Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

WOMEN'S HEALTH AND PAEDIATRICS
MATERNITY UNIT

VAGINAL BIRTH AFTER CAESAREAN SECTION(VBAC) MANAGEMENT GUIDELINE including Information regarding Uterine scar Dehiscence

Amendments			
Date	Page(s)	Comments	Approved by
7.07.09	3	Antenatal Care section updated	Women's Health Guidelines Group
07.07.09	7	Appendix 1: Flow chart updated	Women's Health Guidelines Group
07.07.09	9	Appendix 3: Audit Tool for Care Provision to women with previous LSCS	Women's Health Guidelines Group
07.07.09	10 & 11	Equality Impact Assessment & Proforma updated	Women's Health Guidelines Group
July 2010	Appendix 1	New previous caesarean section flow chart inserted	Women's Health Guidelines Group
Nov 2014		Whole document review	Women's Health Guidelines Group
Dec 2018		Whole document review	Women's Health Guidelines Group

Compiled by: James Thomas, Consultant Obstetrician & Gynaecologist

In Consultation with: All Consultant Obstetricians & Departmental Operational Managers, Supervisor of Midwives & Associate Director of Midwifery

Ratified by: Women's Health Guidelines Group

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Target Audience:	Maternity Services Staff and Users
Impact Assessment Carried Out By:	Women's Health Guidelines Group

GUIDELINES FOR THE MANAGEMENT OF VAGINAL BIRTH AFTER CAESAREAN SECTION AND INFORMATION REGARDING UTERINE SCAR DEHISCENCE

Introduction

There are very few medical reasons for a repeat elective caesarean section after one previous caesarean section. The majority of operations are performed for maternal choice. Women need to be fully informed of the risks and benefits of both vaginal delivery and repeat elective caesarean section in an unbiased and non-judgemental manner, to allow them to make a fully informed decision.

Antenatal care

A decision will be made antenatally regarding mode of delivery (plan for vaginal birth after caesarean section [VBAC] or elective Caesarean section).

The booking midwife should give the woman an appointment for the 'VBAC discussion group' by 16 weeks gestation. There, they will receive full counselling in a standardised manner and in a relaxed setting about the risks and benefits of both options, and possible implications for subsequent pregnancies and labours of each choice (NICE, 2004). Women can agree a decision about their mode of birth with a Consultant Obstetrician at 24-32 weeks gestation. They will have an individualised plan of care, including mode of birth, agreed and clearly written in their notes. There should be consideration regarding possibilities including PROM, monitoring and Induction of Labour.

The care pathway for women with previous LSCS can be seen at Appendix 1 and shows the responsibilities of each member of staff in the woman's care. All women with one previous LSCS should be given a 'Birth after a previous Caesarean Section' Patient Information leaflet and this is to be documented in woman's maternity records.

Birth Reflections

There are many women who have suffered psychological trauma relating to their previous delivery.

Issues relating to this may well need to be addressed prior to delivery, regardless of their decision to have either an Elective Repeat Caesarean Section or a VBAC.

All women who have had a previous caesarean section should be offered the chance of an appointment with the birth reflection midwives at their booking appointment.

Uterine Scar Dehiscence

Uterine scar dehiscence or rupture is a very rare event. Incidence increases where there has been previous uterine surgery or trauma. The rates of scar dehiscence can be quoted as follows (RCOG, 2007);

Type previous surgery or trauma	Incidence of uterine scar dehiscence (RCOG, 2007)	Equivalent rate of scar dehiscence for individual
No previous uterine surgery/trauma	2 per 10,000	1woman in every 5000
Elective CS following previous LSCS	12 per 10,000	1 in 833
VBAC labour, following one previous LSCS	36 per 10,000	1 in 277
VBAC labour following two previous LSCS*[1]	92 per 10,000	1 in 109
VBAC labour following three or more prev LSCS	No studies to inform	No studies to inform

**Data suggests that the difference in rates of scar dehiscence for VBAC after 1 and after 2 previous CS is not statistically significant (RCOG, 2007).*

Uterine scar dehiscence is a serious event which is managed by urgent delivery of the baby and repair of the uterus. The incidence of infant mortality and morbidity is quoted as follows (NICE, 2004; RCOG, 2007).

Out of every 10,000 women who attempt VBAC, there will be;

- 9964 women who do not experience uterine scar dehiscence
- 12 uterine scar dehiscence's in which the baby is unaffected.
- 12 uterine scar dehiscences in which the baby is admitted to NICU (+/- lasting damage).
- 12 uterine scar dehiscences in which the baby dies (this is equivalent to the Perinatal Mortality Rate for first pregnancies)

Where there is a previous CS the incidence of uterine scar dehiscence and perinatal infant mortality and morbidity needs to be discussed within the context of the reported rates of 72-76% for VBAC labours (Recent maternity statistics).

Where women have already had a successful VBAC, the success rate for subsequent labours is 90%.

Women in pre-term labour have a lower incidence of uterine scar dehiscence (Durnwald et al, 2006) but similar VBAC success rates to those having VBAC at term, women having VBAC labour at or beyond 41 weeks have a lower success rate (all other references RCOG, 2007).

[1] The likelihood of needing a blood transfusion and/or hysterectomy is higher for these women than for women having VBAC labour following one previous LSCS.

Type of incision	Occurrence of scar dehiscence if VBAC
LSCS tranverse uterine incision	0.2-1.5 % Estimate by ACOG, 1999
LSCS vertical uterine incision	1 – 7 % Estimate by ACOG, 1999
Classical CS (midline incision in uterine body)	4 – 9 % Estimate by ACOG, 1999
Inverted T or J incision	2% (RCOG, 2007)
Previous myomectomy/ complex uterine surgery	Insufficient and conflicting evidence (RCOG, 2007).

Women who have an agreed plan for VBAC can remain under the care of the community midwife until admitted in labour/ attend post-dates pregnancy review at a consultant obstetrician clinic, unless they have another ongoing obstetric issue or wish to discuss the plan of management further.

Special circumstances late in pregnancy

Labour before 36 completed weeks; If a woman who is planning a VBAC labours spontaneously before 37 weeks, she must be reviewed by the obstetric team and a documented plan made.

Breech presentation; women can be referred for a presentation scan at Maternity Day Assessment Unit in the usual way. External Cephalic Version is only a relative contraindication where there is previous uterine surgery/trauma; the MDAU midwives will refer women to the relevant consultant obstetrician.

Post-dates pregnancy; Women planning VBAC will have had an appointment made for post-dates discussion at consultant obstetric clinic. Discussion should be preceded by a cervical assessment +/- sweep to enable discussion regarding the most appropriate form of induction and its likelihood in succeeding. Induction of labour advice given will depend upon the reasons for previous CS and the increase in incidence of uterine scar dehiscence that each method brings.

These are;

Circumstances surrounding induction of labour	Incidence of scar dehiscence (from RCOG, 2007)	Equivalent rate of scar dehiscence for individual
Spontaneous VBAC labour, one previous LSCS	36 per 10,000	1 woman in every 277 women
Oxytocin	87 per 10,000	1 in 126
Prostaglandins	140 per 10,000	1 in 71

Midwives can offer and perform a membrane sweep in the community from 41 weeks. Women may wish to postpone induction or elective CS for post dates until 42 weeks so as to maximise the possibility of spontaneous labour.

Pre-labour rupture of membranes at term and planning VBAC; induction of labour carries an increase in the risk of uterine scar dehiscence and women may wish to avoid this and wait for labour to establish spontaneously. There is no data which looks at pre-labour spontaneous rupture of membranes in women planning VBAC. NICE (2001) suggests that labour starts spontaneously within 24 hours for over 80% of women whose membranes rupture prior to labour. The plan for supporting expectant management for VBAC women may require the woman to remain in hospital; a plan for the length and location of waiting and the required observations will be made in conjunction with a consultant obstetrician.

Women who make a decision to have a VBAC at home

It is recommended that women who have had a previous LSCS deliver in hospital.

If a woman chooses to deliver her baby at home, the midwife should arrange for the woman to see a Community Team Leader and make an appointment with a consultant obstetrician, to confirm a plan of care for home VBAC.

A written plan must be made. A copy should be 'filed' under archived reports on Badgernet and a hard copy placed on the 'Labour Plan' clipboard on Labour Ward.

When the midwife attends the woman at home and established labour is confirmed, the Labour Ward Shift Leader must be informed. The written plan must then be shared with the Obstetric Team of the day. ***If a woman contacts the unit and wishes to deviate from the agreed plan she must be invited to attend and discuss this with a consultant obstetrician.***

(Refer to ASPH Guidelines for the Management of Homebirth)

Management of VBAC labour:

Routine pathway
Women should be advised to come to labour ward when they believe they are in labour. If an antenatal decision about mode of delivery is not clearly documented in the notes, the woman should be reviewed by the obstetric registrar and the case should be discussed with the duty / on-call consultant obstetrician. The plan of care as below must be clearly documented in the handheld records.

The VBAC care package aims to

a- Monitor the condition of the baby and use this to make a judgement on the likelihood of uterine scar dehiscence
b- Avoid prolonged or uncorrected dysfunctional labour
c- Keep the woman safely prepared should a category 1 CS become necessary.

Routine Care measures include;

- Site a 16 gauge intravenous cannula
- Take blood for full blood count, group and save
- Continuous CTG monitoring (55-72% of uterine scar dehiscences are preceded by an abnormal fetal heart rate pattern; RCOG, 2007)
- Restrict oral intake to water once in established labour
- Administration of ranitidine (6 hourly) and metoclopramide (8 hourly)
- Strict use of partogram
- Observe for suggestions of a dehisced uterus:
    - abnormal CTG
    - vaginal bleeding
    - constant scar pain or tenderness, particularly when acute in onset.
    - development of haematuria
    - maternal tachycardia, hypotension or shock.
    - cessation of uterine contractions.
    - shoulder tip pain
    - loss of station of presenting part.
- Epidural anaesthesia is not contraindicated

Suboptimal progress in labour as defined by partogram

Progress in labour should be closely monitored; deviations must be reported to the team leader and obstetric registrar. **The use of oxytocin may be appropriate but must be discussed with the duty consultant before recommending it to the woman; the standard regime should be followed.** Progress should be assessed by both cervical dilatation and descent of the head (by abdominal and vaginal assessment). If progress remains poor despite oxytocin augmentation, Caesarean section must be advised.

Management of Second Stage:

- The length of the second stage should be carefully monitored.

- If the woman has an epidural it is acceptable to allow an hour (from full dilatation) for descent of the head before active pushing is started.

- Progress should be reviewed by the midwife after 30 minutes of active pushing and if the vertex is not visible the team leader should be informed

- If the vertex is still not visible after 45 minutes of pushing, the obstetric registrar must review the woman.

- If birth is not imminent within 60 minutes of active pushing expedited delivery should be advised.

- If any unreasonable delay is suspected, then the consultant on call should be informed.

Suspected uterine rupture or scar dehiscence

If at any stage there is a clinical suspicion of uterine rupture or scar dehiscence **immediate** delivery is required. The duty consultant must be informed by the medical or midwifery staff but Caesarean section should not be delayed.

Maternal resuscitation may be necessary before delivery.

If uterine rupture or scar dehiscence is confirmed, the on call consultant obstetrician should be contacted and asked to attend. Operative management will depend on the site and severity of the rupture or scar dehiscence. Hysterectomy may be necessary in some circumstances. Be prepared for DIC.

Any cases of uterine rupture must be reported on Datix. A full case review will then take place.

Management of third stage

This should be actively managed, as previous uterine surgery may make the uterus less able to perform effectively in the third stage. The woman should be observed for bleeding following the completion of third stage, and for the presence of haematuria.

Monitoring

Compliance with this guideline will be monitored yearly by **ongoing audits and** review of maternity records. Where deficiencies are identified action plans will be developed and changes implemented and disseminated as required. Audit tool see Appendix 3

References

ACOG Practice Bulletin. Vaginal birth after previous caesarean delivery. International Journal of Gynaecology and Obstetrics 1999;66:197-204.

Durnwald CP et al (2006) The Maternal-Fetal Medicine Unit caesarean registry: safety and efficacy of a trial of labour in pre-term pregnancy after a previous cesarean delivery. Am J Obstet Gynecol 2006. 195:1119-26

National Institute of Clinical Excellence (NICE) 2004 *Caesarean section clinical guideline No: 13.* www.nice.org.uk

NHS Institute for Innovation (2007) Focus on Normal Birth and Reducing Caesarean Sections. www.Institute.nhs.uk . go to the section on Quality and Value, then high volume care

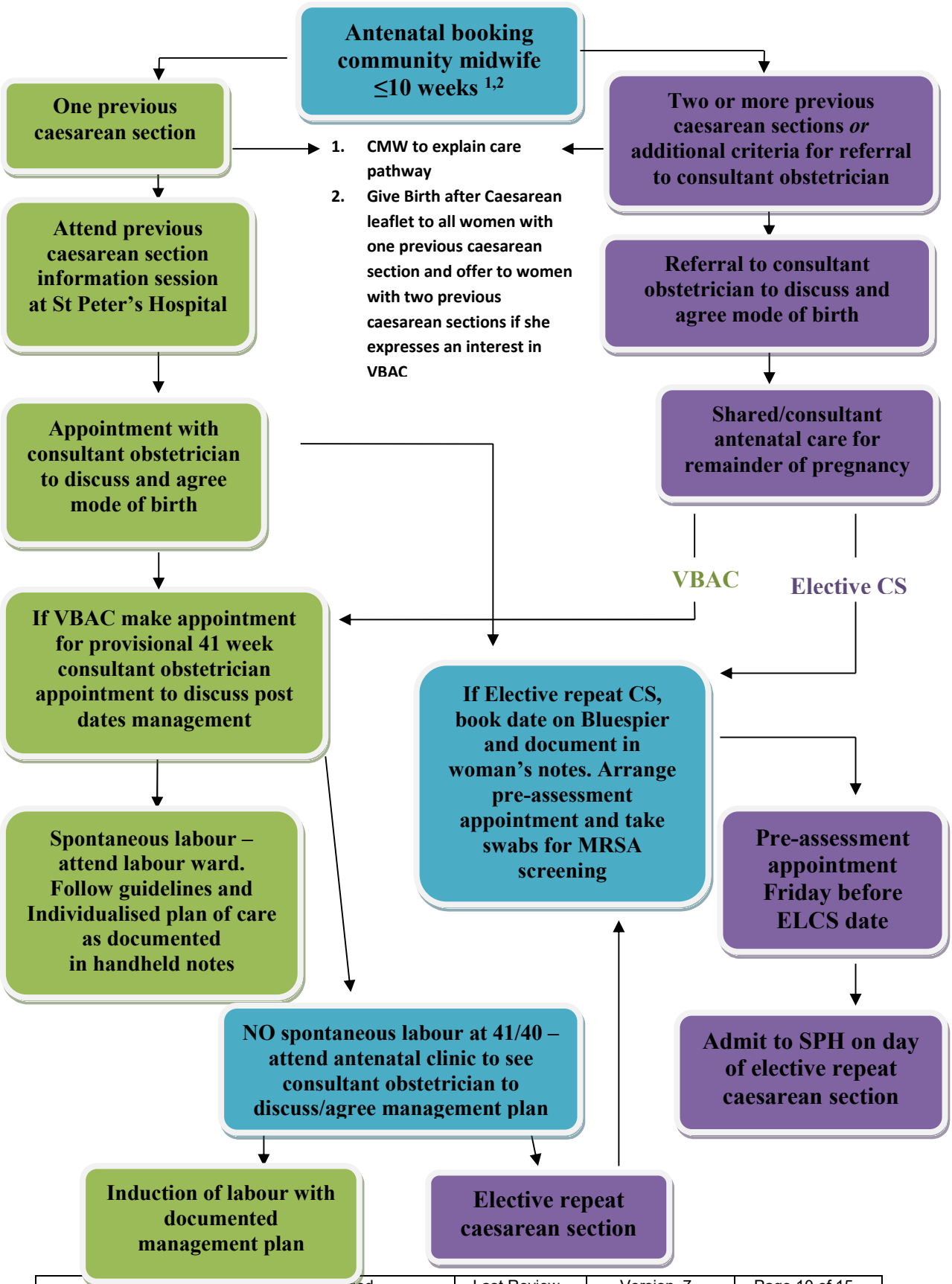
Royal College of Obstetricians and Gynaecologists (RCOG) 2001 *The National Sentinel Caesarean Section Audit*

Royal College of Obstetrician and Gynaecologists (RCOG) 2002 *The Rising Caesarean Rate: From audit to action. Conference Report.* www.rcog.org.uk

Royal College of Obstetrician and Gynaecologists (RCOG) 2007 Birth after previous caesarean birth. Green Top Guideline No. 45. www.rcog.org.uk

Appendix 1

Previous Caesarean Section Flow Chart



Appendix 3; Audit Tool for Care Provision to Women with Previous Caesarean Section

Hospital Number:

Documented Antenatal Care Plan					
Leaflet given	YES	NO	Not recorded		
Appt attendance re mode of birth	< 30 weeks	≥30 weeks	No record of discussion re mode of birth antenatally	In labour when plan made *State reason if known*	
Individual Management Plan for labour documented	YES	NO	**Individual plan for monitoring of FH in labour**	YES	NO
Labour Care					
Circumstances	Induction – post-dates	Induction – pre-labour srom	Spontaneous onset at any gestation	Other *State:*	
Labour care provided (circle all recorded)	CTG IV access FBC G&S partogram…… ranitidine metoclopramide epidural oral intake water only				
Second stage	Total Time in second stage (mins) Time actively pushing (mins)	Vertex not visible 30 mins active pushing Shift leader informed yes / no	Vertex not visible 45 mins active pushing Registrar review obtained yes / no	Birth not imminent 60 mins active pushing Plan for delivery made yes / no	
Third stage	Active at em CS	Active at instrumental birth	Active at normal birth	Physiological *State reason*	
Other data					
Actual place of birth	Hospital – planned	Hospital – emergency transfer State reason:	Home – planned	Home/ ambulance – not planned	

EQUALITY IMPACT ASSESSMENT TOOL

Name: **Women's Health Guidelines Group**

Policy/Service: **Vaginal Birth After Caesarean Section (VBAC)**

Background • Description of the aims of the policy • Context in which the policy operates • Who was involved in the Equality Impact Assessment
• To offer guidance to healthcare professionals caring for women who have had a previous caesarean section. • Maternity Services • Women's Health Guidelines Group
Methodology • A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age) • The data sources and any other information used • The consultation that was carried out (who, why and how?)
Consultation was undertaken at the Annual Perinatal audit day May 2009, with multidisciplinary attendance, including lay members of the MSLC
Key Findings • Describe the results of the assessment • Identify if there is adverse or a potentially adverse impacts for any equalities groups
No impact
Conclusion • Provide a summary of the overall conclusions
No impact
Recommendations • State recommended changes to the proposed policy as a result of the impact assessment • Where it has not been possible to amend the policy, provide the detail of any actions that have been identified • Describe the plans for reviewing the assessment
None

Guidance on Equalities Groups

Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)	**Religion or belief** (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration)
Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)	**Sexual orientation including lesbian, gay and bisexual people** (consider whether the policy/service promotes a culture of openness and takes account of individual needs
Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)	**Age** (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior)
Culture (consider dietary requirements, family relationships and individual care needs)	**Social class** (consider ability to access services and information, for example, is information provided in plain English?)

If further assessment is required please see the Integrated Single Equality Scheme.

For advice in respect of answering the above questions, please contact, HR Manager, on extension 2552.

PROFORMA FOR RATIFICATION OF POLICIES AND GUIDELINES BY RATIFYING COMMITTEE

Policy/Guidelines Name:	Vaginal Birth After Caesarean Section(VBAC)
Name of Person completing form:	Women's Health Guidelines Group
Date:	November 2014

Author(s)	Mr James Thomas
Name of author or sponsor to attend ratifying committee when policy/guideline is discussed	Mr James Thomas
Date of final draft	November 2014
Has this policy/guideline been thoroughly proof-read to check for errors in spelling, typing, grammar and consistency?	Yes
By whom:	Women's Health Guidelines Group
Is this a new or revised policy/guideline?	revised

Describe the development process used to generate this policy/guideline.
Women's Health Guidelines Group, Supervisors of Midwives
Who is the policy/guideline primarily for?
Maternity services staff & users
Is this policy/guideline relevant across the Trust or in limited areas?
Maternity service
How will the information be disseminated and how will you ensure that relevant staff are aware of this policy/guideline?
Newsletters, intranet, mandatory training sessions, notice boards
Describe the process by which adherence to this policy/guideline will be monitored.
Compliance with this policy will be audited using the tool provided at Appendix 3. The results of this audit will be reviewed at the labour ward forum and action plans monitored
Is there a NICE or other national guideline relevant to this topic? If so, which one and how does it relate to this policy/guideline?
See references
What (other) information sources have been used to produce this policy/guideline?
Focus on Normal Birth and Reducing Caesarean Section (DH policy, 2007)
Has the policy/guideline been impact assessed with regard to disability, race, gender, age, religion, sexual orientation?
No impact
Other than the authors, which other groups or individuals have been given a draft for comment?
Women's Health Guidelines Group, Labour Ward Forum, SOM's
Which groups or individuals submitted written or verbal comments on earlier drafts?
Women's Health Guidelines Group, Labour Ward Forum, SOM's
Who considered those comments and to what extent have they been incorporated into the final draft?
Women's Health Guidelines Group,
Have financial implications been considered?
No impact