Document No: 43423

TITLE: Vaginal Birth after Caesarean (VBAC)

1. Statement/Purpose/Description

To ensure the safe management of a planned Vaginal Birth after Caesarean (VBAC). VBAC is a safe option for the majority of women.

Women who have had a previous Lower Segment Caesarean Section should be facilitated in making an informed choice between VBAC and planned repeat Caesarean Section, after a full discussion regarding advantages/disadvantages and possible risks.

It is important that all decision making involves the woman, Lead Maternity Carer (LMC) and Consultant Obstetrician as appropriate, as per Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)

Planned 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). A successful VBAC includes having an assisted birth.

Refer to RANZCOG Patient Education Leaflet – Vaginal Birth after Caesarean Section – Edition #6

2. Scope

All Lakes District Health Board midwifery, medical staff and LMC's.

3. Definitions

BP	Blood Pressure
CTG	Cardiotocograph
EFM	Electronic Fetal Monitoring
ERCS	Elective Repeat Caesarean Section
IV	Intravenous
LMC	Lead Maternity Carer
LSCS	Lower Section Caesarean Section
SHO	Senior House Office
VBAC	Vaginal Birth After Caesarean

4. Procedure/Management

4.1. Women who have had previous LSCS are to be referred, at approximately 20 weeks, to Antenatal Clinic.

- Review clinical records for the course of labour, reasons and surgical issues in the previous caesarean labour.
- Discuss the options and mode of delivery with the woman in the antenatal period, and give them a copy of leaflet – Vaginal Birth after Caesarean (RANZCOG).

Antenatal discussion should include informing the woman of likely successful outcome (average 70%), risk of scar rupture and possible consequences, and recommended labour guidelines for managing women undergoing VBAC

- VBAC is contraindicated in women with:
  - Previous uterine rupture;
  - Previous high vertical classical caesarean;
  - Three or more previous caesarean sections
- Women with prior history of two uncomplicated low transverse caesarean sections, in an otherwise uncomplicated pregnancy at term, with no contraindication for vaginal birth, who have been fully informed by a Consultant Obstetrician, may be considered suitable for a planned VBAC.
- A cautious approach is advised when considering planned VBAC in women with twin pregnancy and short interdelivery interval, as there is uncertainty in the safety and efficacy of planned VBAC in such situations.
- A management plan is documented in the woman's clinical notes. This will include a discussion around post term management and potential complications. Induction of Labour can be considered if patient wishes to avoid elective LSCS.

4.2. Usual booking in, blood and scan results available in the woman's clinical record.

4.3. There is no requirement to inform the Consultant Obstetrician when a woman is admitted in labour for a planned VBAC and progresses well and the CTG is reassuring. Please update the Consultant Obstetrician at morning handover of the VBAC admission and history. Recommended to labour and birth in a secondary facility.

4.4. Insert large bore IV cannula and take bloods for full blood count, group and hold when labour established.

4.5. Use of a partogram and continuous electronic fetal monitoring is required when in active labour. It is not unreasonable for women in established but early labour to mobilize for short periods, in the absence of any concerns as long as regular Fetal monitoring is maintained.

4.6. Clinical staff are to be familiar with Appendix 1. EFM Definitions and Classifications

4.7. The use of syntocinon is not contraindicated but must be used with extreme caution.

4.8. Inform the on call registrar /SMO of the following:

- Abnormal progress in labour
- CTG abnormalities
- If delivery is not imminent after 30 minutes of effective pushing.

4.9. Signs and Symptoms of Rupture of Uterus - It is possible that only one sign may be present.

- Fetal bradycardia is the most common and characteristic clinical manifestation of uterine rupture. Variable or late decelerations may precede the bradycardia but there is no pattern specific to rupture
- Abdominal pain – severe, constant lower abdominal pain that worsens during contractions (plus or minus shoulder tip pain). May be accompanied by vomiting and suprapubic tenderness.
- Raised pulse rate – may rise slowly.
- Blood loss – fresh vaginal blood loss which may be mistaken for a “show”.
- Sudden changes in fetal heart rate pattern – tachycardia or bradycardia (may not occur until later).
- Cessation of contractions – rupture may occur at the height of a strong contraction, whereupon the contractions cease.
- Maternal shock – faintness, tachycardia, hypotension.
- Fetal parts more easily palpable and recession of the baby’s head.
- Haematuria.
- Loss of station of presenting part.
- Undetectable fetal heart rate.
- Dilatation of the cervix regresses.

4.10. Emergency Management if suspected uterine rupture

- Call 777 and include the Obstetric, Neonatal and Anaesthetic emergency teams.
- Monitor maternal BP, pulse, O_2 saturations.
- Expedite delivery - Forceps delivery if feasible otherwise emergency caesarean section.
- Maternal oxygen at 6 litres via rebreathing mask unless instructed by medical team to administer at a higher level.
- Provide reassurance and emotional support to patient and Whanau.
- Document events and times as soon as practical.

5. Equipment Used

N/A

6. Points to Note/ General Information

- In general, up to 70% of women who attempt VBAC have a successful vaginal birth.
- The greatest likelihood of VBAC is seen when the first caesarean is carried out for breech presentation, or if reach at least 4 cm dilatation.

- A critical time for the woman undergoing a VBAC is the place where she got "stuck" last time.
- The probability of requiring a caesarean for uterine rupture is 30 times **lower** than any other unpredictable child birth emergency, such as acute fetal distress, premature rupture of membranes.
- Risk or uterine rupture is not related to whether pregnancy duration was less or more than 40 weeks.
- T shaped or vertical incisions for a previous LSCS increase the risk of uterine rupture by between 4-9%
- The type of incision in the skin does not affect the risk of uterine rupture and does not indicate the type of incision in the uterus.
- Rupture of uterus can rarely occur even when a woman has never had a previous caesarean.
- There is a higher chance of successful VBAC if the last LSCS occurred in early labour and not after full dilatation, onset of labour is spontaneous, labour – including dilatation and effacement of the cervix – progress normally and there is only one previous LSCS.
- Bloodless uterine scar dehiscence may not have negative consequences for mother or baby, whereas complete rupture of the uterus can be a life threatening emergency.
- There is a higher risk of uterine rupture with induced or augmented labour than with spontaneous normal labour and these women must be under secondary care. Incidence of scar rupture; if no labour 1.6/1000, spontaneous labour 5.2/1000, IOL no prostaglandins 7.7/1000, with prostaglandins 24.5/1000.
- There is controversy over the use of epidurals as they may mask early symptoms of uterine dehiscence.
- Women with previous caesarean should be offered continuity of midwifery care during pregnancy, labour and birth.
- Pregnant women, with two previous caesarean births and no additional risk factors for vaginal birth, may be offered a planned vaginal birth after discussing the risks and benefits.
- Practices that increase vaginal birth outcomes:
  - Ambulation
  - Upright positions in 1st and 2nd stages of labour
  - Continuous support in active labour
  - Continuity of care
  - Partnership / case load model of care
  - Water for labour and birth only if fetal monitoring can be carried out.

7. Related Documentation

- Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)
- Induction of Labour Guideline

8. References

- Maternity Services Notice, Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines)
- New Zealand Guidelines Group (2004), Care of Women with Breech Presentation or Previous Caesarean Birth
- New England Medical Journal Lyndon Rochelle 2001
- Vaginal Birth After Caesarean Delivery Up to Date (2005), Vol 13, No 1 & 2. Welischar, J., Quirk, J.G.
- Birth After Previous Caesarean Birth, Royal College of Obstetricians and Gynaecologists. Green Top Guideline No. 45. February 2007
- Vaginal Birth After Caesarean. Ministry Of Health NZ July 2004
- NZCOM Consensus Statement. Vaginal Birth After Caesarean Section. 1996
- RCOG Green-top Guidelines No 45. 2007
- NICE Clinical Guidelines No 55 – September 2007 (page 18)
- RANZCOG Patient Education Leaflet – Vaginal Birth after Caesarean Section – Edition #6

Authorised by: O&G Guideline Group

Appendix 1 - EFM Definitions And Classifications

Table 1 – Definition of normal, suspicious and pathological FHR traces

Category	Definition
Normal	All four features are classified as reassuring
Suspicious	One feature classified as non-reassuring and the remaining features classified as reassuring
Pathological	Two or more features classified as non-reassuring or one or more classified as abnormal

Table 2 – Classification of FHT trace features

Feature	Baseline (bpm)	Variability (bpm)	Decelerations	Accelerations
Reassuring	110 – 160	$\geq$ 5	None	Present
Non-reassuring	100 – 109 161 – 180	$\leq$ 5 for 40-90 min	Typical variable decelerations with over 50% of contractions, for over 90 min. Single prolonged deceleration for up to 3 min.	The absence of accelerations with otherwise normal trace is of uncertain insignificance.
Abnormal	< 100 > 180 Sinusoidal pattern $\geq$ 10 min	< 5 for 90 min	Either atypical variable decelerations with over 50% of contractions or late decelerations, both for over 30 min. Single prolonged declaration for more than 3 min.	