implicated in high rates of uterine rupture in VBAC labors, the study states that Cytotec had only been introduced in 1996, the last year of the study. The study compares uterine rupture rates with induction involving prostaglandin in the years preceding 1996 with 1996 and finds no difference. I expect this is because Cytotec probably wasn't in common use in its first year. I venture to predict that if researchers looked at a later year, rupture rates associated with prostaglandin

would have climbed even higher than they were during the study years.

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