University Hospitals Plymouth NHS Trust

MATERNITY GUIDELINES

# Vaginal birth after caesarean section

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## 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 the opportunity to discuss their birth preferences at booking with the midwife and at the first antenatal consultant/specialist midwife appointment at around 20/40.

## 2.1 Consultant / Specialist Midwife Antenatal Appointment

**Birth Options after Caesarean Clinic**

Women who have had a previous caesarean section, but do not have any additional risk factors, will be invited to be seen in a specialist midwifery clinic to discuss their birth options. This will replace an appointment in a Consultant Antenatal Clinic. During this consultation, the midwife will be responsible for discussing the risks and benefits of both modes of birth and formulating a management plan with the woman. This will be documented in patient's handheld notes.

**Women Requiring an Obstetric Consultation**

Women with the following risk factors will require consultation with an obstetrician:

- > 1 previous caesarean
- Co-morbidities or obstetric factors warranting consultation with an obstetrician
- Previous surgery to the uterus (e.g. myomectomy)
- Classical or other unusual incision
- BMI >35
- Inter-delivery interval <12 months
- Intra or postoperative c-section complications

This discussion should be documented - the checklist for woman who have had a previous caesarean section is available in ANC and assists with this process (appendix 2). Women should be provided with written information to support decision-making.

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 discussions 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. VBAC counselling

Women considering their options for birth after a single previous lower segment CS and no previous vaginal birth 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 200/0.5%)
- Blood transfusion (2% vs. 1%)

### 3.4 Benefits of VBAC

- Reduced risk of serious complications in future pregnancies
- Reduced risk of respiratory problems in the newborn (2-3% vs 4-6%)

## 4. Contraindications to VBAC

- Women with a prior history of classical CS*
- Previous uterine rupture
- 3 or more previous CS

- Placenta praevia
- 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

- Multiple pregnancy
- Fetal macrosomia
- Short inter-delivery interval (<12 months)
- Postdates pregnancies
- Maternal age 40 or above
- Antepartum stillbirth

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 on the delivery suite, with continuous fetal 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 should be advised to telephone triage to discuss admission to hospital at the onset of frequent, painful contractions.
- Women with a previous caesarean section who present in unplanned labour should be seen by an experienced obstetrician to determine feasibility for VBAC
- Continuous fetal monitoring throughout labour and delivery is recommended and should be documented in the antenatal management plan.
- IV access should be obtained
- Blood for FBC and group and save should be taken and sent to the labs.
- Ranitidine 150mg, orally, 6 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 pain
- 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. If cervix favourable ARM+/-oxytocin, if cervix unfavourable for Cook Cervical Ripening balloon 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 balloon will take place on delivery suite by an appropriately trained member of staff following an antenatal assessment. Women are to remain inpatients on Argyll Ward following insertion. Transfer back to delivery suite should occur if the Cook balloon falls out or on the onset of regular contractions. A CTG is indicated at the onset of frequent and painful uterine activity. If the woman does not labour after 18 hours, the Cook balloon must be removed and then transferred to delivery suite for suitability for ARM +/- oxytocin when able.

*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 emergency CS in induced/augmented labours is increased by 1.5 x compared to spontaneous labours in VBAC.*

## 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 leaflet 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.
Midwives running the specialist Birth Options after Caesarean Section Clinic will be responsible for discussing the risks and benefits of both modes of birth and formulating a management plan with the woman.

### 10.2 Medical staff

Medical staff are 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 are responsible for deciding upon and documenting an individual management plan. The plan must include what to do should labour commence early or if labour commences later than planned. A documented plan for care during labour should also be made using the standardised management plan (see Appendix 2)

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

| | | |
|---|---|---|
| | • Further stretch and sweep until T+12<br>• Cook catheter/- ARM +oxytocin at T+12 | |
| 41weeks and 5 days | Cook catheter /- ARM+oxytocin at T+12 | Caesarean Section |
| **Postnatal** | Day 1 of caesarean section – Complete CS Data Sheet and file in patient notes –**Send Copy to GP**. | |

# Birth after Previous Caesarean Section: Management Plan

| **Previous Birth Details** | | |
|---|---|---|
| Previous delivery details reviewed? | Yes/No | Type of uterine incision:<br>EBL:<br>Problematic wound healing: No / Yes<br>Will delivery interval be <12 months? No / Yes |
| Elective CS details | Reason: | |
| Emergency CS details | Category:<br>Reason:<br>Dilatation:<br>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<br>Offer VBAC workshop<br>Consultant appointment at 40/40<br><br><u>Plan if no spontaneous labour by T+12 (Consultant to complete)</u><br>IOL with Cook's Catheter Balloon at **T+**<br>Not for IOL, ERCS at **T+**<br><br><u>Recommendations for intra-partum care</u><br>Hospital birth<br>IV access<br>Continuous CTG: | |
| Undecided | 34/40 Consultant appointment | |
| ERCS | 20/40-34/40 consultant appointment<br>Gestation for ERCS: **/40**<br>Plan if labour occurs before scheduled ERCS date:<br>**For emergency CS / patient preference is for CS /discuss at time** | |
| Other comments | | |

| **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. | |

## Section: Discussion Points

| **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<br>Position<br>Signature<br>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**

*Guidelines can now be found on the network share (drive) 'G:\DocumentLibrary\UHPT Clinical Guidelines\Maternity'.*

Maternity Hand Held Notes, Hospital Records and Record Keeping:

Guideline development within the maternity services SOP

**References**

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

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|---|---|---|---|
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