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Vaginal Birth After Cesarean: New Insights Manuscripts from an NIH Consensus Development Conference, March 8–10, 2010

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Introduction

In 1980, amid concern over rising cesarean delivery rates, the National Institute of Child Health and Human Development sponsored a Consensus Development Conference on cesarean childbirth, at which the consensus panel found vaginal birth after cesarean (VBAC) to be a reasonable alternative to repeat cesarean for many women. By 1996, VBAC rates had increased to over 28%, but the increase was short lived, such that VBAC accounts for fewer than 8% of births after cesarean today. The reasons for this shift are not entirely understood, but likely include concerns about potentially serious complications of VBAC attempts, as well as non-medical factors such as administrative policies, medicolegal pressures, professional society guidelines, and patient and provider preferences.

A growing body of evidence indicates that women's access to a trial of labor after previous cesarean delivery is being widely restricted, with substantial numbers of institutions and care providers refusing to allow attempts at VBAC, often citing concerns about safety or inability to adhere to specific practice guidelines. These restrictions have arisen despite studies that have consistently shown that 60–80% of trials of labor after cesarean end with successful vaginal delivery, and that rates of the most feared complication, uterine rupture, are less than 1%.

The National Institutes of Health Consensus Development Program is designed to create evidence-based consensus statements addressing controversial issues in medicine that are important to health care providers, policymakers, patients, researchers, and the general public. Thus, on March 8–10, 2010, the Eunice Kennedy Shriver National Institute of Child Health and Human Development sponsored a Consensus Development Conference titled Vaginal Birth After Cesarean: New Insights. The goal of this conference was to examine evidence on maternal and neonatal outcomes after trials of labor and repeat cesareans, as well as the complex constellation of other factors affecting VBAC utilization, and reach evidence-based consensus on the appropriate place for VBAC as a childbirth option.

An independent panel of health professionals and public representatives evaluated an evidence report commissioned by the Association for Healthcare Research and Quality, heard presentations from noted researchers in the relevant fields, and the comments from stakeholders attending the conference. The panel was tasked with answering the following conference questions:

1. What are the rates and patterns of utilization of trial of labor after prior cesarean, vaginal birth after cesarean, and repeat cesarean delivery in the United States?
2. Among women who attempt a trial of labor after prior cesarean, what is the vaginal delivery rate and the factors that influence it?
3. What are the short- and long-term benefits and harms to the mother of attempting trial of labor after prior cesarean versus elective repeat cesarean delivery, and what factors influence benefits and harms?
4. What are the short- and long-term benefits and harms to the baby of maternal attempt at trial of labor after prior cesarean versus elective repeat cesarean delivery, and what factors influence benefits and harms?
5. What are the nonmedical factors that influence the patterns and utilization of trial of labor after prior cesarean?
6. What are the critical gaps in the evidence for decision-making, and what are the priority investigations needed to address these gaps?

Manuscripts based on the presentations given at the conference are included in this and the previous issue of Seminars in Perinatology. Papers discussing the epidemiologic and biomedical aspects of the VBAC issue, addressing conference questions 1 – 4, appeared in the previous issue. This issue is primarily devoted to question 5, and explores the non-medical components of the VBAC question. A reprint of the panel's final statement is also included here. In brief, the panel concluded that a trial of labor is a reasonable birth option for many women with a previous cesarean delivery. The panel also found that existing practice guidelines and the current medical liability climate are having a restrictive effect on women's access to attempted VBAC, and that these negative influences should be addressed.

Thus, thirty years later, a second NIH Consensus Conference panel has evaluated the accumulated evidence and affirmed the appropriateness of VBAC for many women with a prior cesarean. It will be interesting to follow the course of access to trials of labor after cesarean, as well as national cesarean and VBAC rates in response to this panel's statement.