Document Control

Title			
Delivery After Previous Caesarean Section Guideline			
Author		**Author's job title** Consultant Obstetrician& Gynaecologist Post CCT Speciality Doctor	
Directorate Women& Children's		**Department** Maternity	
Version	**Date Issued**	**Status**	**Comment / Changes / Approval**
0.1	Sep 2009	Draft	Development of new document
0.2	Sep 2009	Revision	Amended following review by CNST team
1.0	Sep 2009	Final	Approved at Sept MS Guideline Group
1.1	Feb 2010	Revision	Amended to include recommendations of CNST Assessor
2.0	Feb 2010	Final	Approved at February Guidelines Group and Maternity Services Patient Safety Forum
2.1	Aug 2010	Revision	Amended to include the new criteria issued in CNST 2010/11 Standards
2.2	Aug 2011	Revision	Revised for new template. No clinical changes
2.3	Sep 2011	Revision	Changed guideline to become Vaginal Birth with Uterine Scar Guidelines
3.0	Sep 2011	Final	Approved by September guideline group and published on Trust Intranet
3.1	Oct 2012	Revision	Revised against the new CNST 2012-2013 Standards
4.0	Oct 2012	Final	Approved at Oct 12 Maternity Services Guidelines Group and noted at Oct 12 Maternity Services Patient Safety Forum
4.1	Feb 2013	Revision	Minor amendments by Corporate Governance to document control report and formatting for document map navigation and semi-automatic table of contents. Published on Trust intranet.
4.2	Aug 2013	Revision	Amended following implementing VBAC clinic
5.0	Oct 2013	Final	Approval at October Maternity Guidelines Group Meeting
5.1	Apr 2017	Revision	Consultation for updated version
6.0	Sept	Revision	Minor amendments following consultation

	2017		
7.0	Dec 2017	Final	Approved at Maternity services guidelines group meeting
7.1	July 2018	Revision	Changes made re induction of labour Circulated for consultation
8.0	Oct 2018	Final	Approved at Maternity Governance Forum Meeting

Main Contact Consultant Obstetrician& Gynaecologist Lady well unit North Devon District Hospital Raleigh Park Barnstaple, EX31 4JB	**Tel: Direct Dial** – 01271 322577 **Tel: Internal** – **Email**:
Lead Director Medical Director	
Superseded Documents	

Issue Date	**Review Date**	**Review Cycle**
October 2018	October 2021	Three years

Consulted with the following stakeholders: (list all)

- Senior Obstetricians
- Senior midwives
- Senior management team

Approval and Review Process

- Maternity Services Governance Forum

Local Archive Reference
G:\Corporate Governance\Compliance Team\Procedures & Policies\Published Polices\Maternity
Local Path
Maternity\Policies & Guidelines folder
Filename
Delivery After Previous Caesarean Section V8

Policy categories for Trust's internal website (Bob)	**Tags for Trust's internal website (Bob)**
Maternity services	VBAC

CONTENTS

1. Purpose

1.1. There has been continued debate about defining an acceptable caesarean delivery rate and what rate achieves optimal maternal and infant outcomes. However, there is a consensus (National Institute for Health and Care Excellence [NICE], Royal College of Obstetricians and Gynaecologists [RCOG] and American College of Obstetricians and Gynaecologists [ACOG]/ National Institutes of Health [NIH]) that planned VBAC is a clinically safe choice for the majority of women with a single previous lower segment caesarean delivery. Hence, counselling women for and managing birth after caesarean delivery are important issues.

1.2. The purpose of this guideline is to provide evidence-based information on antenatal and intrapartum care of pregnant women who have had previous caesarean delivery, with the options for delivery being either planned vaginal birth after previous caesarean delivery (VBAC) or elective repeat caesarean section (ERCS).

1.3. The policy applies to all maternity staff and must be adhered to. Noncompliance with this guideline may be for valid clinical reasons only. The reason for non-compliance must be documented clearly in the patient's notes.

2. Definitions /Abbreviations

2.1. Scar dehiscence is defined as disruption of the uterine muscle with intact uterine serosa at the level of previous caesarean section scar.

2.2. Scar rupture is defined as disruption of the uterine muscle extending to and involving the uterine serosa or disruption of the uterine muscle with extension to the bladder or broad ligament at the level of previous caesarean section scar.

2.3. VBAC - Vaginal Birth after Previous Caesarean Delivery

ERCS- Elective Repeat Caesarean Section

TOS or TOL - Trial of scar or trial of labour. VBAC is also referred to as trial of scar, or trial of labour.

LSCS - Lower Segment Caesarean Section.

MOD - Mode of delivery

CMW - Community midwife

IOL - Induction of labour

3. Responsibilities

3.1. All Staff:

- It is the responsibility of all healthcare professionals to ensure discussions and decisions made regarding the care of the woman are documented in the notes, and that the woman is able to make informed decisions about her on-going care.

- It is the responsibility of the healthcare professional who is involved in care of woman with previous caesarean delivery to escalate any concern if there is one at any stage.

3.2. Role of midwives

- Ensuring that women have appropriate information with which to make an informed choice about the mode of delivery.
- At VBAC clinics, ensure that the previous medical and delivery records are reviewed to identify the suitability of trial of vaginal delivery.
- Ensuring that a full discussion is undertaken and clearly documented in hospital and handheld notes at VBAC clinics.
- Ensuring that all women with previous caesarean who have any obstetric or medical risk factors other than singleton pregnancy with previous single lower segment caesarean section have an appointment at consultant led antenatal clinic.

3.3. Role of obstetricians:

- Ensuring that the previous medical and caesarean delivery records are reviewed.
- Ensuring that a complete and individualised assessment for suitability for VBAC is performed prior to finalising the plan for delivery.
- Ensuring that women have appropriate information with which to make an informed choice about mode of delivery.
- Ensuring that a full discussion is undertaken and clearly documented in hospital and handheld notes.
- It is the responsibility of the consultant obstetrician for making decision to induce or augment labour and the proposed method of induction.

4. General Principles of "Delivery after Previous Caesarean Section"

4.1. Antenatal management

4.1.1. Assessment for suitability of VBAC

a. Planned VBAC is appropriate for majority of women with a singleton pregnancy of cephalic presentation at 37+0 weeks or beyond who have had a single previous lower segment caesarean delivery, with or without a history of previous vaginal birth.

b. Planned VBAC is contraindicated in women with previous uterine rupture or classical caesarean scar and in women who have other absolute contraindications to vaginal birth (e.g. major placenta praevia).

c. In women with complicated uterine scars (e.g. significant inadvertent uterine extension at the time of primary caesarean, previous myomectomy, previous uterine perforation), decisions should be made on a case-by-case basis by a consultant obstetrician with access to the details of previous surgery.

d. Women who have had two or more prior lower segment caesarean deliveries may be offered VBAC after counselling by a consultant obstetrician.

4.1.2. Antenatal counselling

a. At booking, community midwife will carry out the risk assessment and then refer to midwife VBAC clinic or consultant led antenatal clinic for antenatal counselling. (Appendix A)

- Women with previous one lower segment caesarean section without any other obstetric or medical or fetal complications will be referred to midwife VBAC clinic.
- Those with any other risk factor should be referred to consultant led antenatal clinic.

b. At antenatal counselling appointment (together with either dating scan or detailed scan), previous caesarean section delivery records should be reviewed to identify any factor which would be useful for decision making in current pregnancy (such as indication, type of uterine incision, any perioperative complications). If the woman is transferred from other hospitals, information about the nature of the previous LSCS must be requested.

c. Women should be made aware of

- the risks and benefits of planned VBAC versus ERCS.
- success rate of planned VBAC is 72–75% and it increases to 85-90% in women with previous vaginal delivery, particularly previous VBAC.
- planned VBAC is associated with an approximately 1 in 200 (0.5%) risk of uterine rupture.
- the absolute risk of birth-related perinatal death associated with VBAC is extremely low and comparable to the risk for nulliparous women in labour.
- ERCS is associated with a small increased risk of placenta praevia and/or accreta in future pregnancies and of pelvic adhesions complicating any future abdominopelvic surgery.

d. Discussion should be individualised to the woman's medical circumstances considering her individual chance of VBAC success and future reproductive preferences.

e. Documentation

- The antenatal counselling of women with a previous caesarean birth should be documented in the notes using VBAC checklist. (Appendix B)
- A patient information leaflet should be provided with the consultation.

f. If VBAC is decided,

- Woman should be advised that planned VBAC should be conducted in the hospital with continuous intrapartum care and monitoring with resources available for immediate caesarean delivery and neonatal resuscitation.

- Waiting for spontaneous labour is encouraged.

g. If ERCS is decided,

- Woman should be informed that, it should not be carried out before 39 weeks of gestation because of the risk of neonatal respiratory morbidity (3-4%), unless indicated otherwise.

- Plan of care should also include VBAC or Emergency caesarean section if labour starts spontaneously before this date and it must be documented.

4.1.3. Final decision for MOD

a. After initial counselling visit, women should continue their antenatal care with community midwives until 36 weeks gestation when they will be reviewed at the consultant led antenatal clinics

b. A final decision for mode of birth should be agreed upon by the woman by 36 weeks gestation.

c. If the woman is requesting ERCS in the absence of medical or other obstetric indication, second opinion could be offered

d. Once an informed decision is made, an individual clear plan must be documented in the woman's hand held maternity record and the hospital notes.

4.1.4. Placenta localization

a. If anterior low-lying placenta is identified at 20 weeks gestation, repeat ultrasound should be organised at 30-32 weeks gestation at the fetal scanning clinic.

b. If anterior low lying placenta is confirmed on repeat scan, MRI scan should be organised at 32-34 weeks gestation to assist in excluding/diagnosing morbidly adherent placenta.

4.2. Induction/ Augmentation of labour

4.2.1. Women with VBAC as chosen MOD, should have a review by a consultant or SAS doctor at 40-41+0 weeks of gestation if spontaneous onset of labour has not ensued.

4.2.2. Based on following individual circumstances, further management plan must be discussed, agreed with the woman and documented in the patient's notes.

- bishop score

- previous vaginal birth

- presence of any other obstetric or fetal complications
- patient's motivation/preference on induction of labour, membrane sweep, spontaneous VBAC and her future reproductive preferences.

4.2.3. The decision for induction following one previous LSCS should be made/ discussed with consultant obstetrician.

4.2.4. Woman who has chosen to have IOL should be informed of two to three-fold increased risk of uterine rupture and 1.5-fold increased risk of caesarean delivery, compared with spontaneous labours.

4.2.5. Induction of labour by using mechanical methods (amniotomy or balloon catheter) is associated with a lower risk of scar rupture compared with induction using prostaglandins.

4.2.6. If ARM is not possible, then induction using a balloon should be offered **(see IOL guideline).** Caesarean section should be offered as an alternative to IOL.

4.3. Intra-partum management

4.3.1. SAS doctor or consultant obstetrician on call should review all women with a previous caesarean section on admission. Management plan should be reviewed and if no plan made previously, a plan to be made, agreed with the Consultant on call and documented.

4.3.2. All women in established VBAC labour should receive

- Intravenous access with full blood count and blood group and save
- Oral ranitidine 150 mg 8 hourly
- Continuous electronic fetal monitoring
- Women may use the birthing pool for pain relief if telemetry CTG is used.
- Regular monitoring of maternal symptoms and signs
- Regular assessment of progress in labour at least 4 hrly and more often if necessary.

4.3.3. Epidural anaesthesia is not contraindicated. An increasing requirement for pain relief in labour should raise awareness of the possibility of an impending uterine rupture.

4.3.4. Oxytocin to augment can only be considered after a full obstetric assessment including a vaginal examination and then discussion **must** take place with the Consultant Obstetrician on-call. The decision to carry out a fetal blood sample must be discussed with the Consultant Obstetrician before it is taken, as abnormal CTG may be the earliest sign of uterine rupture.

4.3.5. Emergency caesarean section should be considered, if there is no significant progress of labour in 6-8 hrs despite optimal uterine contraction.

4.3.6. There is no single pathognomic clinical feature that is indicative of uterine rupture but the presence of any of the followings peripartum should raise the possibility of this event.

- Abnormal CTG
- Severe abdominal pain, especially if persisting between contractions
- Acute onset scar tenderness
- Abnormal vaginal bleeding or haematuria
- Cessation of previously efficient uterine activity
- Loss of station of presenting part
- Maternal tachycardia, hypotension or shock
- Chest pain or shoulder tip pain, sudden onset of shortness of breath
- Change in abdominal contour and inability to pick up fetal heart rate at the old transducer site

4.3.7. Management of impending or possible uterine rupture. It is an obstetric emergency.

- Pull emergency bell.
- Activate obstetric emergency bleep and state category 1 caesarean section.
- Give oxygen 8l/min.
- Commence fluid resuscitation.
- Urgent transfer to theatre.
- Crossmatch 2 units blood
- Inform consultant on-call.

4.4. Planned VBAC in special circumstances

4.4.1. Planned preterm VBAC has similar success rate to planned term VBAC but with a lower risk of uterine rupture.

4.4.2. There is limited evidence in view of safety and efficacy of planned VBAC in women with twin gestation, fetal macrosomia (bearing in mind that birth weight cannot be accurately predicted by antenatal ultrasound), antepartum still birth and short interdelivery interval.

4.4.3. If the patient is against guideline for Consultant Unit as place of delivery, manager on-call in conjunction with the community midwifery manager is to discuss an individual plan agreed with the woman.

5. Education and Training

5.1. All relevant healthcare professionals will be able to demonstrate their competence in ante-natal and intra-partum management of a woman with previous caesarean delivery.

5.2. Responsibilities for education and training lies with the senior obstetric/midwifery team. It is the responsibility of the healthcare professional who is involved in care of woman with previous caesarean delivery to escalate any concern if there is one at any stage.

6. Consultation, Approval, Review and Archiving Processes

6.1. The authors consulted with all relevant stakeholders. Please refer to the Document Control Report.

6.2. Final approval was given by the Maternity services guidelines group on.

6.3. The guidelines will be reviewed every 3 years. The author will be responsible for ensuring the guidelines are reviewed and revisions approved in accordance with the Document Control Report.

6.4. All versions of these guidelines will be archived in electronic format by the author within the Maternity Team policy archive.

6.5. Any revisions to the final document will be recorded on the Document Control Report.

6.6. To obtain a copy of the archived guidelines, contact should be made with the maternity Team/ author.

7. Monitoring Compliance with and the Effectiveness of the Guideline

7.1. This guideline applies to all maternity staff and must be adhered to. Non-compliance with this guideline may be for valid clinical reasons only. The reason for non-compliance must be documented clearly in the patient's notes.

7.2. Monitoring of implementation, effectiveness and compliance with the "Delivery after Previous Caesarean Section" Guidelines is the responsibility of the senior clinical/ management team.

8. References

8.1. American College of Obstetricians and Gynaecologists. ACOG Practice bulletin no. 115: *Vaginal birth after previous caesarean delivery*. Obstet Gynecol 2010; 116:450–63.

8.2. Knight M, Brocklehurst P, Spark P et al (2012) uterine rupture by Intended mode of delivery in the UK: A National Case-Control Study. National Perinatal Epidemiology Unit. PLoS Medicine 9; 1-12.

8.3. National Institute for Health and Clinical Excellence. *Caesarean section*. NICE clinical guideline 132. Manchester: NICE; 2011.

8.4. National Institute for Health and Clinical Excellence. *Caesarean Section Quality Standards*, QS32: NICE; June 2013.

8.5. National Institute for Health and Clinical Excellence. *Intrapartum care for healthy women and babies.* NICE clinical guideline CG190. NICE; 2014.

8.6. National Institute for Health and Clinical Excellence. Insertion of a double balloon catheter for induction of labour in pregnant women without previous caesarean section. Interventional procedures guidance [IPG528]. NICE; July 2015.

8.7. Royal College of Obstetricians and Gynaecologists. *Birth after previous caesarean birth*. Green-top Guideline No.45.London: RCOG;2015.

8.8. Royal College of Obstetricians and Gynaecologists. *Placenta Praevia, Placenta Praevia Accreta and Vasa Praevia: Diagnosis and Management*. Green-top Guideline No. 27. London: RCOG; 2011.

8.9. Royal College of Obstetricians and Gynaecologists. Induction of Labour at Term in Older Mothers. Scientific Impact Paper No. 34. London: RCOG; 2013.

8.10. Society of Obstetricians and Gynaecologists of Canada (2005). Guidelines for vaginal birth after previous caesarean birth No: 155; Int J Gynaecol Obstet. 89 (3): 319-31.

8.11. Shipp TD, Zelop CM, Repke JT et al (2001) Interdelivery interval and risk of symptomatic uterine rupture. Obstet Gynecol. 97 (2):175-7.

9. Associated Documentation

9.1. Auscultation and Electronic monitoring guidelines

9.2. Use of Oxytocin in First and Second Stage of Labour guidelines

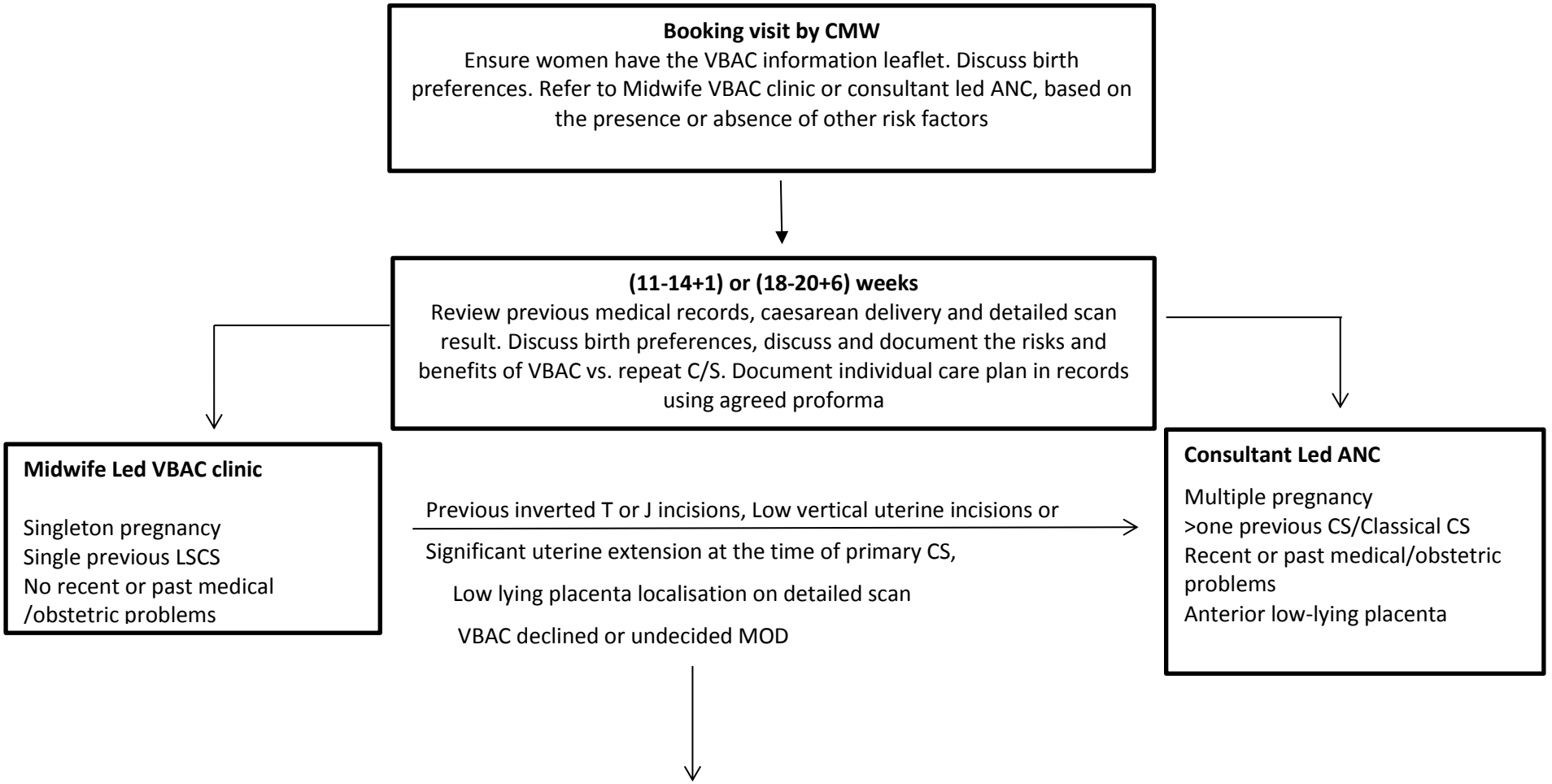
9.3. Induction of labour guidelines

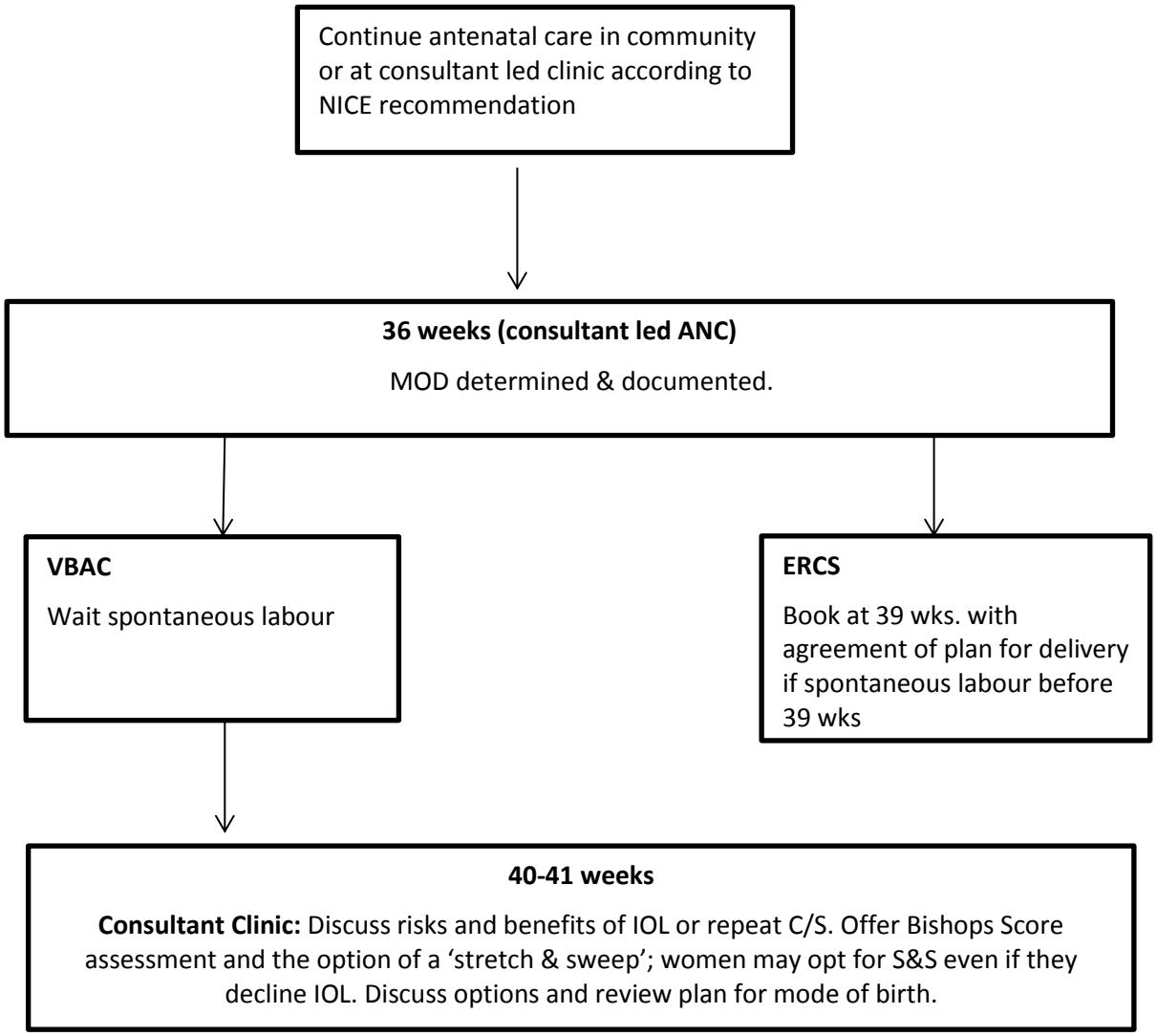
10. APPENDIX A: KEYPOINTS OF THE GUIDELINE

- **A final decision for mode of birth should be agreed upon by the woman by 36 weeks gestation.**
- **Once an informed decision is made, an individual clear plan must be documented in the woman's hand held maternity record and the hospital notes.**
- **The decision for induction following one previous LSCS should be made/ discussed with consultant obstetrician.**
- **If ARM is not possible, then induction using a balloon should be offered (see IOL guideline). Caesarean section should be offered as an alternative to IOL.**
- **Epidural anaesthesia is not contraindicated. An increasing requirement for pain relief in labour should raise awareness of the possibility of an impending uterine rupture.**
- **Oxytocin to augment can only be considered after a full obstetric assessment including a vaginal examination and then discussion must take place with the Consultant Obstetrician on-call. The decision to carry out a fetal blood sample must be discussed with the Consultant Obstetrician before it is taken, as abnormal CTG may be the earliest sign of uterine rupture.**
- **If ERCS is decided, plan of care should also include VBAC or Emergency caesarean section if labour starts spontaneously before this date and it must be documented.**

11. APPENDIX B: ANTENATAL CARE PATHWAY FOR WOMEN WITH PREVIOUS CAESAREAN SECTION

Much of the care given to pregnant women who have had a previous caesarean section will follow the care pathway for healthy pregnant women developed in accordance with the NICE guidance. This addition supplements the routine pathway and should be used in conjunction with it.




Continue antenatal care in community or at consultant led clinic according to NICE recommendation
36 weeks (consultant led ANC)
MOD determined & documented.
VBAC
Wait spontaneous labour
ERCS
Book at 39 wks. with agreement of plan for delivery if spontaneous labour before 39 wks
40-41 weeks
Consultant Clinic: Discuss risks and benefits of IOL or repeat C/S. Offer Bishops Score assessment and the option of a 'stretch & sweep'; women may opt for S&S even if they decline IOL. Discuss options and review plan for mode of birth.

12. Appendix (C) Vaginal Birth after Caesarean Section (VBAC) Discussion Form

(this form is to be completed at the Midwife led VBAC clinic or at Consultant led ANC with the woman)

Patient's details	Date: Time:

- Success rate of VBAC 72%-76% (90% if previous vaginal delivery) …… ☐
- Risk of the scar in the uterus opening 0.5% + the complications of this…… ☐
- Increased risk of blood transfusion with VBAC…… ☐
- Risk to baby similar to woman having her first baby, but higher than with a planned caesarean section…… ☐
- Need to deliver in hospital setting…… …. ☐
- Need for intravenous access and continuous electronic fetal monitoring in established labour …… …… ☐
- Induction and /or augmentation of labour, if needed, will increase the risk of the scar rupture and associated complications by 2-3 times…….... ☐
- ERCS is associated with a small increased risk of placenta praevia and or accrete in future pregnancies and of pelvic adhesions complicating any future abdominopelvic surgery…… ☐

- **Intended mode of delivery at present time – VBAC / Elective CS / undecided**
  (NB this can be changed at any time throughout your pregnancy)

- **If decision is for an elective CS - plans if admitted in labour –**
  VBAC / emergency LSCS / to re-discuss at the time. (please circle)

- **If decision is to attempt a VBAC – plans if not laboured by T+12 –**
  Obstetric Review Stretch & Sweep /ARM only / IOL /for caesarean section
  Other: ……..

- **If decision for IOL, name of Consultant discussed with**: …….

The above points have been discussed with me and I have had the opportunity to ask questions. I have received the VBAC Information Sheet.

Signed…….Printed……..
(Mother)

Date…….
Midwife/Doctor's signature……Printed……