Worcestershire Acute Hospitals NHS Trust

## Vaginal birth after caesarean section (VBAC)

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| **Key Document code:** | WAHT-TP- 094 | |
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| **Approved by:** | Maternity Governance Meeting | |
| **Date of Approval:** | 15th November 2019 | |
| **Date of review:** | 15th November 2022 | |

**Key Amendments**

| Date | Amendments | Approved by |
|---|---|---|
| | | |

### Guideline

The guideline should be used in conjunction with the care pathway Appendix 1. Any discussions and information given to the woman on which to base her decision should be documented on the checklist in Appendix 2

# Plan of Care

### Antenatal Management

See appendix 2 for details on community led antenatal care for women who had uncomplicated caesarean section and no other additional risk factors

### First visit

 At booking visit community midwife should give RCOG VBAC information leaflet.

 **At the consultant booking clinic:**

- In antenatal clinic patient should be seen by the consultant (if consultant is not in the clinic the registrar should review the patient and discuss with the consultant later).
- Previous caesarean section notes must be available and reviewed by the consultant/ registrar at this visit if first section was performed in WAHT. If the previous caesarean section was in another hospital notes should be requested.
- Risks/complications/success rate of trial of VBAC & planned caesarean section should be discussed with the patient, recorded in notes. VBAC check list should be completed with the patient at this visit.
- These women should be booked for hospital delivery.
- Agreed plan for fetal monitoring in labour and mode of delivery should be recorded in notes.
- If the woman is undecided or decides to try VBAC against medical advice she should be counselled by an experienced obstetrician and may require referral to the Opinion / VBAC Clinic.
- If there are no additional risk factors identified and woman is suitable for VBAC this should be clearly documented in the notes & follow up appointment arranged with the community midwife. No further follow up is required in the hospital unless the clinical situation changes / further advice is required.
- Patients with more than previous one caesarean section requesting a trial of vaginal birth must see the consultant. If the consultant is not available then they should be called back to ANC for consultant review
- If the woman has not had her anomaly scan / placental localization by the time of first consultant appointment there should be clear instructions for the community midwife to check the scan report on subsequent follow up & confirm placental position and make appropriate referral if any concerns.

- Suitability for IOL if woman goes postdates should be discussed with the consultant obstetrician and plan documented in hospital and pregnancy notes. If woman is not suitable for trial of IOL with Prostaglandin but ok for trial of spontaneous labour an elective caesarean section date can be booked for 41 weeks & 3 days.
- If a woman if booked for an elective CS but goes in to labour prior to this date there should be a documented plan for labour in her notes.

If there appears to be psychological issues e.g. tochophobia the woman should be referred to the perinatal psychiatrist and the opinion/VBAC clinic. A further follow up should be arranged to see the consultant following these appointments to decide on mode of delivery.

- If the woman needs anaesthetic referral for surgical, medical or anaesthetic reasons she should be referred to the antenatal anaesthetic clinic. It is recommended that such a case should be discussed with the anaesthetist prior to the anaesthetic appointment to avoid different advice being given to the woman as this leads to confusion and patient dissatisfaction.

**Follow up**

 In women with additional risk factors further consultant review should be booked accordingly.
 All women suitable for VBAC should be reviewed by the CMW at 34-36 weeks to support and encourage them for VBAC.
 Plan for fetal monitoring in labour should be clearly documented in the notes

Some women will require a further consultant review after 40 weeks to finalise the plan if not already agreed upon, this should be clearly documented in the notes

 If VBAC is not suitable and elective caesarean section is decided as the mode of delivery it should be booked no earlier than 39 completed weeks unless there is an obstetric/medical indication for earlier delivery.

The effect of being delivered early by caesarean section and the chance of a baby developing breathing problems is:

| Completed weeks | Risk compared to 40 weeks |
|---|---|
| 37 | 40 times higher |
| 38 | 13 times higher |
| 39 | 3.5 times higher |

**Induction of Labour**

NICE states that IOL with history of previous caesarean section can be undertaken with vaginal prostaglandin with or without the use of oxytocin and amniotomy, although the safety data is limited.

There is limited evidence available for the safety and efficacy of induction of labour in this group. The risk of uterine scar rupture is however relatively greater (see below). Women who have never delivered vaginally are at the highest risk from uterine rupture following IOL.

- Suitability for IOL if woman goes postdates should be discussed and plan documented in hospital and pregnancy notes. If woman is not suitable for trial of IOL with Prostaglandin but ok for trial of spontaneous labour an elective caesarean section date can be booked for 41 weeks & 3 days.
- IOL and its risks and benefits should be discussed with the patient and the plan should be documented in the notes (e.g if not for PGE2/Oxytocin etc).
- Timing and method of induction of labour should be decided at the consultant level and documented carefully in the notes.
- IOL should occur in delivery suite.
- PROSTAGLANDIN should be used with caution and only after discussing with the consultant.

- If cervix is favourable for amniotomy (ARM), it should be performed and if no progress/ uterine contractions in two hours oxytocin should be commenced.

**Management in Labour**

**Spontaneous labour**

- On call registrar and duty anaesthetist to be informed as soon as a woman is admitted in labour and kept informed throughout of her progress.
- Continuous fetal heart monitoring should be offered once in established labour.
- Venflon should be sited and blood should be taken for FBC and 'group and save'.
- Analgesia should be given dependent on the woman's wishes.

**Failure to progress in first stage**

- If suboptimal progress, inform the on-call registrar who should review the woman and discuss the case with the consultant.
- If head is descending but there is slow vaginal dilatation consider use of oxytocin as per Induction guideline for multipara. P9 WAHT-OBS-010. Do not exceed 12mu/min.
- If there is regular contraction but no progress DO NOT USE OXYTOCIN.
- If the head remains high and there is slow dilatation of cervix, proceed to caesarean section.

**Optimal progress in first stage of established labour –** once cervix is 4 cm dilated and there are regular 3:10 uterine contractions cervical dilatation of at least one cm per hour will be considered satisfactory progress. In addition cervical effacement and vertex descent should be considered while assessing progress in labour.

**Failure to progress in second stage**

- Inform the on call consultant obstetrician /duty anaesthetist.
- DO NOT USE OXYTOCIN.
- **However** in selective cases where there are no signs of scar dehiscence but ineffective uterine contractions in active second stage oxytocin should only be considered to assist in delivery after careful review of the e case by the consultant
- In cases of emergency caesarean section consider prophylactic oxytocin infusion after delivery of the placenta.

**Risk of Scar Rupture**

Trial of VBAC is safe in carefully selected women.

Uterine scar rupture is a rare complication of trial of VBAC. This risk exists with each trial of VBAC and all subsequent labours should be managed in the same way.
Rates of uterine rupture differ according to whether VBAC labour is spontaneous (0.15–0.4%), induced (0.54–1.4%) or augmented (0.9–1.91%)

VBAC may be considered after two caesarean sections but it is associated with an increase risk of scar rupture.

If prior vaginal birth:
6 per 1000 if prostaglandin is used 2 per 1000 if no prostaglandin is used

**Signs of Scar Rupture**
All staff must be aware of signs and symptoms of scar complications

- Fetal heart rate abnormalities
- Continuous scar pain– may be masked with epidural
- Sudden increase in requirement of analgesia/ missed segment when epidural initially effective
- Rising maternal pulse (may be the only sign)
- Vaginal bleeding
- Haematuria
- Retraction of presenting part on vaginal examination

**Abnormal CTG / Fetal Blood Sampling in trial of VBAC:**
Pathological CTG during a trial of VBAC could be the sign of impending scar rupture. FBS should only be attempted if there is satisfactory progress of labour and no other sign of scar rupture present, otherwise delivery by emergency caesarean section should be considered.

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## APPENDIX 1

### VBAC Care Pathway- (After complicated caesarean section/Other Obstetric risk factors)

**First Contact:** All women who have had a previous caesarean section are given the VBAC leaflet by their midwife at their first visit. EDD should be accurately calculated giving due consideration to length of cycle and early USS.

**10 weeks**

- Booking by midwife
- Ensure women have the VBAC information leaflet.
- If there are additional risk factors other than previous CS the woman should be referred earlier in pregnancy.

**14- 20 weeks** Consultant appointment (All women with previous CS)

- Discussion on mode of delivery, information on VBAC , emergency and elective LSCS
- Complete checklist (Appendix 2)
- Discussion and plan for induction of labour and mode of delivery documented
- If elective caesarean section is decided as the mode of delivery it should be booked 39 – 40 weeks (with the delivery suite and day assessment unit) unless there is an obstetric/medical indication for earlier delivery.
- Discuss induction of labour and its risks & benefits with the patient and document the plan in the notes. (e.g if not for PGE2/oxytocin etc)
- If the woman is for trial of VBAC but not for IOL then book the Caesarean section for a proposed date after 41 weeks & 3 days (e.g for LSCS on -/-/- if not delivered by then.
- Appropriate referral to the Opinion and VBAC clinic.

**CMW follow up**

- Women with no additional risk factors other than previous CS can have CMW follow up after first consultant appointment till delivery
- If CMW identifies any risk factors in the course of antenatal period or has any concerns she should contact the named consultant/ make an appointment for the named consultant clinic( follow up appointment)
- Anomaly scan should be reviewed and placental position checked. If placenta is low lying and no further consultant appointment in place, a follow up appointment at the named consultant clinic should be made.

- Routine antenatal care should continue around these visits
- Appropriate referral should be made to the Opinion and VBAC clinic.

**Third Trimester Consultant appointment:**

- Women with additional medical/surgical/obstetric risk factors should be seen in consultant clinic accordingly for further management plan.
- If any of the above is not in place it should be done at this visit.

**41 weeks:**

- Some women will require a further consultant review after 41 weeks to finalise the plan if not already agreed upon, this should be clearly documented in the notes.
- Discuss options and review plan for mode of birth.
- If woman is suitable for VBAC , offer a “sweep” by community midwife as per IOL guideline

**APPENDIX 2**

**VBAC Care Pathway- Community led care**

## VBAC PATHWAY FOR MIDWIFE LED ANTENATAL CARE IN THE COMMUNITY

**INCLUSION CRITERIA**

- Women who underwent uncomplicated Caesarean section
- No other risk factors that will require consultant led care

**EXCLUSION CRITERIA**

- Women who underwent complicated CS
- Women who underwent Caesarean section with other risk factors that require consultant led care

**COMMUNITY CARE**

- Booking in community
- Request information from GP/Hospital electronic system
  - Letter to patient/GP re: suitability for VBAC
  - Check Athena/eZ notes
  - Check EDS from last delivery
- Discuss with patient to make sure she is eligible for this pathway and get consent
- Early ANC referral or VBAC clinic referral - if the patient wishes

- Give VBAC Information leaflet to the patient; Encourage VBAC
- Referral made for ANC appointment after 20weeks USS
- Routine AN care till 20/40 USS

**ANC VISIT AFTER 20 WEEKS**

- Consultant review
- Confirm suitability to remain under MW led AN Care; Check placental position
- Give information leaflet and complete VBAC Checklist
- Discuss VBAC; Intrapartum care and IOL; Document in patient's notes
- Leave AN Care in the community till term
- Book ANC appointment after EDD - by T+7

**COMMUNITY CARE**

- Regular Antenatal review in the community
- Check and ensure patient is happy to remain in the community care pathway
- Check and ensure Consultant ANC appointment T- T+7
- Provision of AN care as for primip (25,28,34,36,38 weeks)
- Discussion with the consultant or referral to ANC if any risk factors identified
- Sweep at term- 39-40 weeks

**ANC VISIT**

- AN Clinic visit 40 - 41 weeks
- Medical review; Discuss and document patient's preference regarding IOL
- Offer repeat sweep and book IOL at 41+5 weeks
- Discuss intrapartum care plan

**DELIVERY SUITE**

- Intrapartum care as per guideline
- Continuous EFM; IV access

## APPENDIX 3

Affix Patient Label here or record

NAME: . . . . . .

NHS NO:

HOSP NO:

D.O.B: D D / M M / Y Y Y Y MALE ☐ FEMALE ☐

WARD:..... CONS:.....

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### CHECKLIST OF RISKS FOR WOMEN HAVING VAGINAL BIRTH AFTER CAESAREAN SECTION (VBAC)

**VBAC Checklist**

Number of previous vaginal deliveries:.....

Number of previous caesarean sections:.....

Additional information discussed/reviewed:
eg review of previous C/S operation notes, indication/findings

**Prerequisites for VBAC discussed**

- ≤ 2 caesarean sections
- No previous classical C/S, inverted T or J incisions, contraindications to vaginal birth

**Advantages of VBAC discussed**

- 6-7 in 10 will give birth vaginally after 1 previous C/S, if spontaneous labour
- Avoids risks of planned surgery
- Quicker recovery period
- Greater chance of normal uncomplicated birth in the future

**Disadvantages of VBAC discussed**

- Scar rupture or weakening may occur: 1 in 300 VBAC attempts
  (Signs include scar tenderness, pain and changes in fetal heart rate)
- Intrapartum brain damage to the baby 8 in 10,000 (zero with elective c/s)
- 2-3/10,000 additional risk of birth-related perinatal death compared to c/s
  (No higher than if labouring for the first time but higher than at planned c/s)
- 3-4 / 10 women will need an emergency c/s
- Unsuccessful planned VBAC carries an increased risk of blood transfusion, Hysterectomy, scar rupture and endometritis compared to successful VBAC

Name: _____ Signature:_____

Grade: _____ Date: _____

Affix Patient Label here or record

NAME: .....
NHS NO:
HOSP NO:
D.O.B: D D / M M / Y Y Y Y MALE ☐ FEMALE ☐

WARD:..... CONS:.....

## CHECKLIST OF RISKS FOR WOMEN HAVING VAGINAL BIRTH AFTER CAESAREAN SECTION (VBAC)

**Advantages of elective C/S discussed**

- Lower risk of bleeding compared to emergency c/s
- Risk of scar rupture is very low in the absence of labour

**Disadvantages of elective C/S discussed**

- Blood loss leading to the need for blood transfusion
- Risk of bowel or bladder damage during surgery
- Increased risk of thrombosis
- Risk of hysterectomy
- Risk of infection - wound, urinary or chest
- Longer recovery period
- Increased complications in future pregnancies (placenta praevia/accreta, blood transfusion, hysterectomy, ITU admission, organ damage)
- Injury to the baby during surgery - cut or forceps marks
- Admission to the NNU due to breathing difficulties (higher rate than VBAC)

**Individualised management plan for labour discussed with consultant and patient advised:**

- Birth in hospital on delivery suite
- IV access, group & save and CEFM in labour
- Additional points: .....

**If spontaneous labour prior to booked C/S:**

- Preterm VBAC success is similar to term VBAC
- Incidence of uterine rupture is lower than term VBAC
- Emergency c/s may not be appropriate
- Birth in hospital on delivery suite, IV access in labour and CEFM in established labour

**Induction of labour discussed with obstetric consultant**

- Inform women of increased risk of scar complications if induced or augmented (propess 3 in 300 > oxytocin 2.6 in 300)
- IOL would occur on delivery suite
- For IV access and CEFM in labour

| | | | |
|---|---|---|---|
| Decision for mode of delivery: | VBAC | C/S at ..... | |
| If labour prior to term aim for: | VBAC ☐ | C/S ☐ | Discuss on admission ☐ |
| Induction of labour: | IOL at ..... | C/S? if not laboured before..... | |
| Leaflets given: | VBAC ☐ | C/S ☐ | |
| Any other points: | | | |