Spokane Midwives

INFORMED CONSENT FOR PATIENTS ATTEMPTING VAGINAL DELIVERY AFTER CESAREAN SECTION

Initial Please

_____1. I understand that I have had one or more prior cesarean(s).

_____2. I understand that I have the option of: undergoing an elective repeat cesarean or attempting a vaginal birth after a cesarean (VBAC) in hospital or VBAC at home.

_____3. I understand that approximately 70% of women who undergo a VBAC will successfully deliver vaginally.

_____4. I understand that the risk of a uterine rupture during spontaneous labor in someone such as myself, who has had a prior incision in the non-contracting part of my uterus, is around .5%.

_____5. I understand that VBAC is associated with a higher risk of harm to my baby than to me.

_____6. I understand that if my uterus ruptures during my VBAC there may not be sufficient time to transport to hospital and to prevent the death of or permanent brain injury to my baby.

_____7. I understand that the decision to have a VBAC at home is entirely my own, and the options of a hospital VBAC or an elective repeat cesarean has been discussed with me.

_____8. I understand that VBAC carries a lower risk to me than does a cesarean delivery.

_____9. I understand that if I deliver vaginally, I most likely will have fewer problems after delivery and a shorter recovery than if I have a cesarean delivery.

_____10. I understand that if I choose a VBAC and end up having a cesarean during labor, I have a greater risk or problems than if I had had an elective repeat cesarean.

_____11. I realize the Spokane Midwives' malpractice insurance doesn't cover VBAC deliveries.

I have received all the information I want. After discussing the matter with my midwife, I want to attempt a VBAC at home.

_____

Signature of patient Print Name Date

1/99 rev 12/01, 4/06

VBAC INFORMED CONSENT

I (we) have been informed that the medical literature overwhelmingly supports the safety of vaginal birth, or a "trial of labor" following a previous delivery by cesarean section (VBAC). However, due to lack of systematic data collection and analysis, the relative safety of such a labor in a non-hospital setting has not been firmly established.

I (we) understand that the main risk associated with a VBAC is that the scar might open during labor. Most times when this happens, it is small and causes no problem. However, I (we) understand that in rare cases, a VBAC can be life threatening to me and/or my (our) baby and that no assurances can be made that a catastrophic rupture will not occur. I (we) also understand the risk of complications from a repeat cesarean are higher than the risks of VBAC complications. As with other risks associated with childbirth, I (we) accept this risk.

I (we) understand that while Spokane Midwives has malpractice insurance, that insurance does **NOT** cover VBAC deliveries.

I (we) freely choose to labor and hopefully give birth to my (our) baby in the non-hospital setting of my (our) choice, i.e. my (our) home or another similar location. I (we) agree to be transported to the hospital during the intrapartum course if my (our) midwife recommends it, at any time, for any reason.

Signature of mother Print Name Date

Signature of spouse/partner Print Name Date

Signature of attendant Print Name Date

EXCERPTS FROM ACOG VBAC CLINICAL MANAGEMENT GUIDELINES
NUMBER 5, JULY 1999
Replaces Practice Bulletin Number 2, October 1998

Recent Issues

Despite more than 800 citations in the literature, there are no randomized trials to prove that maternal and neonatal outcomes are better with VBAC than with repeated cesarean delivery. Published evidence suggests that the benefits of VBAC outweigh the risk in most women with a prior low-transverse cesarean delivery. Never the less, most studies of VBAC have been conducted in University or tertiary-level centers with in-house staff coverage and anesthesia. The safety of trial of labor is less well documented in smaller community hospitals or facilities where resources may be more limited (15-18). It has become apparent that VBAC is associated with a small but significant risk of uterine rupture with poor outcome for both mother and infant (19-22). Reports indicate that both maternal and infant complications also are associated with an unsuccessful trial of labor. Increasingly, these adverse events during trial of labor have led to malpractice suits. (22-24). These developments, which have led to a more circumspect approach to trial of labor by even the most ardent supporters if VBAC, illustrate the need to reevaluate VBAC recommendations (23, 25)

Clinical Considerations and Recommendations

Who are the candidates for a trial of labor?

- Ø One or two prior low-transverse cesarean deliveries
- Ø Clinically adequate pelvis
- Ø No other uterine scars or previous rupture
- Ø Physician immediately available throughout active labor capable of monitoring labor and performing an emergency cesarean delivery
- Ø Availability of anesthesia and personnel for emergency cesarean delivery.

What are the risks and benefits associated with VBAC?

Neither repeat cesarean delivery nor trial of labor is risk free. When VBAC is successful, it is associated with less morbidity than repeat cesarean delivery. The advantages include fewer blood transfusions, fewer postpartum infections, and shorter hospital stays, usually with no increased perinatal morbidity (11,12,14).

Those patients who fail a trial of labor are at increased risk for infection and morbidity (49-52%). Infants born by repeat cesarean delivery after a failed trial of labor also have increased rates of infection (53). In contrast to previous reports, the most recent series showed that major maternal complications such as uterine rupture, hysterectomy, and operative injury were more likely for women who underwent a trial of labor than those who elected repeat cesarean delivery (50).

Rupture of the uterine scar can be life-threatening for both mother and infant (19-22). When catastrophic uterine rupture occurs, some patients will require hysterectomy and some infants will die or will be neurologically impaired (22,50). In most cases, the cause of uterine rupture in a patient who has undergone VBAC is unknown, but poor outcomes can result even in appropriate candidates.

The occurrence of uterine rupture is dependent on the type and location of the previous incision. Estimated occurrence based on the literature is as follows (18,39):

- Ø Classical uterine scar (4-9%)
- Ø Low-vertical incision (1-7%)
- Ø T-shaped incision (4-9%)
- Ø Low-transverse incision (0.2-1.5%)

What are the contraindications for VBAC?

- Ø Prior classical or T-shaped incision or other transfundal uterine surgery (54)
- Ø Contracted pelvis (18)
- Ø Medical or obstetric complication that precludes vaginal delivery
- Ø Inability to perform emergency cesarean delivery because of unavailable surgeon, anesthesia, sufficient staff, or facility.

Summary

The following recommendations are based on good and consistent scientific evidence (Level A):

- Ø Most women with one previous cesarean delivery with a low-transverse incision are candidates for VBAC and should be counseled about VBAC and offered a trial of labor.
- Ø Epidural anesthesia may be used for VBAC
- Ø A previous uterine incision extending into the fundus is a contraindication for VBAC.

The following recommendations are based on limited or inconsistent evidence (Level B):

- Ø Women with two previous low-transverse cesarean deliveries and no contraindications who wish to attempt VBAC may be allowed a trial of labor. They should be advised that the risk of uterine rupture increases as the number of cesarean deliveries increases.
- Ø Use of oxytocin or prostaglandin gel for VBAC requires close patient monitoring.
- Ø Women with a vertical incision within the lower uterine segment that does not extend into the fundus are candidates for VBAC.

The following recommendations are based primarily on consensus and expert opinion (Level C):

- Ø Because uterine rupture may be catastrophic, VBAC should be attempted in institutions equipped to respond to emergencies with physicians immediately available to provide emergency care.
- Ø After thorough counseling that weighs the individual benefits and risks of VBAC, the ultimate decision to attempt this procedure or undergo a repeat cesarean delivery should be made by the patient and her physician.