VBACfacts®
Don't freak. Know the facts.

5 Completely False Myths About Uterine Rupture

1

FALSE: UTERINE RUPTURE IS SO RARE, THE RISKS ARE MINUSCULE.

It serves no one to minimize this serious complication. I've heard women incorrectly say that they are more likely to be struck by lightning than have a uterine rupture, which is false. The risk of uterine rupture is about 0.4-0.9% after one prior low-transverse ("bikini cut") cesarean depending on multiple factors. (1) This is a similar rate to other obstetrical emergencies that first time moms can experience. (2)

2

FALSE: UTERINE RUPTURE IS SO COMMON THAT VBAC IS UNSAFE.

Meanwhile, other parents have been told – by their obstetrician - that 1 in 4 women will experience a uterine rupture. This is also false. While uterine rupture is a real risk, the American College of Obstetricians and Gynecologists, as well as and the National Institutes of Health, describe VBAC as a safe, reasonable, and appropriate option for most people with one prior cesarean. (3; 4; 5) They do not provide an upper limit on the number of prior cesareans.

3

FALSE: IF THERE IS A UTERINE RUPTURE, THE BABY WILL DIE.

The National Institutes of Health has reported that 6.2% of uterine ruptures result in a fetal demise. (5) While there are several factors that can influence the outcome, it's important for parents and providers to have a frank discussion about these variables, in conjunction with the benefits of VBAC, intended family size, and the risks and benefits of cesareans, so parents can make an informed decision.

4

FALSE: PLANNING A VBAC IS A SELFISH DECISION.

Planning a VBAC, or a repeat cesarean, is not selfish. How someone plans to birth their baby is a highly personal decision based on a variety of factors. The truth is both options are associated with rare, but dire, complications. With VBAC, the risk of uterine rupture is often stressed, but very few women are informed of the serious placental abnormalities associated with cesareans like accreta. Parents are entitled to the honest facts but very few receive it from their provider.

5

FALSE: IN ORDER TO MANAGE A RUPTURE, HOSPITALS MUST HAVE 24/7 ANESTHESIA.

Some hospitals interpret ACOG's "immediately available" recommendation to be a mandate that an anesthesiologist must be in the hospital 24/7. (3) Some hospitals that cannot provide that level of coverage "ban" VBACs and institute mandatory repeat cesarean policies. However, "immediately available" does not have a standard definition. Hospitals across the US have implemented the guideline in different ways in order to honor patient autonomy and avoid cesarean related complications created by hospital VBAC bans.

Want to boost your VBAC knowledge so you can increase VBAC access in your community? CLICK HERE to join our movement!

Are you planning a VBAC? CLICK HERE to learn more about the evidence so you can avoid common pitfalls and boost your VBAC odds!

References: 1. Landon, M. B. (2004). Maternal and Perinatal Outcomes Associated with a Trial of Labor after Prior Cesarean Delivery. N Engl J Med, 351, 2581-2589; 2. Komorowski, J. (2010, Oct 11). A Woman's Guide to VBAC: Putting Uterine Rupture into Perspective. Retrieved from Giving Birth with Confidence: http://www.givingbirthwithconfidence.org/p/bl/ar/blogaid=181 3. ACOG. (2019). ACOG Practice Bulletin No. 205. Vaginal birth after cesarean delivery. *Obstetrics & Gynecology*, 133(2), e110-e127. 4. National Institutes of Health. (2010, June). Final Statement. Retrieved from NIH Consensus Development Conference on Vaginal Birth After Cesarean: New Insights. 5. Guise, J.-M. (2010). Vaginal Birth After Cesarean: New Insights. Rockville (MD): Agency for Healthcare Research and Quality (US).