There is an agreement among obstetric health care providers that a trial of labor after cesarean section (TOLAC) is appropriate for most women who have had a previous low-transverse cesarean delivery. The direction of the scar on your uterus is important to determine if you are a good candidate for a TOLAC. Published evidence suggests that the benefits of TOLAC outweigh the risks in most women.

Most published studies indicate that approximately 60-80% of trials of labor after a previous cesarean delivery result in successful vaginal births. The reason for the previous cesarean delivery can influence the success rate of a subsequent vaginal birth. This is something that can be individually addressed with your physician.

Generally, no repeat cesarean delivery or TOLAC is risk free. When TOLAC is successful, it is associated with less morbidity (fewer problems) than repeat cesarean delivery. The advantages include fewer blood transfusions, fewer postpartum infections, shorter hospital stays, and shorter recovery time. Those patients who are unsuccessful at a TOLAC and undergo a repeat cesarean delivery are at increased risk for postoperative problems. Infants born by repeat cesarean delivery after a failed TOLAC may have slightly increased rates of infection. TOLAC is associated with a small risk for uterine rupture, which can lead to poor outcome for mother and infant. The risk of uterine rupture is increased if more than one cesarean section has been performed previously. The risk of uterine rupture also increases with the use of Oxytocin (Pitocin), a medication used to make the uterine contractions stronger. Estimated occurrence of uterine rupture is between 0.2% and 1.5%. Although this happens very rarely, rupture of the uterus can be life threatening for both mother and infant. Rarely uterine rupture will require hysterectomy (removal of uterus or womb).

In order to safely proceed with a TOLAC it is necessary that we monitor your labor progression and fetal well being even more closely than we would for patients who do not have a uterine scar. An IV (intravenous line) or at least a intermittent infusion device (the catheter, but not connected to the tubing) is required. Oral intake during active labor will be restricted to ice chips and clear liquids.

The fetal heart rate must be monitored closely during active labor. Fetal heart rate monitoring can be done with a telemetry monitor so that you may walk around. You are more likely to require an internal scalp monitor, which is placed very superficially on the baby’s head, as opposed to the conventional external monitor to follow the baby’s heart rate pattern. If Oxytocin (Pitocin) is required to make your contractions stronger, we may place a small plastic catheter inside the uterus that monitors the exact strength of your contractions.