“Vaginal Birth After Cesarean Delivery: A Common-Sense Approach”
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1. Is induction with an unfavorable cervix an absolute contraindication to trial of labor after cesarean delivery (TOLAC)? If not, under what circumstances may it be attempted, and how should it be conducted?

Response from Dr. Scott:
Induction is not absolutely contraindicated, but careful evaluation is warranted before deciding to proceed. My suggestion is to await spontaneous labor when possible. An unripe cervix, particularly in a nulligravid woman, is associated with a greater chance of failed induction, which then results in another cesarean, an increased risk for infection, and more likely an unhappy patient, a situation to avoid.

2. While it can be easy to act on Category III fetal heart rate (FHR) tracings (as in Figure 6), most of us prefer to avert disaster rather than wait for it. For TOLAC, are there any Category II tracings that constitute sufficient reason to proceed to cesarean delivery?

Response from Dr. Scott:
There is no diagnostic FHR tracing that can be relied on to predict uterine rupture. From a practical standpoint, it is more important to stay alert to the possibility of rupture in any TOLAC patient, to watch her closely during labor, and to act decisively on any combination of signs, symptoms, and FHR abnormality suspicious for rupture.
3. How do you counsel a woman regarding TOLAC if her interpregnancy interval is less than 1 year? What if it is less than 6 months? Is there an interpregnancy interval for which you would not offer TOLAC?

**Response from Dr. Scott:**
*Studies are conflicting, but the majority of the literature indicates there is an increased risk associated with short birth intervals (less than 1 year) compared to longer interpregnancy intervals. The absolute risk is low, and TOLAC can still be a reasonable consideration if all other conditions are favorable.*

4. Has there been any analysis of the costs to the provider for offering TOLAC? In comparison to scheduled cesarean delivery, costs of increased counseling time, longer duration of intrapartum time commitment, anxiety, and medical liability risk exposure may be increased substantially and are unreimbursed. From the provider’s view, how can we make the economics of TOLAC more favorable?

**Response from Dr. Scott:**
*I am not aware of a cost analysis in exactly the way you framed the question, but I am not sure it is needed. It is obvious that TOLAC involves more time and effort than repeat cesarean. This is one of many examples of wrong incentives in our health care system. In my view, the physician fee should be the same for a normal vaginal delivery as it is for a cesarean, and it should be higher for vaginal birth after cesarean delivery (VBAC) for the reasons you mention. Whether third-party payers are receptive to a more fair and rational fee schedule is a question I can’t answer. However, since there are a significant number of women who want VBAC, physicians who offer that service will remain competitive and in demand.*

5. If a uterine dehiscence is found at the time of failed TOLAC, what are your recommendations for repairing the “window,” particularly when the lower edge of the dehiscence is micro-thin and difficult to distinguish from the bladder? How do you counsel patients desiring additional pregnancies after a dehiscence?

**Response from Dr. Scott:**
*If I understand correctly from the way you describe the findings, it would be possible to dissect the bladder off the lower uterine segment and close the incision in the usual manner. This would be a good case to use a two-layer closure with an imbricating second layer. There are few data...*
to indicate whether an asymptomatic window does or does not pose an increased risk of rupture in the next pregnancy, but delivery by cesarean would be reasonable, particularly after a failed TOLAC.

6. The American College of Obstetricians and Gynecologists Practice Bulletin on vaginal birth after previous cesarean delivery (Obstet Gynecol 2010;116:450–63) states that external cephalic version is not contraindicated in women considering TOLAC who are at low risk for adverse outcomes. Under what circumstances would you advise against external cephalic version in a woman who would otherwise qualify for TOLAC?

Response from Dr. Scott:
There are few risks or contraindications. Studies to date show that results of external version are similar to women without a previous cesarean.

These were all good questions. Thanks for the opportunity to answer them.