VBAC (Vaginal Birth after Caesarean Section) Guideline

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NHS Shetland Document Development Coversheet*

Name of document	VBAC (Vaginal Birth after Caesarean Section) Guideline		
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Author	Emma Courtier, Midwife		
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Executive lead	Kathleen Carolan, Director of Nursing and Acute Services		
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Proposed groups to present document to:		
Midwives	Consultants	Anaesthetist
Guideline group	ANMAC	

Date	Version	Group	Reason	Outcome
24/03/2022	0.1	Guideline review group	PI	Addition of risk assessment
01/04/2022	0.1	Consultants	PI	No changes
01/04/2022	0.1	Midwives	PI	No changes
01/04/2022	0.1	Anaesthetist	PI	No changes
17/08/2022	0.1	ANMAC	PI/FA	A/INT

Examples of reasons for presenting to the group	**Examples of outcomes following meeting**
• Professional input required re: content (PI)	• Significant changes to content required – refer to Executive Lead for guidance (SC)
• Professional opinion on content (PO)	• To amend content & re-submit to group (AC&R)
• General comments/suggestions (C/S)	• For minor revisions (e.g. format/layout) – no need to re-submit to group (MR)
• For information only (FIO)	• Recommend proceeding to next stage (PRO)
• For proofing/formatting (PF)	• For upload to Intranet (INT)
• Final Approval (FA)	• Approved (A) or Not Approved, revisions required (NARR)

***To be attached to the document under development/review and presented to the relevant group**

Please record details of any changes made to the document in the table below

Date	Record of changes made to document
24/03/2022	Addition of schedule of care appendix
01/04/2022	Addition of risk assessment form appendix
01/04/2022	No further changes

Contents

1. Purpose of this guideline

This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman please ask them their preferred pronouns and then ensure this is clearly documented in their notes to inform all health care professional.

Aim is to provide guidance to all members of staff involved in the care of pregnant women who have had a caesarean section delivery for whatever reason in their previous labours.

Women who have had previous surgery or injury to the uterus should be advised to deliver in Aberdeen but this guideline will cover the management of these women in labour in the event they decline transfer to AMH or present in labour prior to transfer.

This guideline applies to the management of women in pregnancy and labour if following previous surgery or injury to the uterus including those who have had:

- Caesarean section
- Ruptured uterus
- Myomectomy – when the cavity is breached
- Metroplasty – plastic or reconstructive surgery to the uterus
- Perforated uterus – either at termination of pregnancy or during surgical management of miscarriage

An essential element in reducing caesarean section rates is ensuring women are provided with accurate information regarding VBAC.

This guideline should be read in conjunction with:

- Antenatal Care for Uncomplicated Pregnancies (NICE Guideline CG62 March 2008)
- Intrapartum Care NAGUI012 18/08/2021
- Caesarean Section NAGUI006 16/12/2021

2. Incidence

Current national success rate for VBAC is 72-75%, Shetland success rate for VBAC is 75% for 2018-2019

3. Antenatal management

To provide information and counselling to women to enable them to make an informed-choice based on the best available evidence regarding mode of delivery following a previous caesarean section (CS)

4. Antenatal discussion about choice of place of birth with VBAC

Options for choice of place of birth should be discussed with each woman; while promoting safety it is essential to facilitate choice and offer support for each woman. If a woman declines

transfer to Aberdeen Maternity Hospital then a discussion at a risk management meeting should take place and management plan discussed with multidisciplinary team.

Women should be advised that the safest place to have a VBAC is at Aberdeen Maternity Hospital (AMH) where there is 24/7 onsite Obstetric and Neonatal team, operating theatres, blood bank and laboratory services.

Women presenting with one or more previous Caesarean sections or other uterine surgery should be counselled by a Consultant Obstetrician to discuss potential modes of delivery. This should include benefits and risks, along with the RCOG "birth choices after Caesarean" leaflet, and the rationale behind our recommendation for delivering in Aberdeen if they request VBAC.

The risks and benefits associated with each place of birth should be discussed with the woman, particularly highlighting analgesia available. Epidural service is not provided in Maternity Unit, GBH.

All women should have a discussion and management plan made in the event that labour/SRM begins prior to transfer or Elective LUSCS which should include timing of Category 3 sections and/or transfer by air ambulance to AMH if there are no clinical concerns, taking into account there are no other maternity, surgical or anaesthetics issues.

See Appendix 1 – Additional antenatal care

5. Labour care

The following should be discussed in the Consultant clinic and clearly documented within notes:

5.1. Management of Latent phase of labour

- Full routine antenatal assessment should be undertaken by the midwife including BP, urinalysis, assessment of vaginal loss, fetal heart rate should be auscultated for 1 minute, assessment of uterine activity over a period of 10minutes,
- assessment of pain specifically scar pain
- Keep nutrition light with adequate fluid intake if not in active labour
- Vaginal examination only if clinically indicated. Patients in the latent phase of labour (<4cm dilated) without regular painful contractions and no other contraindications may be discharged home only after discussion and/or review by the Consultant Obstetrician
- Patients with term SROM and no other complications following assessment may be discharged home for 24 hours to await labour

5.2. Management of established labour i.e. >4cm dilated with regular painful contractions

Consultant Obstetrician is lead for care and should be informed if there is slow progress. On call midwife will remain within the Maternity Unit, GBH until safe birth of baby

- Inform Consultant of admission and also inform the on-call Anaesthetist and theatre team
- One to one midwifery care must be provided at all times
- Keep interventions to a minimum

- Manage labour to optimise normality
- Encourage mobilisation or upright positions as much as possible
- Continuous fetal monitoring is recommended and should be used once in established labour. If there is a poor quality trace, a fetal scalp electrode (FSE) should be applied. Document if EFM is declined
- Intermittent Auscultation (IA) must be provided if EFM declined. When performed must be in accordance with Intrapartum Care NAGUI012 18/08/2021 Guideline regarding 1st stage (every 15 minutes) and 2nd Stage (every 5 minutes) of labour.
- Insert a large bore cannula and obtain blood with consent for group and save and full blood count (FBC).
- Follow care in labour guideline for management during labour
- Restrict intake to water, fruit squash or isotonic non-carbonated drinks

  Give Omeprazole once established labour confirmed – may be given orally.

5.3. Signs and symptoms of scar rupture

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

Abnormal CTG is the most consistent evidence of uterine rupture, present in 66-76% of cases, therefore continuous electronic fetal monitoring (EFM) is recommended. Particular attention needs to be paid to the abdominal tocograph and uterine activity.

5.4. Failure to progress / slow progress

When there is no/slow progress between vaginal examinations, consider ARM after discussion with consultant. Oxytocin should only be used in exceptional circumstances and is a consultant decision and under consultant supervision

6. Management of second stage

Follow care in labour guideline.

- Inform Consultant Obstetrician once 2nd stage confirmed
- Maximum 1 hour Active Pushing

7. Management of third stage

Women are advised to have an active 3rd stage with IM Oxytocin

8. Audit and monitoring

As a minimum the following specific requirements will be monitored:

- Documented antenatal discussion on the mode of delivery
- Documented plan for the place of labour
- Documented individual management plan for labour
- Documented plan for labour should this commence early
- Documented plan for labour should this not commence as planned, that has been discussed with the consultant obstetrician
- Documented plan for the monitoring of the fetal heart in labour
- successful number of VBACs

9. References

https://www.nice.org.uk/guidance/ng192/resources/caesarean-birth-pdf-66142078788805

https://www.nice.org.uk/guidance/cg190/resources/intrapartum-care-for-healthy-women-and-babies-pdf-35109866447557

https://www.nice.org.uk/guidance/ng121/evidence/evidence-review-s-previous-caesarean-section-pdf-241806242808

Birth after Previous Caesarean Birth – Greentop Guideline No 45

Appendix 1 – Additional antenatal care

Additional Care	
Booking <12 weeks	Named midwife will provide and discuss with women RCOG 'Birth options after caesarean section' leaflet
20-22 weeks	Consultant review – information giving The woman's previous birth experience and outcomes with the aid of the previous notes whenever possible • Identify any risk factors and refer appropriately • Discuss risks and benefits of VBAC and planned caesarean section • Induction of labour, premature labour, spontaneous rupture of membranes • Care in labour including recommendations for continuous fetal monitoring in labour • Recommendation of consultant led unit for place of birth • If indicated the Consultant Obstetrician will arrange for Consultant Anaesthetist to review women during antenatal period. • Provide Aberdeen's VBAC leaflet
32 weeks	Consultant review – confirming decision about method and place of delivery Risk assessment form completed and signed Discuss options if the woman presents in labour prior to transfer or Elective LUSCS and document in management plan
39 weeks (for women transferring to AMH)	Confirm an appointment at antenatal clinic in AMH to discuss options if the woman goes past her dates
39 weeks (women who have declined transfer to AMH)	Appointment at antenatal clinic to discuss options if the woman goes past her dates • induction would not be offered in Shetland but can be organised for Aberdeen • Post-dates EL LUSCS booked for Shetland

Appendix 2 – Risk Assessment Form for women who have declined transfer to Aberdeen Maternity Hospital

Risk Assessment: Vaginal Birth after Caesarean Section		
Name DOB	Address CHI	 Parity
Risk Previous Caesarean Section requesting to have a VBAC	**Action**	**Rationale**
Antenatal	• Discussion of place and mode of delivery – advise to deliver in AMH. • Thorough discussion of risks/benefits to VBAC vs EL LUSCS. • Information leaflet provided. • Management plan discussed and recorded in badgernet	• To enable the woman to make an informed choice with regards to her place of delivery. • 72–75% chance of successful VBAC. If successful, shorter hospital stay and recovery. • Delivery in Aberdeen Maternity Hospital is advised due to the limited obstetric/neonatal facilities in Shetland.
Intrapartum Increased risk of Uterine rupture at scar site. Risk: 1:200 births.	• Inform On call Midwife, Obstetrician and Anaesthetist/theatre team when admitted in labour. • On call midwife to be present in ward throughout labour • Continuous fetal monitoring in active labour • **Monitor woman for signs of scar rupture**	• In order to prepare staff in the event of an emergency • To monitor fetal wellbeing. Uterine rupture may lead to rapid deterioration in fetal condition. • Uterine Rupture may lead to rapid deterioration in maternal/fetal condition. Early detection is vital to avoid complications.

	○ severe abdominal pain persisting between contractions ○ acute onset scar tenderness ○ abnormal vaginal bleeding ○ haematuria ○ cessation of previously efficient uterine activity ○ maternal tachycardia, hypotension, fainting or shock ○ loss of station of the presenting part ○ change in abdominal contour and inability to record fetal heart • **Opt for Caesarean Section if:** ○ Delay in 1st Stage ○ Maternal signs of Scar rupture ○ Avoid Prolonged 1st or 2nd stage ○ Avoid induction of labour or augmentation	• Prompt action will reduce the risk of complications • May place additional stress on the uterus. • Two- to three-fold increased risk of uterine rupture and around 1.5-fold increased risk of caesarean delivery in induced and/or augmented labour compared with spontaneous VBAC labour.
Post Natal Care	Routine if mother and baby well	

Sign…….. Print……. Date……. (Patient)

Sign…… Print……. Date……. (Midwife)

Sign…… Print…….. Date…….. (Consultant Obstetrician)