VAGINAL BIRTH AFTER CAESAREAN SECTION (VBAC)

1. OPTIMAL OUTCOMES
   - Appropriate management and support of women considering VBAC

2. PATIENT
   - Pregnant woman who has had one previous lower segment Caesarean Section (LSCS)

3. STAFF
   - Registered Midwives
   - Medical officers

4. EQUIPMENT
   - Cardiotocography (CTG) Monitor
   - Doppler
   - Intravenous Cannula (IVC) (16 gauge)

5. CLINICAL PRACTICE
   - Woman who has had one previous LSCS
     - Antenatal
       - Discuss reasons for previous LSCS and woman’s preferences for and understanding of birth options for this pregnancy
       - Discuss ways to optimise vaginal birth and provide the VBAC information sheet at booking visit
       - Insert VBAC checklist into medical records and complete as indicated
       - Refer woman to an obstetric consultant or registrar in the second trimester of pregnancy following the morphology ultrasound to receive counselling regarding the risks and benefits of VBAC in her case
       - Document medical discussion and agreed management plan in the medical record
       - Insert vaginal examination for stretch of cervix from 37 weeks gestation
     - Labour
       - Aim to perform the following:
         - One-to-one care by a midwife
         - Continuous electronic fetal heart rate monitoring (EFM)
         - Insertion of 16 gauge intravenous cannula and collect blood for full blood count and group and hold
         - Take maternal observations in labour as per 1st stage labour guideline
         - Regular assessment of progress of labour, including at least 4th hourly vaginal examination
         - Consult obstetric registrar or consultant if progress is inadequate
         - Avoid prolonged labour
         - Observation for loss of contractions, loss of station, continuous pain in lower abdomen between contractions
       - Use Oxytocin with great caution and only after the agreement of the consultant on call

6. HAZARDS / SUB-OPTIMAL OUTCOMES
   - Uterine rupture
   - Fetal morbidity or mortality
   - Hysterectomy
   - Woman not given informed choice regarding VBAC
   - Inappropriate management of VBAC including failure to consult and refer in the presence of inadequate progress
7. DOCUMENTATION

- Antenatal notes
- Integrated clinical notes
- Yellow card
- Partogram
- ObstetriX Database

8. EDUCATIONAL NOTES

- **Benefits of vaginal birth after caesarean:**
  - Earlier initiation of breastfeeding
  - Earlier mobilisation for the mother
  - Reduced blood loss
  - Decrease infection, adhesions and readmission to hospital
  - Reduced risk of a placenta praevia, accreta, abruption, caesarean section or unexplained stillbirth in future pregnancies
  - Earlier resumption of normal activities

- **Women who are most likely to achieve VBAC are:**
  - those who have already had a previous vaginal birth
  - those who had a previous LSCS for a non-recurrent reason - eg breech or suspected fetal compromise
  - those who labour spontaneously before 42 weeks
  - those with a normal body mass index (BMI)
  - those who are motivated

- **BMI affects chances of successful VBAC.** Obesity (BMI >= 30kg/m2) halves the success of VBAC

- **VBAC is contraindicated in women who have:**
  - A previous classical caesarean or upper segment incision caesarean birth
  - A previous myomectomy which breached the capsule of the uterus
  - Any maternal or fetal condition that would contraindicate a vaginal birth

- **Risks of VBAC:**
  - Uterine rupture is associated with significant risks of both maternal and fetal morbidity or mortality
  - The following are associated with an increased risk of uterine rupture:
    - Birthweight greater than 4,000g
    - Induction of labour
    - Maternal age >35 years
    - Short maternal stature (<164cm)
    - Post-term pregnancy (>42 weeks)
  - The risk of uterine rupture varies according to the following:
    - in spontaneous labour 3:1,000
    - induced with Syntocinon 5.4:1,000
    - induced with Prostaglandin 24:1,000
    - augmented with Syntocinon 19.1:1,000
    - inter-delivery interval of less than 18 months 48:1,000
  - Perinatal mortality as a direct result of uterine rupture is 2-3:10,000 (the same risk for primips in labour)
  - The risk of neonatal death in VBAC is 12.9:10,000 compared with 1.1:10,000 for elective repeat caesarean section, however the numbers are small
  - The risk of hypoxic-ischaemic encephalopathy (HIE) in VBAC is 8:10,000 compared with virtually zero for elective repeat caesarean section, however again the numbers are small
VAGINAL BIRTH AFTER CAESAREAN SECTION (VBAC)

- An abnormal CTG is the most consistent early finding in uterine rupture and is present in 55-87% of these events, hence the importance of continuous electronic fetal monitoring. However if this is declined 15 minutely auscultation of the fetal heart rate in established labour is a second-best alternative
- **Signs and symptoms of uterine rupture include:**
  - Decelerative fetal heart rate changes (acute and prolonged)
  - Sudden onset of vaginal bleeding
  - Maternal hypotension and tachycardia
  - Continuous pain over scar
  - Cessation of contractions
  - Loss of fetal station on vaginal examination
- Epidural analgesia is not contraindicated

9. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE GUIDELINES

- First stage labour care for women with a low risk pregnancy
- Caesarean Birth – Maternal Preparation and Receiving the Newborn
- Intrapartum Fetal Monitoring
- Obesity in pregnancy, labour and postpartum
- Vaginal examinations in labour

10. REFERENCES

4. Royal College of Obstetricians and Gynaecologists (2007). Birth after previous caesarean section green-top guideline No 45. RCOG
5. Women’s Hospitals Australia clinical practice guideline (2005). Vaginal birth after Caesarean or repeat elective caesarean
12. Smith GC Jama 2002
<table>
<thead>
<tr>
<th>TOPIC</th>
<th>DATE / GESTATION</th>
<th>MIDWIFE/DOCTORS PRINTED NAME / SIGNATURE</th>
</tr>
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<tbody>
<tr>
<td>At Booking visit options for VBAC vs rpt CS discussed and documented as per RHW Local Operating Procedure</td>
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<tr>
<td>RHW VBAC handout given and discussed</td>
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<td>Woman referred to MGP if wishes (NB place not confirmed unless receives call from MGP)</td>
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<tr>
<td>Plans for optimising success discussed (eg positive attitude / spontaneous labour / continuous support in labour)</td>
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<tr>
<td>Operative notes and Partogram of previous birth requested for Dr's appt – including notes from other hospitals where possible, if previous birth not at RHW</td>
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<tr>
<td>Medical appt booked for obstetric referral and consultation at 20 weeks following morphology scan</td>
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<tr>
<td>Clearly document discussion and plan regarding risk vs benefits of VBAC in hospital medical records and woman's Antenatal Card</td>
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<tr>
<td>Document that woman is aware of RHW LOP for VBAC (cannula/CTG / regular VE for progress / Delivery Suite). If woman declines any of the recommendations discuss and ask woman to sign disclaimer “Women choosing care outside of RHW guideline” (Appendix A)</td>
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<tr>
<td>Document specific fears or concerns voiced by woman / partner related to VBAC / rpt CS</td>
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<tr>
<td>Stretch and sweep offered weekly from 37 weeks</td>
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<tr>
<td>Induction of labour limitations and risks discussed</td>
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<tr>
<td>Book for medical review at 40 weeks to discuss post dates IOL options versus repeat CS</td>
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<tr>
<td>Notes of previous caesarean section reviewed</td>
<td>Yes</td>
<td>Not available</td>
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<tr>
<td>Lower segment uterine incision</td>
<td>Yes</td>
<td>No / Not sure</td>
</tr>
<tr>
<td>History of myomectomy or classical CS, T or J incision</td>
<td>Yes</td>
<td>No / Not sure</td>
</tr>
<tr>
<td>2 layer uterine closure</td>
<td>Yes</td>
<td>No / Not sure</td>
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<tr>
<td>Inter-delivery interval</td>
<td>&gt;18 months</td>
<td>&lt;18 months</td>
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Please note here any particular concerns or requests that this woman has: