VAGINAL BIRTH (TRIAL OF LABOUR) AFTER CAESAREAN SECTION– ANTENATAL PREPARATION

1. PURPOSE
To enable women, who have had a previous caesarean section, to make an informed choice for the method of delivery in a subsequent pregnancy. Accurate information on the benefits and risks of Vaginal Birth after Caesarean Section (VBAC) and repeat elective caesarean section should be provided to women who have had a previous caesarean section.

OPTIONS

1. Elective Repeat Caesarean Section – Planned caesarean section in a woman who has had one or more repeat caesarean sections, whether or not the caesarean section occurred at a scheduled time. There will be women for whom an elective caesarean section may be the primary choice of management due to medical reasons and/or maternal choice.

2. Vaginal Birth (Trial of Labour) after Caesarean Section (VBAC) – women who have had a previous caesarean section will be offered the option of a vaginal birth in a subsequent pregnancy. There will be women for whom a VBAC may be the primary choice of management, after careful review by the Obstetric team of past medical history.

ABSOLUTE CONTRAINDICATIONS TO TRIAL OF LABOUR

- Previous classical Caesarean section or vertical lower uterine segment incision
- Full thickness myomectomy
- Another reason for a caesarean birth

RELATIVE CONTRAINDICATIONS

- More than one previous caesarean section
- Morbid maternal obesity
- Fetal weight > 4kg

BENEFIT AND RISK COUNSELLING

As with any birth, there are possible complications that women should be aware of, but the likelihood of severe injury or death in a VBAC, repeat caesarean section or unplanned caesarean is low. An attempted VBAC is associated with increased perinatal morbidity and mortality compared to elective Caesarean section, but the absolute risk is low. Serious maternal morbidity is associated with both attempted VBAC and elective Caesarean section, but absolute risk is low.

The evidence to date suggests that for most women who have undergone prior lower uterine segment caesarean section, and have no contraindications to VBAC, should be offered a VBAC, after providing appropriate counselling.

All women planning a trial of labour should be appraised early in the antenatal period with respect to their intrapartum care. The information provided should include:

- The advisability of admission to hospital relatively early in labour.
• The importance of intensive maternal and fetal surveillance
• The likelihood of achieving a vaginal birth.
• The necessity of emergency caesarean section in the vent of poor progress in labour or fetal distress.

Women who have had a previous caesarean section should be referred to an Obstetric consultant during the antenatal period to discuss labour and birth management (at approximately 24 weeks gestation).

Most series report a likelihood of vaginal birth (if this is attempted) in the range 60-80%. This likelihood is reduced by maternal morbid obesity or fetal weight > 4kg but does not appear to be substantially affected by the indication for the previous caesarean section.

RISKS TO WOMEN
Women attempting a VBAC have a:
• risk of an emergency caesarean section
  o if a woman undergoes non elective caesarean section, in this instance, then she has an increased risk of haemorrhage, blood transfusions and infection than those women who opt for an elective C/S although absolute risk of these complications is low.
• increased risk of being unsuccessful if the following risk factors are present: induced labour, no previous vaginal birth, body mass index greater than 30, and previous caesarean section for dystocia. If all these risk factors are present the literature suggests a lower success rate of 40%(1)
• risk of symptomatic scar rupture with TOL is reported to be 5-7 per 10002. The risk of uterine rupture is increased by induction of labour, an interpregnancy interval of less than 18 months, and more than 1 previous caesarean section.
• hysterectomy rates for women attempting VBAC is reported to be 0.5 per 1000
• women considering the mode of birth for a pregnancy subsequent to a caesarean section should be counselled that the decision to have an elective caesarean section might increase the risk of serious complications in future pregnancies. It has been reported that placenta accrete was present in 0.24%,0.31%,0.57%,2.1%,2.3% and 6.7% of women undergoing their first, second,third, fourth, fifth and sixth or more caesarean sections respectively.

BENEFIT TO THE NEONATE
Women considering VBAC should be informed that an attempt at vaginal birth reduces the risk of the neonate developing respiratory problems which may require admission to the neonatal unit(1-3).

RISKS TO THE NEONATE
A trial of labour is associated with increased perinatal morbidity and mortality compared to elective Caesarean section. Much of this is attributable to the background rate of perinatal death after 39 weeks gestation. Where 0.4 per 1000 may have a perinatal death related to rupture, a further 1.4 per thousand can be expected to have an antenatal, intrapartum or neonatal death after 39 weeks gestation. This excess of perinatal mortality for 1.8 per 1000 must still be acknowledged in counselling about birth options, as it may be an unacceptable risk for many women and health professionals.

Hypoxic Ischaemic encephalopathy (HIE) is significantly greater in TOL (0.7 per 1,000) compared to zero risk with elective Caesarean section.

ANTEPARTUM MANAGEMENT
• The woman’s previous birth experience and expectations should be discussed at booking. Written information about TOL should be provided – RANZCOG ‘VBAC- a guide for women’ information sheet and KEMH VBAC information pamphlet are both available in the antenatal clinic.
• Medical records of the first labour should be obtained from the hospital in which the birth took place. This needs to include the partogram (if labour occurred) and the operative notes.(4).
• Discussion regarding benefits and risks of attempting TOL to take place between a midwife/doctor and the woman.
• A signed consent form for TOL to be obtained by a doctor, ideally at 36 weeks, with documented Consultant involvement on the MR004 (see below).
• Highlight the plan for TOL with the VBAC Management Plan for Women in Labour green sticker in the Obstetric Instruction sheet (MR004)(4). Any deviation from standard care that the woman chooses is documented on the Non Standard Management Form sticker, which should be placed in the patient’s notes and signed by the patient and the consultant.
• Perform an ultrasound to check for placental localisation and any abnormal placentation if not previously documented.

INDUCTION
Women who have had a previous caesarean section may be offered induction of labour but need to be informed that the success rate for a VBAC is decreased.

Prostaglandins are not licensed in Australia for use in women with a uterine scar.

The decision for induction of a woman with a previous caesarean scar should consider any other risk factors present, e.g. grand multiparity, BMI above 40 and be discussed with the Obstetric Consultant.

See Clinical Guidelines, Care of a woman attempting a vaginal birth after caesarean intrapartum care.

REFERENCES (STANDARDS)
1. Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG). College Statement C-Obs 38. Planned Vaginal Birth after Caesarean Section (Trial of Labour). July 2010

National Standards – 1.7.1
Legislation - Nil
Related Policies – B 5.12 Care of a Woman attempting a vaginal Birth after Caesarean Section
Other related documents – Nil

RESPONSIBILITY
Policy Sponsor Medical Director OGCCU
Initial Endorsement May 2000
Last Reviewed April 2014
Last Amended Review date April 2017

Do not keep printed versions of guidelines as currency of information cannot be guaranteed. Access the current version from the WNHS website