

CLINICAL GUIDELINE FOR VAGINAL BIRTH AFTER CAESAREAN SECTION (VBAC)

1. Aim/Purpose of this Guideline

1.1. Due to a rise in the caesarean section rate there are increasing numbers of pregnant women who have had a prior caesarean section. These women should all receive a referral to an obstetric consultant clinic where they should receive counselling and discussion about their options for delivery so that they are aware of the risks and benefits of both elective Caesarean section and vaginal birth.

1.2. This guideline informs obstetrics and midwives on the management of a woman who has had a previous caesarean section during pregnancy and labour

2. The Guidance

2.1. Patient Suitability for VBAC

- Women who have had one uncomplicated lower section caesarean section (LSCS), and have an otherwise uncomplicated pregnancy should be encouraged to attempt a VBAC. The success rate is between 72 to 75% if the woman has never had a vaginal birth and 85 to 90% if she has
- VBAC may also be suitable for other women after consideration and discussion of the risks
- The success rate for women who have had a previous vaginal birth and who had a LSCS for fetal reasons is extremely good and these women in particular should be encouraged and supported to attempt a VBAC.
- Women admitted in preterm labour with a history of previous LSCS have a similar success rate to those who labour at term but a lower risk of uterine rupture¹ and therefore should be encouraged to reconsider a VBAC even though they may have originally requested an elective LSCS.

2.2. Situations in which further discussion with a consultant is needed:-

- Women with a complicated pregnancy or difficulties at previous CS
- Two OR MORE caesarean sections
- Women requiring induction of labour

2.3. Contraindications¹

- Previous uterine rupture
- Previous classical caesarean section

2.4. Antenatal Counselling and Management

- A VBAC Information Sheet (appendix A) should be given to the woman by the community midwife at the time of booking and this should be documented in the woman's hand held notes. The woman should be encouraged to read this prior to attending the consultant clinic.
- The woman should be seen in the consultant clinic before 24 weeks gestation. Any requirement for additional obstetric clinical appointments should be individualised.
- At the clinic suitability for VBAC should be considered. If there are any concerns identified by a middle grade obstetrician regarding the suitability this should be discussed with the consultant
- Risks of VBAC should be discussed with the woman and include:-
 - 0.5 % risk of uterine rupture, which can be associated with significant maternal and perinatal morbidity/mortality. The risk is lower if a previous vaginal birth has occurred. The risk is no higher after two previous CS
 - 4/10,000 risk of perinatal mortality which is no different to the risk for women having their first birth but higher than that with elective LSCS
 - <1 in 1000 risk of neonate developing hypoxic ischemic encephalopathy (which has variable outcomes).
 - 1% additional risk haemorrhage requiring a blood transfusion
 - The risk of adverse outcome is higher in an attempted VBAC that results in emergency CS
- Benefits of VBAC should also be discussed and should include:-
 - Reduces the risk of neonate having respiratory problems such as transient tachypnoea or respiratory distress syndrome after birth – risk is 2-3% with VBAC and 4-5% with elective LSCS¹
 - Further caesarean increases risks in future pregnancies e.g. placenta praevia and accreta and hence caesarean hysterectomy, complications of adhesions during surgery and bladder and bowel trauma.
 - Quicker recovery period. Able to return to normal activities such as lifting and driving sooner than with a CS.
 - Potential of avoiding major surgery and the associated complications
- The antenatal counselling should be documented using the Discussion Form (appendix B). The woman should be asked to sign it and it should be filed in the woman's hand held notes
- A plan in the event of labour starting prior to the scheduled CS date should be discussed with the woman and documented on the Discussion Form.
- A plan should labour not commence spontaneously by term +12 should be discussed with the woman and documented on the Discussion Form.
- Women should be informed that if they are admitted in preterm labour the success rate of VBAC is similar to that at term however there is a lower risk of uterine rupture
- An overall success rate for planned VBAC of 72-75% should be given (85 - 90% if previous vaginal birth). This will be influenced by the risk factors for unsuccessful VBAC (appendix C) The success is similar after two previous CS
- For women opting for elective repeat CS who have an anterior low lying placenta, a multidisciplinary approach to management of potential accreta should be adopted.

2.5. Intrapartum Management

- Women should be advised to deliver at Consultant Unit
- IV access secured on admission in labour and full blood count (FBC) and group and save (G&S) sent
- The SpR on call for delivery suite should be informed of the admission
- Women who have opted for an elective repeat CS but who present in labour should have a discussion with an experienced obstetrician to determine feasibility of VBAC
- There is no contraindication to epidural
- Continuous fetal monitoring via cardiotocograph is required for all women attempting a VBAC once labour is established
- Maternal monitoring – hourly blood pressure (BP) and pulse
- Watchful of signs of uterine rupture
 - Abnormal CTG
 - Severe abdominal pain- persisting through contractions
 - Chest pain/shoulder tip pain, shortness of breath
 - Acute onset scar tenderness
 - Abnormal vaginal bleeding/haematuria
 - Cessation of previously good contractions
 - Signs of maternal shock
 - Loss of station of the presentation part
 - Sudden loss of effectiveness of previously good working epidural

2.6. Induction and augmentation

- There is a 2-3 times increase risk of uterine rupture with induction of labour (IOL) with prostaglandins or augmentation of labour¹
- There is a 1.5 x increase in need for LSCS with IOL/augmentation.
- The decision to induce, and method used should be made by a consultant and the plan clearly documented in the woman's notes. A routine post date's induction must not be booked by a midwife without seeking the advice of a consultant obstetrician.
- IOL by mechanical methods (amniotomy or foley catheter) is associated with a lower risk of scar rupture that using prostaglandins. This is level D evidence and Prostaglandins are supported by NICE. However, they are not licensed for use in women who have had a previous LSCS and this fact should be discussed with the woman and documented. Oxytocin should not be used for augmentation of established labour unless discussion with a consultant obstetrician has taken place.
- If the labour deviates from normal then the woman should be reviewed by an obstetrician and a clear plan for the management of the continuing labour must be documented in the notes.
- If oxytocin is used it should be titrated carefully so that the woman is not contracting more than 4 in 10 minutes.
- The decision to use Oxytocin in the second stage of labour should only be made by a consultant
- Any woman being induced or having their labour augmented should be informed of the risks and this should be documented in the hand held notes.

3. Monitoring compliance and effectiveness

Element to be monitored	<ul style="list-style-type: none"> • The audit will take into account record keeping by obstetricians and midwives • The results will be inputted onto an excel spreadsheet • The audit will be registered with the Trust's audit department
Lead	<ul style="list-style-type: none"> • Maternity risk management midwife
Tool	<ul style="list-style-type: none"> • Is it documented that the VBAC information sheet was given to the woman at the time of booking with the obstetrician • Was the woman seen in the consultant clinic before 36 weeks gestation • Was the antenatal counselling documented using the Discussion Form • Is there an individual plan in the event of labour starting prior to the scheduled date • Is there an individual plan should labour not commence spontaneously • Is the need for continuous electronic fetal monitoring identified on the discussion sheet • Was there an individual management plan written for the woman when she presented in labour • Was the intended method of fetal heart monitoring documented when the woman presented in labour •
Frequency	1% or 10 sets, whichever is the greater, of all health records of women who have had a vaginal birth after caesarean section, will be audited over the duration of this guideline
Reporting arrangements	<ul style="list-style-type: none"> • A formal report of the results will be received annually at the maternity risk management and clinical audit forum, as per the audit plan • During the process of the audit if compliance is below 75% or other deficiencies identified, this will be highlighted at the next maternity risk management and clinical audit forum and an action plan agreed.
Acting on recommendations and Lead(s)	<ul style="list-style-type: none"> • Any deficiencies identified on the annual report will be discussed at the maternity risk management and clinical audit forum and an action plan developed • Action leads will be identified and a time frame for the action to be completed by • The action plan will be monitored by the maternity risk management and clinical audit forum until all actions complete
Change in practice and lessons to be shared	<ul style="list-style-type: none"> • Required changes to practice will be identified and actioned within a time frame agreed on the action plan • A lead member of the forum will be identified to take each change forward where appropriate.

	The results of the audits will be distributed to all staff through the risk management newsletter/audit forum as per the action plan
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4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Document Title	Clinical guideline for vaginal birth after caesarean section (VBAB)		
Date Issued/Approved:	19 th October 2016		
Date Valid From:	19 th October 2016		
Date for Review:	19 th October 2019		
Directorate / Department responsible (author/owner):	Karen Watkins Consultant obstetrician Obs and gynae directorate		
Contact details:	01872 252729		
Brief summary of contents	This guideline informs obstetrics and midwives on the management of a woman who has had a previous caesarean section during pregnancy and labour and who is requesting a vaginal birth		
Suggested Keywords:	VBAC, vaginal birth after caesarean section		
Target Audience	RCHT ✓	PCT	CFT
Executive Director responsible for Policy:	Medical Director		
Date revised:			
This document replaces (exact title of previous version):	Vaginal birth after caesarean section (VBAC) Guideline		
Approval route (names of committees)/consultation:	Maternity guideline group Obs and gynae directorate meeting		
Divisional Manager confirming approval processes			
Name and Post Title of additional signatories			
Signature of Executive Director giving approval			
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet	✓	Intranet Only

Document Library Folder/Sub Folder	Midwifery and obstetrics
Links to key external standards	CNST 2.10
Related Documents:	
Training Need Identified?	

Version Control Table

Date	Version No	Summary of Changes	Changes Made by (Name and Job Title)
December 2009	1.0	Initial document	Karen Watkins Consultant obstetrician
November 2010	1.1	Reviewed and compliance monitoring tool added	Karen Watkins Consultant obstetrician
September 2012	1.2	Reviewed, no changes to clinical content. Changes to compliance monitoring tool only	Karen Watkins Consultant obstetrician
6 th October 2016	1.3	Amended in line with latest evidence	Rob Holmes Consultant Obstetrician

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.

This document is only valid on the day of printing

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Initial Equality Impact Assessment Screening Form

Name of service, strategy, policy or project (hereafter referred to as <i>policy</i>) to be assessed: Clinical guideline for vaginal birth after caesarean section (VBAB)	
Directorate and service area: Obs and gynae	Is this a new or existing Procedure? Existing
Name of individual completing assessment: Jan Clarkson	Telephone: 01872 252270
1. Policy Aim*	This guideline informs obstetrics and midwives on the management of a woman who has had a previous caesarean section during pregnancy and labour and who is requesting a vaginal birth
2. Policy Objectives*	Ensure current evidenced based management of a woman having a vaginal birth following a caesarean section
3. Policy – intended Outcomes*	Safe out come for woman and baby
4. How will you measure the outcome?	Compliance monitoring tool
5. Who is intended to benefit from the Policy?	Pregnant women and their babies
6a. Is consultation required with the workforce, equality groups, local interest groups etc. around this policy? b. If yes, have these groups been consulted? c. Please list any groups who have been consulted about this procedure.	No

*Please see Glossary

7. The Impact			
Please complete the following table.			
Are there concerns that the policy could have differential impact on:			
Equality Strands:	Yes	No	Rationale for Assessment / Existing Evidence
Age	X		All woman
Sex (male, female, trans-gender / gender reassignment)	X		All woman
Race / Ethnic communities /groups	X		All woman
Disability - learning disability, physical disability, sensory impairment and mental health problems	X		All woman
Religion / other beliefs	X		All woman
Marriage and civil partnership	X		All woman
Pregnancy and maternity	X		All woman
Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian	X		All woman
You will need to continue to a full Equality Impact Assessment if the following have been highlighted: <ul style="list-style-type: none"> • You have ticked “Yes” in any column above and • No consultation or evidence of there being consultation- this <u>excludes</u> any <i>policies</i> which have been identified as not requiring consultation. or • Major service redesign or development 			
8. Please indicate if a full equality analysis is recommended.		Yes	No X
9. If you are not recommending a Full Impact assessment please explain why.			
N/A			
Signature of policy developer / lead manager / director		Date of completion and submission	
Names and signatures of members carrying out the Screening Assessment	1. Rob Holmes 2.		

Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead,
 c/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa,
 Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.

Signed: Sarah-Jane Pedler

Date: 19TH October 2016

Vaginal Birth after Caesarean Section (VBAC) Patient Information Sheet

Can anyone have a VBAC?

If you have previously had a straight forward caesarean sections, it is usually possible for you to have a VBAC after discussion with your medical team.

How successful is VBAC?

About 3 out of 4 women with a straight forward pregnancy who go into labour will have a successful vaginal birth. This is similar to women who are in their first pregnancies.

If however you have had a vaginal birth, either before or after your caesarean delivery, about 9 out of 10 women will have a vaginal birth

What are the benefits?

If VBAC is successful:

- Major surgery is avoided and its associated complications.
- There is less abdominal pain after birth.
- A shorter stay in hospital
- Recovery time is quicker and you can begin to get back to normal activity as soon as baby is born
- A greater chance of an uncomplicated normal birth in the future
- Reduces chance of baby having breathing problems by 1-2%

Is VBAC safe for me and my baby?

There are a few potential risks of VBAC and these include:-

- There is the risk of the scar in the uterus opening which would result in an emergency caesarean section and could be serious for both mother and baby. The risk of this happening is only 0.5 % (1 chance in 200). This risk is increased 2 to 3 times if you are induced, and therefore induction
- Should only be attempted when there is a good reason.
- 1% increased risk of requiring a blood transfusion or having an infection in the uterus compared to women having a planned caesarean section.
- Risk to baby of death or serious brain damage is very small and is no different than the risk of women having their first birth (about 2 in 1,000). It is however higher than the risk with a planned caesarean section.

Does anything different happen when I am in labour?

It is important that you labour in a consultant led unit so that should any problems arise during your labour appropriate health professionals are available to look after you and your baby.

On admission a cannula will be put in your hand in case it is needed and your baby's heart beat will be monitored throughout the whole of your labour to monitor for any signs of distress.

What happens if I have I go into labour prematurely?

For women who labour prematurely, who have had a previous caesarean delivery the success rate is approximately 75% but there is a lower risk of uterine rupture. Therefore if this happens you may decide to continue with the labour even though you were planning an elective caesarean. This will be discussed with you when you are seen at the hospital.

What happens if I labour before the booked Caesarean section?

We have the facilities to offer Caesarean section 24 hours a day and therefore you should not be worried about going into labour before the date you have been given for caesarean. Many women however decide that if they are in established labour on admission that they will continue in labour rather than opt at this stage for a caesarean. If this is the case then let the midwife looking after you know.

You can however opt to continue with your plans for caesarean section and provided you are not in advanced labour, the caesarean delivery will be arranged.

Vaginal Birth after Caesarean Section (VBAC) Discussion Form
(This form is to be completed by the doctor with the woman)

Patient's Details

Date of Discussion.....
Gestation.....
Obstetrician

- Success rate of VBAC is 72 – 75% (85-90% if previous vaginal delivery)
- Risk of the scar in the uterus opening is 1 chance in 200 (0.5%) + the complications of this
- Risk of blood transfusion with VBAC 2%
- Risk to baby similar to woman having her first baby, but higher than with a planned CS
- VBAC less likely if induced labour, no previous vaginal delivery, BMI > 30 and previous CS for labour dystocia.
- Induction of labour will increase the risk of the scar opening and associated complications by 2 – 3 times. Propess[®] is not licensed but the use of prostaglandins for IOL is supported by NICE.
- Need to deliver in Consultant Unit
- Need for continuous electronic fetal monitoring
- Need for intravenous access

Intended mode of delivery	VBAC / Elective CS / undecided		
If labours prior to Elective CS	VBAC / Emergency CS / to re-discuss at the time		
If not laboured by T ⁺¹²	ANC at T ⁺³⁻¹⁰ / Propess [®] / ARM + Synto [®] / Cervical catheter / Elective CS		
Elective Caesarean Section	Date	Gestation	Steroids yes/no
Pre-op Assessment in DAU	Date	Time	

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

Patient's Signature _____ **Print** _____ **Date** _____

Doctor's Signature _____ **Print** _____ **Date** _____

Appendix C

Risk factors for unsuccessful VBAC

- Induction of Labour
- No previous vaginal birth
- BMI greater than 30
- Previous section for dystocia
- Greater than 41 weeks gestation
- Less than 2 years from previous caesarean
- Advanced maternal age