

## 1. Introduction and who the guideline applies to:

It is essential that women who have undergone a previous caesarean section receive timely and accurate information about the risk involved with a subsequent pregnancy to enable them to make an informed choice about the mode of delivery. Women who choose to undergo a vaginal birth after caesarean section should be cared for in a consistent and safe manner, minimising any risk that may be involved.

It is possible for most women to have a successful vaginal delivery following a previous lower segment caesarean section (LSCS).

This guideline is based on NICE guidance on Caesarean Section and RCOG Green Top guideline on Birth After Previous Caesarean Section; it is aimed at all Health Care Professionals involved in the care of pregnant women who have had one or more previous Caesarean Sections. Its purpose is to provide evidence-based information to inform the care of women undergoing planned vaginal birth after previous caesarean section (VBAC).

### What's new?

- Changed from 2 hourly to 4-hourly cervical assessments in cases of VBAC augmentation. (Unless individualised plan states otherwise).

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## 2. Antenatal care

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### 2.1 Referral

- All women who have previously delivered by Caesarean Section should be referred antenatally for review at a hospital antenatal clinic to discuss and plan mode of delivery; the plan should be in place before 37 weeks gestation.
- This should be to the General Obstetric Clinic or the woman’s existing specialist clinic if referred to one.
- This should be done by the community midwife or the antenatal core midwives.

### 2.2 Counselling

Antenatal counselling should include options of VBAC or elective LSCS, including success rates and contraindications.

- The woman should be advised to give birth in a unit with appropriate monitoring and blood transfusion facilities and immediate access to Caesarean section.
- She should be offered continuous electronic fetal monitoring during labour.
- Women should be informed that overall, the chances of a successful planned VBAC are 72-75%, and slightly higher for women who have had one or more vaginal deliveries as well as a Caesarean Section.
- Women should be informed that the chances of subsequent successful VBAC can increase to up to 90% after one successful VBAC.
- Women should be informed that the risk of scar dehiscence or rupture is 1:200 or 0.5% with VBAC.
- Women should be informed that an emergency Caesarean section may increase the chances of heavy bleeding needing a blood transfusion, infection

(such as intrauterine infection), a longer hospital stay and complications in future pregnancy like placenta praevia and placenta accrete.

- The antenatal counselling of women with a prior caesarean birth should be documented in the notes.
- There should be provision of the 'UHL VBAC' patient information leaflet with the consultation.
- It is the obstetrician's responsibility to counsel the woman and provide the above information and to document it in the health care record

### **2.3 Type of previous caesarean section:**

- Women with one previous Lower Uterine Segment Caesarean Section should have a discussion regarding the mode of delivery
- Women with two previous Lower Uterine Segment Caesarean Sections may opt for VBAC, but this has to be in discussion with a Consultant Obstetrician
- Women with a previous Classical Caesarean Section or a history of uterine rupture should be offered a planned repeat Caesarean Section

### **2.4 Decision regarding mode of birth:**

- A final decision for mode of birth should be agreed between the woman and member(s) of the maternity team before the expected/planned date of delivery (ideally by 37 weeks of gestation)
- For women who opt for an elective Caesarean Section, a plan for the event of onset of labour prior to the planned date should be discussed
- It is the obstetrician's responsibility to counsel the woman and provide the above information
- The 'VBAC Antenatal Counselling Form', (the intrapartum care plan is on the reverse of this form) including a plan for continuous electronic fetal heart rate monitoring, should be completed and placed in the notes where VBAC is chosen.
- It is the responsibility of the obstetrician to document the agreed mode of delivery and complete the VBAC Antenatal Counselling Form.

## **3. Vaginal Birth After Caesarean Section (VBAC)**

### **3.1 Prolonged pregnancy and VBAC**

A plan should be made antenatally for women with prolonged pregnancy who have chosen to have VBAC.

- Spontaneous labour should be encouraged as there is evidence to suggest it is associated with reduced incidence of scar dehiscence as well as a higher rate of successful vaginal birth.
- A membrane sweep at term is NOT contraindicated in women with previous Caesarean section, and may reduce the need for formal induction of labour.

- An antenatal plan for post-dates should be made for women who have chosen to have **VBAC**;
  - Women not wishing to have IOL should be booked for caesarean section at term +7 onwards when they initially attend the general obstetric clinic.
  - If women wish to have an IOL, an individualised care plan should be made by a Consultant Obstetrician in the notes including the counselling that has taken place and whether prostaglandins may be used. Where prostaglandins are felt appropriate, women should specifically be made aware that this is an unlicensed indication for the drug and that there is an increased risk of uterine rupture and decreased rate of vaginal delivery.
  - Where induction is not appropriate, the appropriate paperwork for the caesarean section should be completed and a pre-operative appointment should go ahead.

### **3.2 Induction of labour in women having VBAC**

- Induction of labour in women having VBAC requires approval by the Consultant Obstetrician during the pregnancy.
- Induction of labour may be offered for obstetric reasons, however both the woman and the health care professional need to be aware of an increased risk of scar dehiscence/rupture (1 in 50 if labour is induced using Prostaglandins, 1 in 100 where labour is induced with oxytocin without Prostaglandins).
- Induction of labour in these women must be performed and monitored on a medical / combined care unit with access to EFM, a blood bank and theatre facilities.
- The woman should be monitored on Delivery Suite once in active labour.
- Women may be offered induction of labour as long as they have been carefully counselled (and this has been fully documented) by a senior obstetrician. The intervention of choice should be foley's balloon induction or artificial rupture of membranes +/- oxytocin. Where this is not possible, women may be given propess if appropriate (not prostin) only after agreement by a named obstetric Consultant and they should be specifically informed that this is an unlicensed use of the drug (as per Trust guidelines on unlicensed drugs) as well as the increased risk of uterine rupture and decreased rate of vaginal delivery. The senior obstetrician must carefully assess and counsel the woman, taking into account her individual history and requests.

### **3.3 Labour prior to elective caesarean section**

A plan should be made antenatally for women who have chosen to have an elective Caesarean Section but who then go into labour prior to the booked date for the Caesarean Section.

- A plan should be made antenatally as per recommendation one and documented in the notes by the Obstetrician discussing modes of delivery.
- The woman should be informed that if she presents in early labour prior to the booked date for Caesarean Section an emergency Caesarean Section will be performed or an option may be given to attempt VBAC in the absence of other contraindications.
- However, the woman should be informed about the possibility of delay in carrying out an emergency Caesarean Section, which will be prioritised based on maternal and fetal wellbeing.
- The woman should be informed that if she presents in advanced labour the risks of emergency Caesarean Section in the second stage may outweigh the risks of vaginal delivery.

#### **4. Intrapartum care**

Continuous and consistent Intrapartum Care should be provided to enable early detection and management of scar dehiscence or rupture.

Early diagnosis of uterine scar rupture followed by expeditious laparotomy and resuscitation is essential to reduce associated morbidity and mortality in mother and infant. There is no single pathognomonic clinical feature that is indicative of uterine rupture but the presence of any of the intra/peripartum concerns listed below should raise the concern of the possibility of this event:

##### **4.1 Intrapartum care and observations:**

- Abdominal palpation on admission / onset of labour
- Intravenous access, FBS, G&S
- Continuous electronic fetal heart rate monitoring as per Fetal Heart Rate Monitoring in Labour guideline
- Epidural anaesthesia is not contraindicated
- 'Routine' observations in labour as per Intrapartum care guideline unless otherwise requested
- The presence of any of the following signs associated with uterine rupture must be immediately reported to medical staff:
  - abnormal CTG
  - severe abdominal pain, especially if persisting between contractions
  - breakthrough pain despite working epidural
  - chest pain or shoulder tip pain, sudden onset of shortness of breath
  - acute onset scar tenderness
  - abnormal vaginal bleeding or haematuria
  - cessation of previously efficient uterine activity
  - maternal tachycardia, hypotension or shock
  - loss of station of the presenting part

- It is the midwife's responsibility to notify medical staff of the woman's admission, follow any subsequent care plan, support the woman through labour, record observations and observe for signs of dehiscence and refer to medical staff where any deviations from the norm are noted
- It is the obstetrician's responsibility to make the initial assessment and plan for labour (which may be a review of notes and agreement with the VBAC personal Intrapartum Care Plan, or further detailed review in person as required). It is good practice to reconfirm and document the patient's understanding of the risks associated with VBAC, particularly when proceeding with induction or augmentation of labour.
- It is the obstetrician's responsibility to act on any request for review by the midwife
- CTG concerns are considered to be one of the first signs of impending uterine rupture. In the event of CTG abnormality, fetal blood sampling (FBS) should generally be avoided and instead a full clinical review must take place. The decision to perform an FBS on a patient undergoing trial of VBAC must be discussed with the on call consultant obstetrician.

There should be close and critical review of the progress of spontaneous labour.

- Vaginal examinations should be offered every 4 hours during the active phase of labour to detect any delay in progress as soon as possible. Any delay should be promptly reported to the ST3 registrar or above.
- Where a woman presents in early labour she should be reviewed by an ST3 registrar or above. A management plan including frequency of observations and auscultation of the fetal heart before labour is established should be documented by the reviewer in the health record.

## **4.2 Oxytocin augmentation**

If Oxytocin augmentation is used caution needs to be exercised.

- Undertake only after discussion with the Consultant Obstetrician, including the decision to augment as well as an individualised management plan for review of subsequent progress and when to abandon augmentation.
- Although augmentation is not contraindicated it should be performed following careful obstetric assessment by a ST3 registrar or above and maternal counselling.
- Oxytocin augmentation should be titrated such that it should not exceed the maximum rate of contractions of four in 10 minutes
- 4 hourly cervical assessments should be offered to show adequate progress, thereby allowing augmentation to continue (unless individualised plan states otherwise).

- Women should be informed that Oxytocin augmentation for delay in first or second stage of labour reduces the chances of another caesarean section but increases the risk of uterine rupture and chance of an instrumental birth.

### **4.3 Immediate postnatal care**

Routine digital palpation / routine examination of the previous scar should NOT be performed after a vaginal delivery.

- This may only necessary if there is persistent vaginal bleeding

## **5. Education and Training**

No new skills required in order to implement this guideline

## **6. Monitoring & audit criteria**

None

## **7. References**

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## 8. Keywords

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VBAC Vaginal birth after Caesarean section Birth Choices

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**The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs. As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.**



### Contact and review details

<b>Author / Lead Officer:</b> Original Working Party: Obstetricians and Midwives		<b>Executive Lead</b> Chief Medical Officer
<b>Reviewed by:</b>	S Narain - Consultant O Olajide – Clinical Trust Fellow	<b>Date Reviewed:</b> September 2021
<b>Approved by:</b>	Guidelines Group Maternity Service Governance Group	<b>Date Approved:</b> August 13th 2013, 16.09.15, 19.09.18, 17/11/2021

### REVIEW RECORD

Date	Issue Number	Reviewed By	Description Of Changes (If Any)
August 2013	V1	Lorraine Matthews	Requirement to document management plan for women in early labour
July 2015	V2	P McParland, L Harvey and O Diejomaoh	General update and change in view of midwife led VBAC clinic commencing in October 2015
September 2018	V3	N Archer and K Jones	General update in response to reviewed RCOG guidance 2017
September 2021	V4	S Narain and O Olajide	General update, changes to antenatal care information & visit at term, information given to planned ELCS presenting in labour, interval of vaginal examination in augmented labour, information given about augmentation and supporting references.

# Appendix 1: Mode of delivery form

Patient Name:  
ID:

Parity:  
Number of previous CS:  
Indication for previous CS:

**Prerequisites for VBAC**

- One or two previous CS
- No previous upper segment incision to uterus
- No previous uterine rupture
- No other contraindications to vaginal birth
- Birth in hospital on delivery suite
- Continuous EFM in established labour

Leaflets given: VBAC  Elective CS

**Advantages of VBAC discussed:**

- 72-75% success after 1 previous CS (with spontaneous onset of labour)
- Avoids risks of planned surgery (VTE, visceral injury etc)
- Faster recovery
- Greater chance of uncomplicated vaginal birth in future

**Disadvantages of VBAC discussed:**

- Risk of scar rupture approximately 1:200
- Risks to the baby with VBAC are comparable to those in first time labour, but higher than with a repeat CS
- 25% risk of emergency CS in labour (with higher risks than elective CS)
- 1% increased risk of needing blood transfusion over women having elective CS

**Advantages of Elective CS at 39 weeks discussed:**

- Reduced risk of scar rupture

**Disadvantages of Elective CS discussed:**

- Risk of haemorrhage and blood transfusion
- Risk of infection (wound, urinary or chest)
- Risk of thrombosis (DVT/PE)
- Risk of bowel or bladder injury
- Risk of hysterectomy (as a life-saving procedure)
- Risks to baby:
  - Injury (1:100)
  - Breathing difficulty leading to NNU admission (1:10 at 37 weeks, 1:100 at 39 weeks)
- Longer recovery
- Implications for future pregnancy: risk of placenta praevia or accreta

**Induction of labour (IOL) in the presence of a uterine scar**

- Increased risks of scar complications with IOL or augmentation
  - Mechanical methods: similar to spontaneous labour, but commonly need syntocinon therefore approx. 1:100
  - Prostaglandins plus syntocinon 1:50
  - Syntocinon alone 1:100
- Aim will be ARM +/- Syntocinon; balloon catheter if ARM not possible
- Obstetric consultant to be involved in all decision making, care plan will be individualised
- IOL to occur on delivery suite

**MOD DECISION:**  VBAC  Elective CS

- *If for VBAC but no spontaneous labour:*
  - IOL if appropriate  Elective CS at .....weeks
- *If for Elective CS but presents in spontaneous labour:*
  - Aim for VBAC  Aim for repeat CS  Discuss on admission
- *If for IOL – Consultant authorising:* \_\_\_\_\_

Date:  
Name:  
Signature: \_\_\_\_\_ Designation: \_\_\_\_\_

## Appendix 2: Suggested ICP– please individualise; use yellow care plan

### Plan for Labour

- Intravenous access, FBC, G&S when in labour
- Continuous electronic fetal monitoring in established labour
- Epidural analgesia may be used unless contraindicated
- Senior obstetric assessment before Oxytocin augmentation
- Avoid hyperstimulation
- 4-hourly vaginal examination for women in spontaneous, non-augmented labour
- 4-hourly vaginal examination when oxytocin in use unless individualised care plan states otherwise.
- Routine intrapartum maternal observations unless otherwise specified
- *Immediate medical review* if any of the following occur (or other concerns regarding scar):
  - Abnormal CTG
  - Severe abdominal pain between contractions
  - Chest or shoulder tip pain, sudden onset of shortness of breath
  - Acute onset scar tenderness
  - Abnormal vaginal bleeding or haematuria
  - Cessation of previously efficient uterine activity
  - Maternal tachycardia, hypotension or shock
  - Loss of station of the presenting part
  - Breakthrough pain despite working epidural
- Any decision for FBS must be discussed with the consultant first (FBS generally discouraged in VBAC)

### Plan for 3<sup>rd</sup> stage:

- Routine active third stage
- Active third stage plus Oxytocin Infusion
- Other \_\_\_\_\_

### Plan for Baby:

- Routine care
- Neonatal review at birth
- Other \_\_\_\_\_

• Name: \_\_\_\_\_ Date: \_\_\_\_\_

• Signature: \_\_\_\_\_ Designation: \_\_\_\_\_