VBAC and risks of multiple C-sections

Understanding VBAC and trial of labor after cesarean

VBAC means vaginal birth after cesarean. The labor process that may lead to VBAC is called a trial of labor after cesarean, often abbreviated TOLAC. These terms matter because VBAC describes the outcome, while TOLAC describes the planned attempt. A person may plan TOLAC and have a vaginal birth, or may need an unplanned repeat cesarean if labor does not progress safely.

For many medically appropriate candidates, VBAC can be a reasonable and evidence-supported option. It avoids abdominal surgery in the current birth, usually involves a shorter hospital stay than cesarean delivery, and may reduce postoperative pain, wound complications, and thromboembolic risk. For people hoping for more children, VBAC can also reduce future pregnancy risks by limiting the number of uterine surgeries.

Still, VBAC is not simply "natural birth after surgery." It is labor with a uterine scar, and the scar changes the risk profile. The central safety question is whether the uterus can tolerate contractions without scar separation. That is why clinicians review prior operative reports, incision type, number of previous cesareans, previous vaginal births, gestational age, fetal size estimates, placental location, and the reason for the earlier

cesarean before recommending a birth plan.

Why multiple C-sections change the risk calculation

A single cesarean section can be lifesaving, and repeat cesarean is sometimes the safest choice. The concern is that risks tend to accumulate with each operation. Repeated abdominal and uterine surgery increases the chance of adhesions, which are bands of internal scar tissue that can make later operations longer, technically harder, and more prone to injury of the bladder, bowel, blood vessels, or uterus.

Multiple C-sections also increase the chance of serious bleeding and transfusion, postoperative infection, and complications related to anesthesia or wound healing. In a future pregnancy, the uterine scar and placental implantation site become especially important. Placenta previa, in which the placenta covers or approaches the cervix, and placenta accreta spectrum, in which the placenta attaches too deeply into the uterine wall, are more common after prior cesareans. Placenta accreta can cause life-threatening hemorrhage and may require hysterectomy at delivery.

This is one reason VBAC may be particularly relevant for someone planning a larger family. Avoiding one repeat cesarean may lower the number of uterine scars carried into later pregnancies. However, the decision is not automatic. The risks of a successful VBAC are different from the risks of an unsuccessful TOLAC, and an emergency cesarean after labor can carry more complications than a planned repeat operation.

Uterine rupture: rare, serious, and time-sensitive

Uterine rupture is the complication most closely associated with VBAC counseling. It means the uterine wall separates through the previous scar or another weakened area. This can cause sudden fetal distress, maternal hemorrhage, loss of uterine tone, abdominal pain, abnormal bleeding, or changes in contraction pattern, although presentation can vary. Because the baby’s oxygen supply may be compromised quickly, rupture is treated as an obstetric emergency.

For many people with one prior low transverse uterine incision, the risk of

uterine rupture is often described as less than 1%. That low percentage is reassuring, but it should not be minimized: when rupture occurs, it can be life-threatening for both mother and baby. Reported risk may be higher after two prior cesareans, with some sources citing about 1.36% under appropriate care. Individual risk is influenced by incision type, induction or augmentation methods, interpregnancy interval, prior vaginal birth, and other clinical details.

Prior uterine incision type is critical. A low transverse incision is generally the most favorable scar for TOLAC consideration. Classical or high vertical incisions involve the upper, more contractile uterus and carry a substantially higher rupture risk; they are often considered contraindications to VBAC. Because the skin incision does not reliably indicate the uterine incision, obtaining the prior operative report can be medically important.

When VBAC may be more favorable

VBAC tends to be more favorable when the previous cesarean was for a nonrecurring reason, such as breech presentation, placenta previa that has resolved in this pregnancy, or fetal distress not expected to repeat. A previous vaginal birth, especially a previous successful VBAC, also increases the likelihood of success. Spontaneous labor at term, a normally located placenta, a cephalic baby, and no major contraindication to vaginal birth are additional reassuring factors.

Success rates are commonly discussed as approximately 60% to 80% after one prior C-section, though estimates vary by population and clinical circumstances. After two or more prior C-sections, success rates may be lower, roughly 50% to 71% in some reports. These numbers are not personal predictions; they are starting points for individualized counseling.

A medically literate discussion should include both absolute risk and contingency planning. For example, a candidate with a low transverse scar, previous vaginal birth, spontaneous labor, and immediate surgical backup has a different risk profile than someone with two prior cesareans, no previous vaginal delivery, suspected macrosomia, and need for cervical ripening. The goal is not to prove that VBAC or repeat cesarean is universally better, but to match the delivery route to the person’s clinical situation and values.

When repeat cesarean may be safer or necessary

A planned repeat cesarean may be recommended when the risk of labor is unacceptably high or when vaginal birth is otherwise contraindicated. Examples may include a prior classical uterine incision, previous uterine rupture, some extensive uterine surgeries, placenta previa, certain fetal presentations, or other maternal-fetal conditions where labor could be unsafe. Some people also choose repeat cesarean after counseling because predictability, prior trauma, or personal risk tolerance strongly shapes their decision.

Planned repeat cesarean has its own benefits. It avoids the uncertainty of labor and the possibility of emergency cesarean after a prolonged TOLAC. It may be scheduled with a prepared surgical team, blood products if needed, and neonatal support. For someone with a contraindication to labor, that planning can be protective.

However, repeat cesarean should not be viewed as risk-free. It is major abdominal surgery and can involve hemorrhage, infection, blood clots, injury to nearby organs, postoperative pain, and longer recovery. With each additional cesarean section, scar tissue and placental risks become more clinically significant. For someone who is certain this is their final pregnancy, the future-pregnancy risk may carry less weight; for someone hoping for several more pregnancies, it may carry much more.

Hospital readiness and monitoring during VBAC

Facility capability is a key safety factor in VBAC planning. Because uterine rupture and fetal distress require rapid response, many guidelines emphasize that TOLAC should occur in a setting prepared for emergency cesarean delivery. This includes surgical staff, anesthesia, obstetric clinicians, nursing support, and neonatal care that can mobilize quickly if needed.

Continuous fetal monitoring during VBAC is commonly used because fetal heart rate abnormalities may be an early sign of uterine rupture. Monitoring does not prevent rupture, but it can help the team recognize a problem promptly. Intravenous access, clear escalation plans, and informed consent for urgent cesarean are also part of safe planning.

Induction after previous cesarean requires special caution. Some cervical ripening and labor-inducing medications may increase uterine rupture risk, and protocols vary. Mechanical methods and careful oxytocin use may be considered in selected situations, but this is highly individualized. A person considering induction after previous cesarean should ask how the hospital manages dosing, monitoring, and thresholds for repeat cesarean if labor is not progressing.

Shared decision-making across this pregnancy and future pregnancies

The best birth plan usually comes from shared decision-making: the clinician contributes risk assessment and emergency planning, while the pregnant person contributes values, prior experiences, family plans, and preferences. This is especially important when the decision is preference-sensitive rather than dictated by a clear contraindication.

Helpful questions include: What type of uterine incision did I have? Why was my previous cesarean done? What is my estimated chance of VBAC success? How many prior cesareans do I have, and how does that affect rupture and surgical risk? Is my placenta normally located? What emergency resources are available at the facility? How would induction, suspected large baby, gestational diabetes, hypertension, or going past the due date change the plan?

It is also reasonable to discuss emotional safety. Some people feel strongly motivated to experience vaginal birth after a difficult cesarean. Others feel safer choosing a planned repeat cesarean after a traumatic labor. Neither response is wrong. The aim is a plan that is medically sound, clearly documented, and flexible enough to respond to labor in real time. A supportive team should explain tradeoffs without coercion, respect informed preferences, and revisit the plan as new pregnancy information becomes available.