PROCEDURE

Vaginal birth after cesarean

Vaginal birth after cesarean is giving birth through the vagina after a previous cesarean delivery.

PURPOSE
To give birth vaginally after a previous cesarean

PROCEDURE TYPE
Therapeutic, bedside vaginal delivery with surgical backup

WHERE IT IS DONE
Hospital labour unit with immediate operating theatre access

ANAESTHESIA
None or epidural; general anaesthesia if emergency surgery is needed

HOW LONG IT TAKES
Labour often hours; pushing may take minutes to hours

PREPARATION
Birth planning, records review, and facility-specific labour instructions

RECOVERY
Usually 1-2 hospital days; drive when comfortable and fully alert

MAIN RISKS
Uterine rupture, emergency cesarean, bleeding, infection

RESULTS
Known immediately: vaginal birth or cesarean delivery

Overview

Vaginal birth after cesarean, usually called VBAC, means giving birth through the vagina after having had a cesarean delivery.

The planned attempt to labour and give birth vaginally is called a trial of labour after cesarean, or TOLAC. VBAC describes a successful vaginal birth. A TOLAC may instead end with an assisted vaginal birth or another cesarean.

VBAC should take place in a hospital that can monitor you and your baby and provide an emergency cesarean if needed. It is not planned as a home birth because a problem with the previous uterine scar can require rapid treatment.

Why the procedure is performed

VBAC offers a way to avoid another abdominal operation. After a successful VBAC, people often have a shorter hospital stay, less postoperative pain, and a quicker recovery than after a cesarean.

Avoiding repeated cesareans may also reduce some risks in later pregnancies. With each cesarean, scar tissue can increase, and the placenta is more likely to attach too deeply or lie over the cervix in a future pregnancy.

A planned VBAC does not guarantee vaginal delivery. Your chance of success is influenced by why your earlier cesarean was needed, whether you have previously given birth vaginally, how labour begins, and factors in the current pregnancy.

Who should and should not have it

VBAC may be an option if you have had one previous cesarean with a low transverse uterine incision. This is a side-to-side cut in the lower part of the uterus. Some people with more than one previous low transverse incision may also be considered after an individual review.

Your skin scar does not show which type of incision was made in the uterus. Your healthcare team may need the operation report from your previous cesarean.

VBAC is more likely to be considered when:

VBAC is usually avoided when labour would carry a high risk of uterine rupture or vaginal birth is not considered safe. Reasons include a previous classical, T-shaped, or certain other high uterine incisions; a previous uterine rupture; or some types of major uterine surgery.

It may also be unsuitable if you have placenta previa, meaning the placenta covers the cervix, or another pregnancy complication that requires cesarean delivery. Labour may be delayed or the plan changed if concerns develop about your health, the baby, or the placenta.

- There is no current reason that vaginal birth would be unsafe
- Your previous uterine incision is suitable for labour
- The baby is positioned for vaginal birth
- The hospital can perform an emergency cesarean promptly
- You understand and accept the possible need for an unplanned cesarean

How to prepare

The treating facility's own instructions take priority because hospitals differ in how they manage labour after cesarean.

Discuss VBAC during pregnancy rather than waiting until labour begins. Ask your team to review your previous cesarean records, including the uterine incision and the reason for surgery.

Your preparation may include:

Follow the hospital's instructions about eating, drinking, and taking medicines. Do not stop a prescribed medicine unless the clinician managing it tells you to do so.

- Discussing the benefits and risks of VBAC and planned repeat cesarean
- Planning when to come to hospital if contractions begin or your waters break
- Reviewing options if labour does not begin by the expected time
- Discussing induction methods that may be appropriate after cesarean
- Planning pain relief, including whether you may want an epidural
- Arranging transport, support, and care for other children

What happens during the procedure

When labour begins, you will usually be assessed in the hospital labour unit. The team will check your contractions, cervix, blood pressure, and the baby's heart rate. An intravenous line may be placed so fluids or medicines can be given quickly if needed.

Continuous electronic fetal monitoring is commonly recommended during labour after cesarean. This records the baby's heart rate and your contractions. A change in the baby's heart rate can be an early sign that the uterine scar is under stress.

You can usually move, change position, and use labour pain-relief methods within the limits of monitoring. An epidural can be used and does not prevent VBAC. It provides pain relief while you remain awake.

If labour progresses safely, you push and give birth vaginally. Forceps or a vacuum device may sometimes be needed to help the birth.

If labour does not progress or there are concerns about you, the baby, or the uterine scar, the team may recommend an unplanned cesarean. In an urgent situation, this may need to happen quickly.

Recovery and what to expect afterward

Pain after VBAC commonly comes from uterine cramps, vaginal soreness, hemorrhoids, or a perineal tear. Ice packs, comfortable positioning, and pain medicines recommended by your maternity team can help.

You can usually eat and drink after birth when you feel ready, unless you need further treatment. Some people feel nauseated, tired, or shaky shortly after delivery.

Gentle walking is encouraged when you can stand safely. Increase activity gradually. Avoid heavy lifting and strenuous exercise until your maternity team says your recovery is progressing well.

Do not drive until you can sit comfortably, turn to check traffic, wear a seat belt, and perform an emergency stop without pain. You must also be fully alert and not taking medicine that impairs driving.

Returning to work is personal and is affected by healing, sleep, feeding, childcare, and the physical demands of your job. Discuss your expected return during postpartum follow-up.

Risks and possible complications

The main risk specific to labour after cesarean is separation of the previous uterine scar, called uterine rupture. This is uncommon but serious. It can cause internal bleeding and reduce the baby's oxygen supply, requiring an emergency cesarean and other treatment.

Other possible outcomes and complications include:

A successful VBAC usually avoids the surgical risks of a repeat cesarean. However, a trial of labour that ends in an emergency cesarean generally carries more risk than a planned cesarean. Your team can help compare these outcomes in the context of your pregnancy.

- Labour ending in an unplanned cesarean
- Heavy bleeding or need for a blood transfusion
- Infection of the uterus or surgical wound if cesarean is needed
- Injury to nearby organs during emergency surgery
- Assisted birth with forceps or a vacuum
- Perineal tears and pelvic floor symptoms
- Complications for the baby if urgent delivery is required

Results and follow up

You will know immediately whether the birth was a VBAC, an assisted vaginal birth, or a cesarean delivery. Your baby will be assessed after birth, and you will be checked for bleeding, tears, blood pressure problems, and other postpartum concerns.

Routine follow-up includes postpartum care and any scheduled checks for you and your baby. If you had a tear, assisted delivery, heavy bleeding, or unplanned cesarean, you may need additional review.

Ask for a discussion about what happened during labour, especially if the birth plan changed. The birth record can help guide decisions in a future pregnancy.

Alternatives

The main alternative is a planned repeat cesarean. It gives a more predictable delivery date and avoids the risk of uterine rupture during labour. However, it is abdominal surgery, usually causes more postoperative pain and a longer recovery, and can increase certain risks in later pregnancies.

If delivery needs to be planned before labour begins, induction may sometimes be considered. Induction after cesarean requires careful selection of methods because some medicines or techniques place more stress on the uterine scar. It may also lower the chance of vaginal birth compared with labour that starts on its own.

Waiting for labour and scheduling a cesarean if labour does not begin by an agreed date is another possible plan. This preserves the chance of spontaneous labour but may make the timing less predictable.

There is no option to avoid delivery. The decision is between approaches to birth, each with different risks, recovery needs, and effects on future pregnancies.

When to call your healthcare team

Before birth, contact your maternity unit promptly if contractions begin, your waters break, you have vaginal bleeding, or your baby is moving less than usual. Follow the unit's specific instructions about when to come to hospital.

After birth, seek urgent medical advice for fever, worsening abdominal or pelvic pain, a painful or foul-smelling vaginal discharge, increasing redness around a tear, severe headache, vision

changes, or one-sided leg swelling.

Call emergency services for:

Routine soreness, questions about feeding, contraception, pelvic floor recovery, or returning to activity can usually be discussed with your maternity team at standard follow-up unless symptoms are worsening.

- Heavy bleeding that is soaking pads rapidly or causing weakness
- Severe or constant abdominal pain, especially with faintness
- Chest pain or difficulty breathing
- Fainting, collapse, confusion, or a seizure
- Thoughts of harming yourself or your baby

Common questions

Will I be asleep?

Usually not. You are awake during labour and vaginal birth. You may choose an epidural for pain relief. If an emergency cesarean is required, an epidural may be topped up, or general anaesthesia may occasionally be needed.

Can I drive home?

You should not drive yourself home immediately after giving birth. Arrange transport. Resume driving only when you can move comfortably, concentrate fully, and make an emergency stop safely.

How painful is it?

Labour pain differs between people and between births. Options may include breathing and movement, water, inhaled pain relief, injected medicine, and an epidural. Soreness after birth is common, particularly if you have a tear or assisted delivery.

When will I know if VBAC has worked?

You will know at the time of birth. Before then, your team can estimate the likelihood of vaginal birth, but they cannot guarantee it.

Can labour be induced after a cesarean?

Sometimes. The safest method depends on your uterine scar, cervix, pregnancy, and hospital policy. Some induction medicines are avoided because they can increase stress on the scar.

Can I have more children after VBAC?

Yes. A successful VBAC may reduce the number of uterine scars from cesarean surgery, which can be helpful in future pregnancies. Each later pregnancy still needs an individual birth plan.

Sources

- American College of Obstetricians and Gynecologists. Practice Bulletin No. 205: Vaginal Birth After Cesarean Delivery. Obstetrics & Gynecology . 2019;133:e110-e127.
- American College of Obstetricians and Gynecologists. Deciding Between a VBAC and a Repeat Cesarean.
- National Institute for Health and Care Excellence. Caesarean birth. NICE guideline NG192.
- Royal College of Obstetricians and Gynaecologists. Birth After Previous Caesarean Birth. Green-top Guideline No. 45.
- Society of Obstetricians and Gynaecologists of Canada. Guidelines for Vaginal Birth After Previous Caesarean Birth. Journal of Obstetrics and Gynaecology Canada . 2019;41:992-1011.