57 Vaginal Birth After Cesarean Section (VBAC)

1. A Classic uterine incision is high risk for catastrophic uterine rupture during a subsequent pregnancy (both before or during labor) and increases maternal and perinatal morbidity or mortality
2. Low-transverse uterine incision has less blood loss and better healing, with better maintenance of integrity in subsequent pregnancies
3. Trial of labor is successful in 60–80% of women
4. Previous successful vaginal delivery is the greatest predictor for successful VBAC
5. History of dystocia, a need for induction of labor, and maternal obesity are associated with a lower likelihood of successful VBAC
6. Contraindications for VBAC:
    (a) Previous classic or T-shaped incision or extensive transfundal uterine surgery
    (b) Previous uterine rupture
    (c) Medical or obstetric complication that precludes vaginal delivery
    (d) Inability to perform emergency cesarean delivery because of unavailable surgeon, anesthesia (provider), sufficient staff or facility
    (e) Two prior uterine scars and no vaginal deliveries
7. All VBAC patients should be type-and-crossed
8. Epidural analgesia does not delay the diagnosis of uterine rupture or decrease the likelihood of successful VBAC

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