Achieving Successful VBAC

The prevention of/or lowering cesarean rate does not make much sense medically, unless one understands the why of it.

First mothers trade off a few hours of pain in labor for at least two weeks of post-surgical pain that vaginal birth moms don't have. Women who desire more children after a cesarean face the dilemma of a repeat cesarean or the risk of a VBAC. If repeat cesareans are done there is an increased risk of placenta acretas (placenta grown through the uterine wall) and maternal morbidity and hysterectomy. If VBAC; the risk of rupture in labor is higher with multiple cesareans. So for women's health and future fertility VBACS are important. They can be successfully accomplished if during pregnancy one works a little harder.

A year ago (June 2010) the Los Angeles Times and prior to that the Sacramento Bee reported a 300 percent rise in maternal mortality rates related to childbirth in the last ten years. Doctors attributed the increase in death rates to women such as "Well women are having babies later, more infertility treatments, more obesity and a rise in diabetes (too much sugar and fast food). The controversy wasn't just that maternal mortality rates tripled in the last ten years but that the rise went unreported…

The researcher from the California State Health Department reviewed the rise maternal deaths in the last ten years and found that while women are delaying child bearing and there is a rise in infertility treatments and obesity these accounted for only a small rise in death rates.

The largest jump in maternal mortality was due to the doubling of our cesarean rate from about 25 percent in the 1990's to 50 percent in the year 2009. Cesarean sections were promoted to women as safer for the baby, safer for the mother, less pain, less pelvic floor trauma, better timing and the danger of allowing women with previous cesareans even to labor.

These assertions except for time in labor were based on junk science and lies. Cesareans are major surgery. The abdominals connective tissue is severed; the uterine muscle is cut. As this occurs, the patient morphs into a high risk patient for future births because of the uterine scar. Baby's interest can be served but are not always and deeper maternal anesthesia can play a role in newborn issues like respiratory, depression and oxygen deprivation.

All of this was reviewed by the American College of Obstetricians and Gynecologists (ACOG) "steering committee". ACOG then revised its stand on VBACs again. The Technical Bulletin which is the technical practice guidelines (standards) for obstetricians. In the 60's and 70's the rule was once a cesarean always a C-section. By the 80's women were encouraged to try a vaginal birth(VBAC) even after more than one cesarean and doctors offered a trial of labor (TOL) to most women even with more than one c/section.. The ACOG guidelines for VBAC stated that the obstetrician was to be readily available. ACOG reversed this guideline to state immediate availability by the 1990s. This required physicians to be in hospital

during labor which most doctors are not willing or able to do. This gave rise to the doubling of our c/s rates. It seems in this case long term outcomes were not considered.

By 2011, when the scandal broke about maternal death rates (still low but a tripling of the numbers) ACOG reversed its stand again. Now ACOG suggests a trial of labor for women even with two prior low transverse cesareans. But real little information was given on how to accomplish these VBACS.

So I present to you our own in house VBAC Study occurring at the Gentle Birth Center in Glendale, now the Natural Birth and Women's Center. This is the "how we did it" to produce safe labors, and great long term outcomes and in fact better births.

The VBAC Study at the Birth Center –

A total of 138 attempted vaginal deliveries after one prior C/S.

VBACS outcomes: 120 women delivered vaginally at the birth center without complications.

13 were transferred during labor to the hospital. Of the 13 transferred, 6 delivered vaginally. All six women were given epidurals and Pitocin. All had stalled labors but were at least 6 centimeters dilated when they were transferred

. Of those six vaginal deliveries 3babies were delivered by vacuum extractions. All six mothers and infants did well. There were no maternal hemorrhages and no neonatal admissions to the NICU.

7 of the transferred group were delivered by repeat cesarean. In that group, all but one had cervical dilatation greater than 6 centimeters at the time of transfer from the birth center. All cesarean mothers subsequently did well and there were no admissions of neonates to the NICU. Many of the 13 transfers had failure of the fetus to descend adequately into the pelvis. But in many of these women this was not linked to the previous reason for the previous C/S .

Our experience has a very high success rate of vaginal births after a previous C-section. 120 of these women achieved spontaneous vaginal deliveries without incident. The following information is how we achieved that remarkable success:

1) All women wishing to VBAC were evaluated for an adequate gynecoid pelvis. These were the majority of women.

2) All were put on strict diets tailored to each individual woman with her weight and food philosophy factored in. These diets were designed to build healthy babies, and muscle while controlling weight. These diets included a strong individualized nutrition component. The goal was to eliminate gestational diabetes, big babies, hypertension issues and maternal infection. All are diet related.

3)A strict walking program was initiated to make sure babies were head down and deep in the pelvis.

The goal was to ensure babies were be born between 37 and 40 weeks. (This controlled fetal size to some extent and decreased the risk of babies being overdue and having meconium in labor.)

4) The cervix needed to be soft and pliable prior to labor (So that labors were not prolonged). If the cervix did not soften and efface (thin out) well prior to the onset of labor the mothers were supplemented with certain homeopathic remedies. Never blue or black cohosh herbals as they can elevate maternal blood pressure to dangerous levels. These homeopathic remedies should be given ONLY by the midwife delivering the baby as there are 53 different one and they do not help or cause harm if the wrong ones are given. (DOULAS ARE NOT QUALIFIED TO DO THIS!)

5)The fetus was evaluated for general health with a "biophysical profile sonogram (BPP)" which measures fetal muscle tone, breathing, amniotic fluid levels, condition of the placenta , fetal heart rate and breathing motions . And all though it is not part of the BPP we also looked for descent of the baby (how deep in the pelvis) and the length and placement of the umbilical cord.

Adequate amniotic fluid suggests the placenta is functioning and the baby is healthy. Amnionic fluid is made by the baby and placenta. If the baby's placenta is healthy and has reserves, the baby is head down, the cervix is soft, the labor is not extremely long or difficult, the mother is otherwise healthy- This leaves only the mechanics of labor i.e. the strength of uterine contractions and descent and rotation of baby to worry about

6) All VBAC women were monitored with an external fetal heart monitor intermittently during labor because fetal distress is the first sign of a rupturing uterus. Mothers were labored in and out of the shower (vertically) but monitors were used. This gave us a heads up if a scar was threatened. As a mid-wife with over 30 years of clinical experience I have seen ruptured ruptures and prevention must be addressed prior to labor.

Because VBACS do contain a small risk of uterine rupture we wanted short, easy labors without extra risk factors. We wanted no extra augmentation for labor, no drugs, hormones, or herbs. Just straight forward, natural labors, well monitored fetuses and mothers. If we did our job with just a little cooperation of the baby we had 120 successful vaginal deliveries at the birth center.

I believe VBACS are safe when the proceeding plan is carefully followed. Today at the Natural Birth and Women's Center our tradition of safety and success with VBACS continues.

Tonya Brooks