



American College of Nurse-Midwives Responds to ACOG's 2010 VBAC Recommendations

ACOG's revised guidelines are unlikely to increase access to TOLAC and VBAC in the U.S.

On July 21, 2010, the American College of Obstetricians and Gynecologists (ACOG) released a revised practice bulletin on vaginal birth after previous cesarean section (VBAC). The new recommendations were developed in consideration of available empirical evidence and expert opinion following the 2010 National Institutes of Health (NIH) Consensus Development Conference Statement, "Vaginal Birth After Cesarean: New Insights" (1). http://consensus.nih.gov/2010/images/vbac/vbac_statement.pdf

Background

The number of VBACs in the U.S. has declined markedly since 1996 (2, 3, 4). While the possibility of uterine rupture is commonly cited as the primary reason to avoid a trial of labor after cesarean (TOLAC), the NIH consensus statement describes the nonmedical factors that have also played a major role in restricting access to TOLAC, including professional association practice guidelines. In 1999, ACOG issued a changed guideline stating that TOLAC should only be performed in institutions equipped to respond to obstetric emergencies and in settings where physicians capable of performing a cesarean delivery are "immediately available" to provide emergency care (5). A 2008 joint statement by ACOG and the American Society of Anesthesiologists further reinforced the need for immediate availability of anesthesia and other medical resources in TOLAC (6). Many institutions, particularly community hospitals and those in rural areas have been unable to comply with these standards and have stopped offering TOLAC and VBAC altogether.

Medico-legal factors have further exacerbated these barriers to TOLAC. In many areas of the country, women seeking to avoid a repeat cesarean section have few or no options available to them. Women must choose between traveling great distances for a trial of labor, or remaining in communities in which skilled clinicians working within an integrated health care delivery system are not available. This lack of access often leaves women with no other option but to deliver by cesarean section, despite their preference for a trial of labor, causing many to become passionate advocates for VBAC and for reducing unnecessary medical interventions in childbirth.

The New ACOG Guidelines

The ACOG practice bulletin “Vaginal Birth After Previous Cesarean Delivery,” Number 115, August 2010, offers a comprehensive examination of many types of data on risks and benefits of TOLAC versus elective repeat cesarean delivery, or ERCD (7). The guidelines emphasize thorough patient counseling with documentation in the medical record, individualized clinical management plans, and respect for women’s autonomy. Consistent with ACNM’s current position on VBAC, ACOG calls for informed consent for women and well-established and ongoing communication between midwifery and obstetric providers. ACOG’s recognition of the woman as the primary decision maker in her own care is a step in the right direction in terms of access to VBAC. Unfortunately, the 2010 practice bulletin does not go far enough in calling for the comprehensive changes in practice, integrated care delivery services, and research that are needed in order to truly expand women’s access to a safe trial of labor after cesarean.

The 2010 practice bulletin includes a combination of prior recommendations and new evidence based recommendations that generally broaden the opportunities for more women who desire to proceed with a trial of labor (8). Of the past recommendations that are being carried forward and the added new recommendations, only three are based on good and consistent scientific evidence (Level A). These include counseling and offering TOLAC to women with one previous cesarean delivery with a low-transverse incision and the use of epidural analgesia during labor, both of which were recommendations in past ACOG statements. The third Level A recommendation changes the previous guideline discouraging the use of misoprostol prostaglandins for cervical ripening or labor induction in women with previous cesarean or major uterine surgery to stating that misoprostol should NOT be used.

Level B evidence (limited or inconsistent scientific evidence) provides the background for the majority of the new recommendations. External cephalic version for breech presentation with one prior low transverse incision is no longer contraindicated. VBAC is no longer contraindicated in women at higher risk for complications (previous classical or T-incision, prior uterine rupture or uterine surgery); rather, such women are now considered “not generally candidates for planned TOLAC” (p. 9). Additionally, ACOG recommends that women undergoing induction or augmentation of labor should be counseled about associated risks, including increased likelihood of uterine rupture and decreased likelihood for a successful VBAC. The 2010 guidelines also state that women may now be candidates for TOLAC in the following situations:

- Two prior low transverse incision cesarean births
- Twin gestation with one prior low transverse incision cesarean birth
- Gestation beyond 40 weeks
- Suspected macrosomia
- Prior low vertical incision
- Unknown type of previous uterine incision, unless high suspicion of classical incision

For women with three or more previous cesarean births there is still limited data, and no recommendations are made.

Perhaps most controversial are the remaining recommendations, which are based primarily on consensus and expert opinion (Level C). The recommendations in this section of the 2010 guidelines are contradictory, offer little insight into changing the clinical practice environment, and represent no real change in ACOG's position. The bulletin states that "the potential risks and benefits of both TOLAC and elective repeat cesarean delivery should be discussed," and that "respect for patient autonomy supports that patients should be allowed to accept increased levels of risk," noting that "after counseling, the ultimate decision to undergo TOLAC or a repeat cesarean delivery should be made by the patient in consultation with her health care provider" (p. 9). Nonetheless, the document still clearly states that "a trial of labor after previous cesarean delivery should be undertaken at facilities capable of emergency deliveries" (p.9).

ACOG maintains this opinion while explicitly acknowledging that this very guideline limits women's opportunities for TOLAC, resulting in reduced VBAC rates and increased cesarean delivery rates. ACOG concedes that "although there is reason to think that more rapid availability of cesarean delivery may provide a small incremental benefit in safety, comparative data examining in detail the effect of alternate systems and response times are not available" (p. 8). In other words, the recommendation persists, despite the low level of evidence supporting immediately available cesarean delivery. Clearly, women and infants would benefit from research examining TOLAC/VBAC outcomes and safety in alternate settings in which optimal interdisciplinary education, communication, and transfer mechanisms have been well established to address potential complications.

ACNM Responds

ACNM's philosophy is that all women—including those who have had a prior cesarean birth—should have access to information, counseling and birthing options provided by vigilant, skilled clinicians within a coordinated maternity care delivery system. While integrated resources should be made available in all settings, immediate access to emergency delivery solely to safeguard against the potential risks associated with TOLAC should not be the focus. Rather, risk associated with TOLAC should be considered within the spectrum of perinatal benefits and risks associated with nulliparous women in labor. Uterine rupture, a rare, often unpredictable complication of both trial of labor after cesarean as well as repeat elective cesarean delivery, is a primary factor underlying the ACOG recommendations. Yet the risk of uterine rupture associated with TOLAC is similar statistically to that of other obstetrical emergencies for a woman experiencing her first birth. Furthermore, it should be noted that the benefits of labor and vaginal birth are often omitted from this discussion. The focus is exclusively on risk, which does not yield a complete picture. Provided with the latest evidence and comprehensive counseling, women must be allowed to make decisions regarding TOLAC and give birth in the settings that best meet their individual needs. It is unclear how these fully informed women will be at liberty to choose a TOLAC when facilities continue to refuse them this option, claiming compliance with the 2010 ACOG guidelines.

ACOG's 2010 practice guidelines may help to expand access to TOLAC for women with certain clinical presentations. However, ACOG's continued recommendation that TOLAC be undertaken at facilities

capable of immediate emergency deliveries virtually assures that the 2010 guidelines alone will fail to appreciably increase access to TOLAC and VBAC in the U.S. The NIH VBAC consensus statement recommends that “hospitals, maternity care providers, health care and professional liability insurers, consumers and policymakers collaborate on the development of integrated services that could mitigate or even eliminate current barriers to trial of labor” (p. 37). Only a long-term, system-wide, concerted effort based on quality evidence and further research in all settings will accomplish this goal. ACNM welcomes this important and necessary collaboration.

References

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