LOCAL OPERATING PROCEDURE

CLINICAL POLICIES, PROCEDURES & GUIDELINES

Approved by Quality & Safety Committee February 2022
Review December 2025

NEXT BIRTH AFTER CAESAREAN SECTION (NBAC)

This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.

1. AIM

- Appropriate management, counselling and support of a woman who has had at least one prior caesarean section (CS)

2. PATIENT

- Any pregnant woman whose last birth was a CS

3. STAFF

- Medical and midwifery staff

4. EQUIPMENT

- Nil

5. CLINICAL PRACTICE

- Discuss and document at booking visit:
  - reasons for previous CS
  - woman's preferences, understanding and suitability for birth options this pregnancy
  - advise woman who has no contraindication to vaginal birth that she has the choice of an elective repeat CS (ERCS) or attempting a vaginal birth. Provide the Next Birth After Caesarean (NBAC) patient information sheet (see appendix 1)
- Review previous operation notes/medical records:
  - note if any contraindication to vaginal birth exists
  - if not already available, request operation notes/medical records of previous CS if performed elsewhere by communicating with the relevant hospital. This may require the woman to sign a consent form for release of medical information
  - if previous CS was performed overseas, ask woman if she can obtain any documentation/records
- Advise against Vaginal Birth After Caesarean Section (VBAC) in woman who has:
  - a previous classical, vertical, upper segment, inverted T or J incision, previous hysterotomy, ≥ 3 previous caesarean sections, complex uterine surgery (including myomectomy which breached the uterine cavity)
  - any maternal or fetal condition where vaginal birth is contraindicated
- Refer to consultant when previous operation report states 'not for VBAC', individualised plan to be made when woman would like to consider VBAC

Woman who has had ONE previous lower segment caesarean section (LSCS)

Antenatal

- Discuss ways to optimise vaginal birth if woman is considering and suitable for a VBAC (e.g. positive mindset and supportive network, minimise weight gain if overweight, await spontaneous labour)
- Review availability for referral to Midwifery Group Practice (MGP) if woman wishes and planning a VBAC
- Complete NBAC checklist in eMaternity at booking, following counselling at 32 weeks and 36 weeks within:
  - *considerations* folder **or**
  - *antenatal screening tools and resources* folder

- Refer woman to the NBAC group at 24-26 weeks regardless of preferred mode of birth, as outlined in appendix 2. Information regarding the risk and benefits of VBAC or ERCS will be discussed as outlined in this LOP
- Ensure woman booked back to planned model of care (MOC) for ongoing antenatal care following NBAC group attendance
- Review in obstetric clinic at 32 weeks (some women will require earlier consultation e.g. < 18 month birth interval):
    - with obstetric registrar who has discussed the woman with a consultant, or
    - with consultant
    - consent should be signed at this appointment for either VBAC or ERCS
    - document discussion, name of the registrar and consultant (who was involved with discussion and decision making)
- Recommend alternate visit schedule for GPSC woman with previous caesarean (see below)
    - 28 weeks GP
    - 30 weeks midwife RHW (in lieu of 31 week visit)
    - 32 weeks obstetric clinic RHW. **Consent signed** at this appointment for either VBAC or CS
    - 34 weeks GP
    - 36 weeks midwife/obstetric clinic (if undecided at 32 weeks) RHW. Ensure consent signed
    - 38 weeks GP
    - 39 weeks midwife RHW
    - 40 weeks obstetric clinic RHW. Plan if labour does not occur by 41 weeks e.g. IOL or ERCS
- Document medical discussion and agreed management plan in the medical record and on NBAC checklists in eMaternity
- **Discuss the following for a woman requesting/needing ERCS**:
    - process for booking ERCS at 39^{+0} - 39^{+6} weeks gestation, unless other obstetric indication requires earlier birth
    - plan if labour commences prior to booked ERCS date
    - possibility of later gestation for ERCS as per woman's preferences
- **Discuss the following with a woman requesting VBAC**:
    - requirement of written consent (on standard consent form) antenatally for planned VBAC after counselling completed based on procedure, risk and benefits as specified in this LOP and educational notes (give woman photocopy of signed consent form to keep with antenatal card)
    - requirement of regular antenatal care with planned MOC
    - recommendation for twice weekly vaginal examinations and membrane sweep from 38 weeks gestation, to optimise chance of spontaneous labour
    - face-to-face clinic appointment with obstetric consultant at 39-40 weeks to discuss ongoing plan if labour does not occur by 41 weeks. This counselling may include option of induction of labour (IOL) or ERCS as an end point, if spontaneous labour does not occur
    - ensure discussion and counselling for IOL includes:
        - timing of IOL for woman attempting VBAC
        - cervical preparation with balloon catheter, if required
        - contraindication of prostaglandin use for woman attempting VBAC
        - artificial rupture of membranes (ARM) ± waiting for up to 24 hours whilst admitted to ward
        - management in circumstance of pre-labour spontaneous rupture of membranes or following ARM in woman with known Group B streptococcus (GBS) positive result (see educational notes and RHW Rupture of Membranes- Pre-labour at term- Assessment and Management LOP)
        - discussion and plan if labour does not establish after ARM alone, including use of oxytocin. This may be considered to initiate labour in an adequately counselled woman (with discussion that risk of uterine rupture increases with IV oxytocin, see educational notes). If oxytocin is to be used, commence it ideally before 1000 hours during weekdays. Consider oxytocin cessation once labour established and cervix is ≥6cm. After 12 hours of oxytocin, birth should be imminent
- Book IOL or ERCS date at the 39-40 week obstetric visit
    - Obtain written consent (on standard consent form) for IOL by consultant obstetrician. This consent must outline the increased risks of uterine rupture and associated maternal and fetal risks (give woman photocopy of signed consent form to keep with antenatal card)

Woman who has had TWO previous LSCS:

- Discuss at booking visit reasons for previous LSCS and woman's preferences for and understanding of birth options for this pregnancy
- Refer woman for obstetric consult 32 weeks gestation (unless indications for earlier consultation)
    - Where woman is considering VBAC:
        - Refer woman to NBAC group

        - Refer woman to MGP wherever possible
        - Document medical discussion and agreed management plan in medical record
        - Complete NBAC checklists – eMaternity
        - Recommend vaginal examination for membrane sweep of cervix from 38 weeks gestation
- Refer for obstetric consultant appointment at 39 weeks to recommend repeat CS if spontaneous labour does not occur by 40 weeks. Complete consent and recommendation for admission (RFA) form at this visit

Intrapartum care for woman aiming for VBAC

- Arrange one-to-one midwifery care during labour and medical review
- Advise continuous electronic fetal heart rate monitoring (CEFM) once regular uterine activity
- Advise insertion of a 16-gauge intravenous (IV) cannula and send blood for full blood count (FBC) and group and hold
- Take maternal observations in labour as outlined in RHW First Stage of Labour – Recognition of Normal Progress and Management of Delay LOP
- Assess progress of labour regularly. Recommend at least fourth hourly vaginal examination
- Notify obstetric registrar or consultant if progress is inadequate
- Avoid prolonged labour, aiming for birth to occur within 12 hours of established labour
- Allow one hour for passive descent in second stage and one hour of active pushing if no prior vaginal birth, or 30 minutes active pushing if woman has had a previous vaginal birth. Following this time, request medical review
- Observe for loss of contractions, loss of station of presenting part, continuous pain in lower abdomen between contractions, abnormal fetal heart rate changes, sudden onset of vaginal bleeding, maternal hypotension and tachycardia. Notify obstetric registrar or consultant immediately/initiate rapid response if any concerns regarding signs or symptoms of possible uterine rupture
- Individualise plan for woman with pre-labour rupture of membranes (and not in established labour):
    - woman with history of GBS positive swab (see education note and RHW Rupture of Membranes- Pre-labour at term- Assessment and Management LOP).
    - augmentation of labour with oxytocin should occur only after consultant review and discussion
- Advise woman that epidural analgesia is not contraindicated in VBAC but may increase her chance of instrumental birth

6. DOCUMENTATION

- Medical records
- Antenatal Card
- Consent for Medical Procedure/Treatment (Adults and Mature Minors) SMR020.001
- Antenatal checklist – Supporting Women in Their Next Birth after Caesarean (NBAC) SMR060.615

7. EDUCATIONAL NOTES

- The NBAC session is strongly recommended for all women who have the potential option of vaginal birth. This is to ensure that everyone receives consistent information on both mode of birth options to enable informed decision making
- Vaginal birth rate for women attempting a VBAC is approximately 65%[7]
- Benefits of VBAC are outlined in Appendix 1
- A woman is more likely to achieve VBAC if she:
    - has already had a previous vaginal birth
    - has had a previous LSCS for a non-recurrent reason e.g. breech or suspected fetal compromise, and not for a reason related to arrest of labour
    - goes into labour spontaneously
    - has cervical dilatation >4cm on admission to hospital
    - has a normal body mass index (BMI). BMI ≥ 30kg/m^2 halves the success of VBAC
    - is motivated and has one-to-one midwifery care in labour
    - has a low-risk pregnancy
- 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[1]
    - Induction of labour[1]
    - Maternal age >40 years of age
    - Term pregnancy (>37 weeks)[1]

- Post-term pregnancy (>42 weeks)[1]
- The risk of uterine rupture varies according to the following:
  - Spontaneous labour 5:1000[1]
  - Term gestation 8:1000[10]
  - Induced labour 15:1000[1]
  - Augmented with oxytocin 19:1000[1]
  - Inter-delivery interval of < 18 months 48:1000[11]
  - ≥ two caesarean sections 9-37:1000[7]
- Perinatal mortality as a direct result of uterine rupture is 2-3:10,000 (the same risk for a nulliparous woman in labour)[1]
- The risk of neonatal death in VBAC is 4:10,000 compared with 1:10,000 for ERCS[1]
- The risk of hypoxic-ischaemic encephalopathy (HIE) in VBAC is 8:10,000 compared with virtually zero for ERCS[1]
- The risk of hysterectomy after uterine rupture is 14-33%[1]
- RHW Rupture of Membranes- Pre-labour at term- Assessment and Management LOP advises immediate augmentation of labour for a woman who is GBS positive, has ruptured membranes and is not in established labour. This is to reduce the risk of early onset neonatal GBS sepsis, estimated to be 0.5:1000[13]. A decision to proceed with augmentation for this indication in a woman with a previous CS must be considered carefully. The risk of uterine rupture in an augmented labour is 15:1000[1]
- An abnormal CTG is the most consistent early finding in uterine rupture and is present in 66-76% of these events, hence the importance of continuous EFM[1]

8. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE GUIDELINES

- Caesarean Birth – Maternal Preparation and Receiving the Neonate(s)
- Group B Streptococcus (GBS) Screening and Prophylaxis
- Rupture of Membranes – Prelabour at term – Assessment and Management
- Australian College of Midwives (ACM) Guidelines for Consultation and Referral
- Sweeping Membranes to Encourage Spontaneous Labour
- Induction of Labour
- First Stage of Labour – Recognition of Normal Progress and Management of Delay
- Second Stage of Labour – Recognition of Normal Progress and Management of Delay
- Supporting Women in their Next Birth After Caesarean Section (NBAC) Guideline MoH GL20014_004 NSW Health
- Fetal Heart Rate Monitoring Guideline MoH GL2018_025 NSW Health
- Australian Commission on Safety and Quality in Health Care - Clinical Care Standard – Management of Peripheral Intravenous Catheters

9. RISK RATING

- Medium

10. NATIONAL STANDARD

- Standard 2 - Partnering with Consumers
- Standard 5 - Comprehensive Care
- Standard 8 - Recognising and Responding to Clinical Deterioration

11. REFERENCES

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12. Queensland Clinical Guidelines. Vaginal birth after caesarean (VBAC). Guideline No. MN20.12-V5-R25. Queensland Health. 2020.
13. Royal College of Obstetricians and Gynaecologists. 2017 Group B Streptococcal Disease, Early-onset (Green-top Guideline No.36) https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg36/

REVISION & APPROVAL HISTORY
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Flowchart added May 2015
Previous title *Vaginal Birth After Caesarean Section (VBAC)*
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FOR REVIEW: DECEMBER 2025

Appendix 1

Patient information leaflet

NEXT BIRTH AFTER PREVIOUS CAESAREAN SECTION

This information is to help you to make a choice about your next birth. Discuss this with your midwife or doctor. Many women who have had a previous caesarean section can safely have a vaginal birth in their next pregnancy. This is called Vaginal Birth after Caesarean, or VBAC.
Studies have shown that up to 7 out of every 10 women with a previous caesarean can have a safe and successful VBAC.

Can I have a VBAC?
Yes - in most cases.
We advise you not to attempt a VBAC if:

- you have had a previous classical (up-and-down cut in the womb) caesarean
- you have had other surgery to the upper part of your womb
- you need a caesarean section for another reason e.g. placenta praevia
- you have had a previous uterine rupture
- your baby is not headfirst
- you have had three or more caesarean sections
- it has been less than 18 months since your last caesarean section

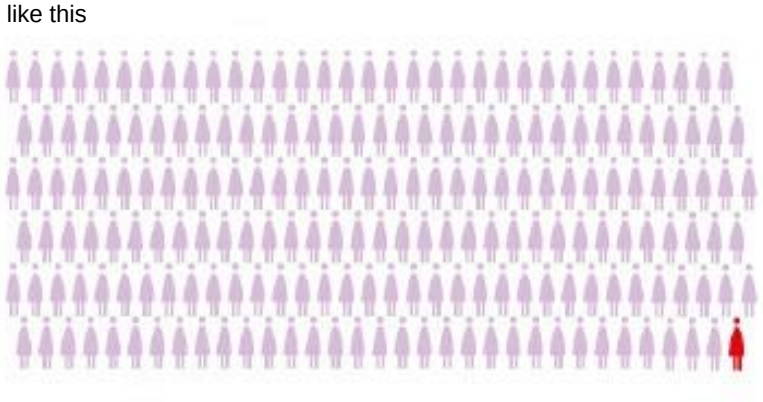
What are the advantages of successful VBAC?

- Lower risk of:
  - heavy bleeding
  - blood clots in the legs or lungs (Deep Vein Thrombosis)
  - other complications of surgery e.g. damage to internal organs
- Shorter hospital stay, a quicker recovery, and a quicker return to normal activities (e.g. driving)
- Lower risk of problems in future pregnancies and births

What are the risks of trying for a VBAC?

- You may still need a caesarean section in labour (about 1 in 3 women)
- Having a caesarean section in labour can increase the risk of severe complications
- Increased chance of forceps or vacuum
- Increased chance of significant tearing
- Uterine rupture, meaning that the scar in the uterus tears. This happens in about 1 in 200 women planning a VBAC. If this happens you will need to have an emergency caesarean

1 in 200 looks like this



- Increased risk of blood transfusion
- In an extremely small number of cases of women attempting VBAC, the baby can die because of the uterine scar tearing. This has been estimated to occur in 1 in 2000 women attempting VBAC: the same risk of a baby dying for any woman during her first labour

What are the advantages of elective repeat caesarean section (ERCS)?

- Timing of birth can be planned from the week before your due date (39-40 weeks)
- No need for instrumental birth or risk of significant tearing

- There is much less risk of a uterine rupture

What are the risks of ERCS?
- Potential surgical complications include infection, organ injury including to bladder or bowel, increased bleeding, compared to successful VBAC
- Anaesthetic risks
- Surgical risks increase with the number of caesarean sections you have
- Blood clots in the leg or lung are more common
- Higher chance of complications, including placental problems, in future pregnancies (e.g. placenta praevia/accreta)

How will we make sure you and baby are safe during a VBAC labour?
We recommend:
- That your baby's heart rate is monitored electronically and continuously throughout your labour
- You have a cannula (drip) in your hand/arm in labour
- Regular assessment of labour progress by your midwife and doctor by feeling your abdomen and vaginal examination

Can labour be induced if I have had a previous caesarean section?
- This needs to be done very carefully and should be discussed with your midwife and doctor

I have had two previous caesareans. Can I have a VBAC?
- The chances of a successful VBAC following two previous caesareans are likely to be reduced when compared to women with one previous caesarean. The risks are increased. If you wish to talk about this option, please speak to your doctor or midwife.

What if my baby is bottom first (breech)?
- Having an obstetrician turn the baby around from bottom to head-first i.e. external cephalic version (ECV) is thought to be safe.
- This would be done around 37 weeks of pregnancy if you wish to have a VBAC.
- Discuss this with your midwife and doctor.

If I'm going to have an ERCS, when is the best time to have it?
- We usually book ERCS in the week before your due date (at 39 or more weeks) so that your baby and its lungs can be as mature as possible.
- If you are planning a VBAC (but would not want an induction of labour) then you can usually wait until closer to 41 weeks to give yourself the best chance of going into labour and having a VBAC
- If you go into labour before your booked caesarean date, your midwife and doctor will discuss your options with you of either proceeding with the CS, or to wait and see if labour proceeds

If you have any further questions, please ask your midwife or doctor for the information contained in our Local Operating Procedure.

Appendix 2

PATHWAY FOR NEXT BIRTH AFTER CAESAREAN (NBAC) CLINIC

RHW booking appointment
Reason for previous CS and options for next birth discussed
Request previous CS report if not from RHW (fax hospital, or ask woman if she has a copy from overseas hospital)

Not for NBAC group clinic if:

- Obstetric indications for repeat CS identified e.g. upper segment, J or T uterine incision

OR

- has had a vaginal birth since primary CS and does not wish to attend NBAC group again

- Refer to obstetric ANC of planned model of care (MOC) for consultant review
- Continue with planned model of care.

Refer to NBAC group clinic regardless of preferred mode of birth if:

If there are no obstetric indications for repeat CS

- Provide NBAC written information sheet and commence NBAC eMaternity checklist prior to NBAC group
- Advise woman NBAC group session will take 45- 60 minutes. This will be followed by 1: 1 phone call – ideally on same day

24-26 weeks gestation NBAC group

- Book NBAC (+/- telehealth) group session for after morphology scan has been performed.
- This is an additional appt. to the antenatal schedule of hospital visits
- Birth options will be discussed/ previous CS report reviewed
- Risks and benefits of VBAC and repeat CS (as per RHW LOP) explained and document

Obstetric Consultant Review following NBAC group

- Arrange medical review at 32 weeks (unless indication for earlier review) with either:
  - Designated MGP Obstetrician
  - Nominated Consultant for GPSC
  - For GPSC schedule this is an **extra hospital visit**
  - Consent should be signed for either VBAC or ERCS at this appointment

Following NBAC Group Discussion

- Continue with planned model of care
- If woman requests or needs a repeat CS, book via woman's designated Consultant for her MOC

Obstetric Appointment at 39-40 weeks gestation for woman planning VBAC

- Book appointment with nominated obstetric consultant for GPSC **OR** MGP designated obstetrician to discuss IOL or CS options if spontaneous labour does not occur by 41 weeks gestation (or earlier if indication for birth before 41 weeks)
- Doctor to discuss and document risks, benefits, and options of IOL
- Obstetric consultant to obtain written consent if IOL chosen, OR
- Complete RFA if CS chosen.
- Book IOL or CS date at this clinic