Clinical Guideline

VAGINAL BIRTH AFTER CAESAREAN SECTION - ANTENATAL

SETTING Women's & Children's Services / Maternity

FOR STAFF Midwifery & obstetric staff

PATIENTS Pregnant women who have had a previous caesarean section

Guidance

The aim of this guideline is to inform the care of women who have had a caesarean section. The guideline aims to inform the decision making regarding choice of vaginal birth after caesarean section (VBAC) or elective repeat caesarean section (ERCS)

This guideline is aimed at women who have had one or two previous uncomplicated caesarean sections and the current pregnancy is otherwise uncomplicated.

VBAC is contraindicated in women who have had a classical caesarean section or any other obstetric contraindication to a vaginal birth. See flow chart (Appendix 1) for further guidance.

Responsibilities of relevant staff groups

Community Midwife:

1. Give the UHBW VBAC patient information leaflet via the APP or in paper format at booking and document that given and discussed
2. Use the flow chart, (Appendix 1) to perform a risk assessment and book an appointment with a Consultant Obstetrician for mid pregnancy. See Booking Appointment Guideline for guidance on timing of appointment
3. Perform AN care as normal

Senior Obstetrician:

1. At first appointment, discuss mode of birth and complete the 'Obstetric Review' sticker, (Appendix 2). The woman's concerns and preferences should be central to the decision-making process
2. Consider the risks and benefits of planned VBAC and ERCS
3. If for VBAC and an otherwise uncomplicated pregnancy, see again at 41 weeks gestation to discuss induction of labour.
4. If uncertain regarding the mode of delivery or considering elective CS, see at 34-36 weeks to confirm mode and timing of birth.

Antenatal Counselling: Appendix 3

1. Women should have the opportunity to discuss the risks and benefits of VBAC and ERCS

    - Use positive language unless specifically contraindicated and ensure that women have all the information regarding the risks and benefits of VBAC and ERCS in

order to make an informed decision. Always take into account the circumstances around the previous birth experience.

- Advise to give birth in a facility that can undertake immediate CS in case of emergency, ie Consultant unit.
- Inform that current evidence recommends continuous electronic foetal monitoring.
- A risk assessment will be carried out by the obstetrician. Plans for antenatal care should be agreed by ST6/7, Subspecialty Trainee or Consultant Obstetrician. Where appropriate, advice normal midwifery care until 41 weeks gestation.
- The discussion regarding birth options should take place at the first Obstetric appointment and documented using the 'Obstetric Review' sticker, (Appendix 2)
- All antenatal counselling of women should be documented in the hand held notes

2. A final decision for mode of birth should be agreed between the woman and the obstetrician by 36 weeks gestation after due consideration to the mother's preferences
3. In case of women booked for ERCS, a plan should be documented for the event of labour starting before the ERCS is scheduled.

Women with more than one previous Caesarean section:

The women should be referred to Consultant led care. The mode of birth should be reviewed on an individual case basis by the Consultant Obstetrician.

Women with a history of two uncomplicated low transverse caesarean sections, in an otherwise uncomplicated pregnancy at term, with no contraindication to vaginal birth who have been fully informed may be considered suitable for VBAC. Use the checklist entitled 'Birth Choices after Caesarean Delivery Pathway' (appendix 3) to aid the discussion and decision making process.

Induction of Labour [redacted]

Decisions regarding induction of labour and/or augmentation if indicated should be discussed between the mother and senior registrar or consultant at 39 weeks. A membrane sweep should be offered and an appointment arranged for review at 40 weeks gestation in the antenatal clinic. At the 40 week review a further membrane sweep may be offered and suitability for induction of labour assessed by the obstetric consultant or SR.

Women should be informed of the following risks with induction of labour:

- Increased risk of need for emergency Caesarean Section during induced labour
- Increased risk of uterine rupture when undergoing induction process compared to spontaneous onset of labour (1:250 using PGE2 and oxytocin, 1:290 with PGE2 alone, 1:770 in spontaneous labour- UKOSS 2011)

The senior obstetrician should discuss the decision to induce the labour, the proposed method of induction, the decision to augment the labour, the time intervals for vaginal examinations and the selected parameters of progress that would necessitate discontinuing the VBAC. This should be clearly documented in the maternal handheld record

Regarding the methods of IOL for women with previous uterine scar:

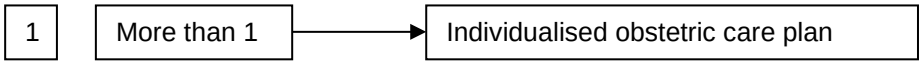
- There is evidence that prostaglandins increase risk of uterine rupture.
- The preferred method of IOL is artificial rupture of membranes (ARM), followed by oxytocin infusion where possible. If ARM is not feasible, a mechanical method of IOL (Cook® balloon) may be used to dilate the cervix prior to ARM.
- The decision to use prostaglandins on women who have undergone uterine surgery is a consultant-only decision and should be clearly documented.

An individualised plan of care including clear guidance on frequency of maternal observations and fetal monitoring, and when to transfer to CDS should be documented by an experienced obstetrician.

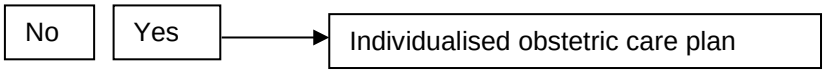
Appendix 1

VBAC Antenatal Care Risk Assessment

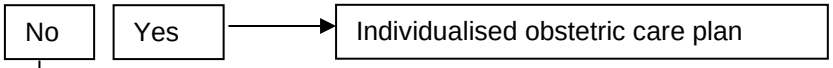
1. How many CS has the woman had?



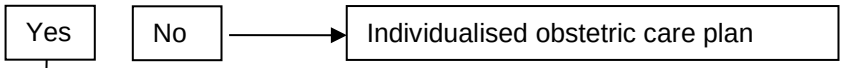
2. Did she have a classical uterine incision at CS?



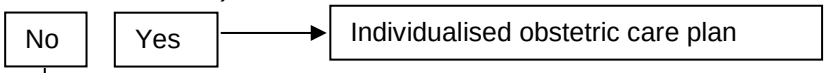
3. Has she had any other uterine surgery? Eg Myomectomy, hysterotomy



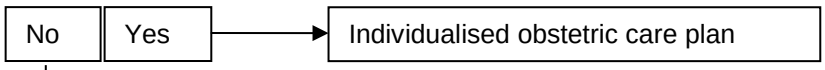
4. Was the CS for non-reoccurring indication? Eg breech, foetal distress, failed induction of labour



5. Does she have any other indication for consultant care? See Booking Appointment and Clinical Risk Assessment in Pregnancy, Labour and Postnatal Period (Selection of Lead Professional) Guideline



6. Has the woman been advised in the past that she will need a repeat CS by an obstetrician?



- Recommend VBAC and obstetric led care
- Refer to 'Giving Birth after CS' Leaflet (RCOG) available via leaflet APP
- 1st obstetric review mid-pregnancy
- Consultant follow up at 36/40 if unsure or considering ELCS
- Consultant follow up at 41/40 if planning VBAC
- Further consultant opinion if other risk factors occur in pregnancy

Appendix 2

Obstetric Review at the first consultant appointment	
Discussed RCOG Giving Birth After Caesarean information leaflet	Yes/No
• 1:200 risk of scar dehiscence (risk increases by 2-3 times if IOL)	Yes/No
• 1:4 chance of emergency caesarean	Yes/No
• Recommend giving birth in a consultant led unit	Yes/No
• Recommend continuous fetal monitoring in labour	Yes/No
• Discussed comparative morbidity data	Yes/No
Mode of birth discussed	Yes/No
Suitable for VBAC	Yes/No*
*Reason why not	
Suitable for vaginal birth if goes into spontaneous labour	Yes/No
If suitable for vaginal birth, follow VBAC guideline in labour	Yes/No
To follow normal MW appointment schedule and return to consultant follow at 36 weeks/39 weeks/41 weeks/……weeks	
Name Signature Grade Date	

Appendix 3

Likelihood of	Overall
Successful vaginal delivery with first pregnancy	60%-63%
Successful VBAC (one previous caesarean delivery, no previous vaginal birth)	3 out of 4 or 72–75%
Successful VBAC (one previous caesarean delivery, at least one previous vaginal birth)	Almost 9 out of 10 or up to 85–90%
Unsuccessful VBAC more likely in: Induced labour, no previous vaginal delivery, body mass index (BMI) greater than 30 and previous caesarean for labour dystocia. If all of these factors are present, successful VBAC is achieved in 40% of cases.	

Likelihood of	VBAC	ERCS	General population
MATERNAL RISKS			
Uterine rupture	1 per 200 / 0.5%	< 2 per 10 000 /< 0.02%	N/A 40:10 000
Blood transfusion	2 per 100 / 2%	1 per 100 / 1%	
Endometritis	No significant difference in risk		
Acreta	Not applicable if successful VBAC	Increased likelihood of placenta praevia/ morbidly adherent placenta	40:100 000
Maternal mortality	4 per 100 000 / 0.004%	13 per 100 000 / 0.013%	4:100 000
FETAL/NEWBORN			
Transient respiratory morbidity	2–3 per 100 2–3%	4–6 per 100 / 4–6% (risk reduced with corticosteroids, but there are concerns about potential long-term adverse effects)	
Antepartum stillbirth beyond 39+0 weeks while awaiting spontaneous labour	10 per 10 000 / 0.1%	Not applicable	13 per 10 000 / 0.1%
Hypoxic ischaemic encephalopathy (HIE)	8 per 10 000 / 0.08%	< 1 per 10 000/< 0.01%	15 per 10 000 / 0.1%

Table A

REFERENCES	Royal College of Obstetricians and Gynaecologists Green-top guidelines. Birth after previous caesarean section. No 45. Oct 2015. NICE. Caesarean Birth. March 2021. www.nice.org.uk/guidance/ng192 Fitzpatrick KE, Kurinczuk JJ, Alfirevic Z, Spark P, Brocklehurst P, et al. (2012) Uterine Rupture by Intended Mode of Delivery in the UK: A National Case-Control Study. PLoS Med 9(3): e1001184. doi:10.1371/journal.pmed.1001184
RELATED DOCUMENTS AND PAGES	Vaginal Birth after Caesarean Section-Intrapartum [redacted] Vaginal Birth After Caesarean Section-Patient Information Leaflet https://www.rcog.org.uk/en/patients/patient-leaflets/birth-after-previous-caesarean/ Booking Appointment and Clinical Risk Assessments in Pregnancy, Labour and the Postnatal Period (Selection of Lead Professional) [redacted] Induction of Labour Guideline [redacted]
AUTHORISING BODY	Antenatal Working Party
SAFETY	There are no known safety concerns
QUERIES AND CONTACT	[redacted] or Community Matron [redacted]