Plymouth Hospitals NHS
NHS Trust

Intrapartum Guidelines

No.30 Vaginal birth after Caesarean Section

1. Definition

Planned vaginal birth after caesarean (VBAC) refers to any woman who has experienced a prior caesarean birth who plans to deliver vaginally rather than by elective repeat caesarean section (ERCS).

2. Patient information and discussion

Ideally, the woman would have been counselled prior to leaving hospital after the original CS about mode of delivery in a subsequent pregnancy, i.e. VBAC versus ERCS. Women should have a detailed discussion about the mode of delivery at booking with the midwife (See Appendix 1 – Antenatal VBAC Care Pathway) and at the first antenatal consultant/specialist midwife appointment at around 20/40. This discussion should be documented - the checklist for woman who have had a previous caesarean section, available in ANC will assist with this process, (appendix 2). An information booklet should be provided in order to assist them in making the decision that is best for them. Confirmation of provision of this information leaflet must be documented in the pregnancy notes.

A management plan for labour and delivery must be made and documented in the notes as soon in the pregnancy as possible but at the very latest by 36/40. Furthermore as up to 10% of women scheduled for ERCS go into labour before the 39/40, a plan in the event of labour starting prior to the scheduled date should be discussed and recorded in the notes. Similarly, a plan should be made for women who have not delivered by their expected due date. This would usually involve an ANC appointment at around term to assess favourability of the cervix, discuss induction of labour or book an ERCS at T+12.

On-going discussion throughout the antenatal period regarding all the issues is encouraged. Where there are communication or language support needs assistance can be obtained via patient advice and liaison service (PALS) and interpretation services.

3. Antenatal care

Women considering their options for birth after a single previous lower segment CS should be informed that overall the chances of successful VBAC are 72-75%.

3.1 Factors associated with successful VBAC

- Previous vaginal birth especially previous VBAC

3.2 Risk factors for unsuccessful VBAC

- Induction of labour
- No previous vaginal birth
- BMI greater than 30
- Previous CS for failure to progress

Women must however also be informed of the risks and benefits both to themselves and their unborn baby.

3.3. Risks associated with VBAC

- Uterine rupture (~1 in 200/1.5%)
- Blood transfusion

3.4 Benefits of VBAC

- Reduced risk of serious complications in future pregnancies
- Reduced risk of respiratory problems in the newborn

4. Contraindications to VBAC

- Women with a prior history of classical CS*
- Previous uterine rupture
- 3 or more previous LSCS
- Placenta previa
- None cephalic presentations

*Women with a previous uterine incision other than an uncomplicated lower segment CS incision who wish to consider vaginal delivery should be assessed by an Obstetrician with full access to details of their previous surgery

Women with a history of two uncomplicated lower segment CS in an otherwise uncomplicated pregnancy at term with no other contraindications to vaginal delivery who have been fully informed by an Obstetrician may be considered suitable for planned VBAC.

5. Cautions to VBAC

- Twin gestation
- Fetal macrosomia
- Short inter-delivery interval
- Postdates pregnancies
- Maternal age 40 or above

Women presenting with any of the above factors should be assessed by an obstetrician for their suitability for a VBAC

6. Place of delivery

Women should be advised that planned VBAC should be conducted in a suitably staffed and equipped delivery suite, with continuous intrapartum care and monitoring and resources available for immediate CS and advanced neonatal resuscitation. Obstetric, midwifery, anaesthetic, operating theatre, neonatal and haematological support should be continuously available throughout planned VBAC. A documented plan of place of delivery should be made in the patient record.

7. Management in labour

- Women with a previous caesarean section who present in unplanned labour should be seen by and experienced obstetrician to determine feasibility for VBAC
- Continuous fetal monitoring strongly recommended throughout labour and delivery is recommended and should be documented in the antenatal management plan.
- Women should be advised to come into hospital at the onset of regular, painful contractions
- IV access should be obtained
- Blood for FBC and group and save should be taken and sent to the labs.
- Ranitidine 150mg, orally, 8 hourly until delivery of the placenta.
- Monitor for signs of scar dehiscence (see below)
- An epidural may be used for pain relief in labour as it does not mask the signs of uterine rupture. However, an increasing requirement for analgesia should raise an awareness of scar rupture.
- Oxytocin should only be used after consultation with a senior Obstetrician

7.1 Signs and symptoms of scar dehiscence

- Abnormal CTG
- Cessation of previously efficient uterine activity
- Loss of station of the presenting part
- PV bleeding in labour
- Acute onset scar
- Haematuria
- Severe abdominal pain, especially if persisting between contractions
- Chest pain or shoulder tip pain, sudden onset of shortness of breath
- Maternal tachycardia, hypotension or shock
- Fetal parts palpable per abdomen

If any of the above occurs the senior duty obstetrician should be informed immediately.

8. Induction of labour

A clear management plan regarding the indication for IOL should be made by a senior obstetrician. This should include; method of induction and augmentation with if cervix favourable ARM+/-Syntocinon, if cervix unfavourable for cook catheter and defined parameters of progress in labour.

IOL for women with previous CS will take place at T+12 unless an earlier IOL is clinically indicated. Mechanical IOL, using a Cook Cervical Ripening balloon has replaced IOL with prostaglandins for women planning a VBAC. Risk of scar rupture in IOL with mechanical methods is lower than with prostaglandins. Insertion of the Cook Cervical Ripening balloon will take place on CDS Triage by an appropriately trained member of staff following an antenatal assessment. Women are to remain inpatients on Argyll Ward for 12-14 hours following insertion or until the onset of regular contractions. CTG is indicated at the onset of regular uterine activity. If the woman does not labour spontaneously after 12 hours, she should be assessed on CDS for suitability for ARM +/- oxytocin

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Women should be informed that the risk of uterine rupture in induced/augmented labours is increased 2-3 x compared with spontaneous labours. The risk of CS in induced/augmented labours is increased 1.5 x compared to spontaneous labours.

9. VBAC in special circumstances

9.1 Preterm
Women who are preterm and considering the options for birth after previous CS should be informed that the planned preterm VBAC has similar success to planned term VBAC i.e. 72-76% but with a lower risk of uterine rupture.

9.2 Breech
A previous CS is regarded as unfavourable for a vaginal breech delivery and is a relative contraindication to ECV.

10. Roles and responsibilities of staff
10.1 Midwifery staff
Midwifery staff are expected to identify women at booking with history of previous CS and refer for consultant care.
Midwives should provide women with the opportunity to discuss labour and delivery options. An information booklet should be provided in order to assist women in making the decision that is best for them. Confirmation of discussion and provision of information leaflet must be documented in the pregnancy notes. As an alternative, this discussion can be documented utilising the VBAC checklist available in ANC and from community office (see appendix 1).

10.2 Medical staff
Medical staff is responsible for providing women with the opportunity to discuss labour and delivery options together with risks and benefits. Any residual risk should be recorded in the notes. Medical staff is responsible for deciding upon and documenting an individual management plan for place of labour and delivery. The plan must include what to do should labour commence early or if labour commences later than planned. A documented plan for the monitoring of fetal heart in labour should also be made, if not already done so by the midwife. Again, the VBAC checklist may be used for documentation purposes

11. Record keeping
It is expected that every episode of care be recorded clearly, in chronological order and as contemporaneously as possible by all healthcare professionals as per Hospital Trust Policy. This is in keeping with standards set by professional colleges, i.e. NMC and RCOG. All entries must have the **date and time** together with **signature and printed name.**

Appendix 1

Antenatal VBAC Care Pathway

Gestation	Pathway
Booking 6-8weeks	Give VBAC information leaflet Send referral via electronic booking for consultant led care and ANC appointment at 20 weeks.
19-20 weeks **Appointment with Consultant/Specialist Midwife**	VBAC CHECKLIST in hand held notes. If VBAC, plan for IOL made Using a Cook catheter at T+12 (or sooner if indicated) on CDS If planning VBAC make a provisional appointment for Consultant ANC at 40/40 If decision not made re. delivery then re-appoint to Consultant ANC at 34/40
34/40 **Appointment with Consultant**	**Planned ERCS: complete consent form and book ERCS for 39/40** **Planned VBAC: make appointment to return to Consultant ANC for 40/40 to discuss and assess suitability for IOL**
38 weeks	**If VBAC** • Offer Stretch and sweep • Spontaneous Labour (Guideline 30) • Care in Labour – Follow High risk care pathway • Provisional consultant appointment booked for T+7 to assess suitability for IOL if patient has not spontaneously gone into labour by T+12.
40 -41+weeks **Consultant Appointment if required**	**VBAC if not Delivered Options:** • Offer stretch and sweep • **Discuss IOL/ERCS at Term plus** • Consent form signed for LSCS >40 weeks. ERCS booking form completed (clarify gestation for delivery). **Complete Checklist**
	<u>IOL</u> • Decision made on an individual basis dependent on Consultant and patient • Write clear Plan on Management page in notes. • Further stretch and sweep until Term +12 • Cook catheter/- ARM +Synto at Term +12

41weeks and 5 days	Cook catheter /- ARM+SYNTO at T+12	Caesarean Section
Postnatal	Day 1 of caesarean section – Complete Caesarean Section Data Sheet and file in patients –**Send Copy to GP.**	

Birth after Previous Caesarean Section: Management Plan

Previous Birth Details		
Previous delivery details reviewed?	Yes/No	Type of uterine incision: EBL: Problematic wound healing: No / Yes Will delivery interval be <12 months? No / Yes
Elective CS details	Reason:	
Emergency CS details	Category: Reason: Dilatation: Fetal position:	
Contra-indications to VBAC:	No / Yes (if yes please state)	

Birth Choice	**Management Plan**	**Name, signature and date**
VBAC	Offer stretch and sweep from 38/40 with CMW Offer VBAC workshop Consultant appointment at 40/40 <u>Plan if no spontaneous labour by T+12 (Consultant to complete)</u> IOL with Cook's Catheter Balloon at **T+** Not for IOL, ERCS at **T+** <u>Recommendations for intra-partum care</u> Hospital birth IV access Continuous CTG:	
Undecided	34/40 Consultant appointment	
ERCS	20/40-34/40 consultant appointment Gestation for ERCS: **/40** Plan if labour occurs before scheduled ERCS date: **For emergency CS / patient preference is for CS /discuss at time**	

Other comments	

Birth Options after Previous Caesarean Section: Discussion Points

Likelihood of VBAC	
One previous caesarean delivery, no previous vaginal birth	3 out of 4 or 72–75%
One previous caesarean delivery, at least one previous vaginal birth	Almost 9 out of 10 or up to 85–90%
>1 previous caesarean delivery	71%
Unsuccessful VBAC more likely in: Induced labour, body mass index (BMI) greater than 30 and previous caesarean for labour dystocia.	

Risk of complications: mother		
	VBAC	**ERCS**
Uterine rupture without IOL (reduced risk if pre-term labour)	5 per 1000 (0.5%)	<2 per 10 000 (0.02%)
Uterine rupture with IOL or augmentation	1-1.5 per 100 (1-1.5%)	n/a
Blood transfusion	2 per 100 (2%)	1 per 100 (%)
Placenta praevia and placenta acreta in future pregnancies	n/a	Increased likelihood
Risks of complications: baby		
Respiratory complications in the newborn	2-3 per 100 (2-3%)	4-5 per 100 (4-5%)
Birth related perinatal mortality or morbidity.	Comparable to a woman in labour with her first baby.	

The above points have been discussed and written information provided.	Name Position Signature Date

Monitoring and Audit

Auditable standards;
Documented management plan for labour
Documented plan for fetal heart rate monitoring in labour
Documented patient information, discussion and patient information leaflet given

Please refer to audit tool, location: 'Maternity on cl2-file11', Guidelines
In addition, please see VBAC audit tool

Reports to:
Clinical Effectiveness Committee – responsible for action plan and implementation of recommendations from audit
Clinical Governance & Risk Management Committee

Frequency of audit:
Annually

Responsible person:
Specialist Midwife, Antenatal Services.

Cross references

Antenatal Guideline 31 - Maternity Hand Held Notes, Hospital Records and Record Keeping

Antenatal Guideline 44 – Guideline development within the maternity services

References

Royal College of Obstetricians and Gynaecologists 2015**. Guideline No. 45 Birth after previous caesarean section.** London, RCOG

Author	Clara Southby, Guideline Committee		
Work Address	Maternity Unit, Derriford Hospital, Plymouth, Devon, PL6 8DH		
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