

5 INTRAPARTUM CARE

5.12 PLANNED VAGINAL BIRTH AFTER CAESAREAN (VBAC) SECTION INTRAPARTUM MANAGEMENT¹

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5.12 PLANNED VAGINAL BIRTH AFTER CAESAREAN (VBAC) SECTION INTRAPARTUM MANAGEMENT¹

For antepartum care refer to [Clinical Guidelines, Section B, 1.1.10 Women with a previous caesarean section](#)

AIM

To provide women who have had a previous Caesarean section and have chosen to attempt a vaginal birth with supportive, safe and quality clinical care.

KEY POINTS

1. Women who have had a previous caesarean section and have chosen to attempt a vaginal birth shall be cared for in the Labour and Birth Suite. A home birth or care in the Family Birth Centre is not appropriate for these women.
2. Women should be advised to present to Labour and Birth Suite / Maternal Fetal Assessment Unit in early established labour (regular painful contractions), or when there is rupture of membranes, bleeding or constant pain.
3. The senior obstetric registrar or consultant and shift coordinator is to be notified when the woman is admitted.
4. Establish intravenous access (leave an intravenous cannula in situ) and take blood for group and hold serum and/or cross matching if appropriate².

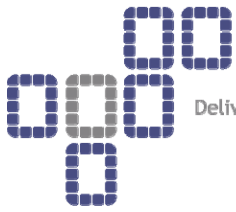
CONTRAINDICATIONS / RELATIVE CONTRAINDICATIONS TO VBAC.

The following conditions are highlighted as being associated with an increased risk of uterine rupture or unsuccessful trial of labour:

- Previous classical or vertical lower uterine segment incision.
- More than 1 previous caesarean section.
- Less than 18 months since the previous caesarean section
- BMI > 40
- Estimated fetal weight > 4kg.

IN LABOUR

- Women can eat and drink as they wish until in active labour Once in active labour women may drink clear fluids e.g. particle free orange juice, apple juice, lucozade, isotonic energy drinks (NOT milk based drinks).
- In attempted VBAC, the Cervicograph ALERT line (gradient denoting rate of 1cm / hr) becomes the ACTION line.



- Trial of Labour mandates vigilant assessment of progress of labour with vaginal examinations at least 3 hourly in the active phase of labour and more frequently as full dilatation approaches. The cervix should dilate at least 1cm per hour in the active phase of labour and active phase of second stage should not exceed an hour in duration, unless birth is imminent¹.
- Analgesia is prescribed on request. There is no contraindication to epidural analgesia.
- Any delay in the latent/active phase of labour or significant fetal heart rate abnormalities should be discussed immediately with the midwifery consultant, obstetric senior registrar and/or consultant on-call for Labour and Birth Suite. Recommendations on how to progress should be discussed with the woman and a plan for care and further assessment documented. (see Clinical Guidelines, Section [B.5.6 Intrapartum Fetal Heart Rate Monitoring](#)).
- The available evidence suggests that the use of oxytocin is associated with a reduced success of vaginal birth and a doubling of scar rupture/dehiscence^{1,6}. However, oxytocin may be used with caution in women with a previous caesarean section, following discussion with the obstetric consultant on-call for Labour and Birth Suite¹.
- Exploration of the uterus to detect dehisced scar after a vaginal birth is not advisable as it may increase the risk of puerperal infections and may cause iatrogenic perforation. However, excessive vaginal bleeding, abdominal pain or unexplained maternal collapse at the birth, will require prompt assessment and the need to repair the dehiscence or rupture if this occurred⁷.

ELECTRONIC FETAL MONITORING (EFM)

Clinical Guidelines, Section [B.5.6 Intrapartum fetal heart rate monitoring](#)

- A uterine scar is an indication for continuous electronic fetal surveillance in labour.
- Continuous fetal monitoring using telemetry is an option available to women if they wish to ambulate during labour.
- It is reasonable for women to have short breaks from electronic fetal monitoring in the following circumstances:
 - If the electronic fetal heart rate monitoring has been and is considered normal;
 - The interruption is for a short period only i.e. 15 minutes;
 - If the number of interruptions is infrequent;
 - If the interruption does not occur immediately after any intervention that might be expected to alter the fetal heart rate.
 - This arrangement has been discussed prior to labour and documented in the antenatal notes using the non standard management sticker.
- Several VBAC studies have reported that in over 70 % of cases of uterine rupture, the first signs or symptoms presented as prolonged fetal bradycardia. Of these cases, only 8 % presented with pain and 3 % with bleeding.

SIGNS AND SYMPTOMS OF UTERINE RUPTURE¹

***Abnormalities in the fetal heart trace, such as variable or late decelerations, prolonged fetal bradycardia, warrant immediate review by senior registrar or consultant. These abnormalities may be the first signs of scar rupture/dehiscence.**

Be vigilant for the symptoms and signs of scar rupture, which may include¹:

- Abnormal fetal heart rate or cardiotocograph
- Abnormal vaginal bleeding or frank haematuria



- Suprapubic tenderness and/or severe constant abdominal pain which continues between contractions
- Maternal tachycardia, hypotension or shock
- Chest pain or shoulder tip pain, sudden onset shortness of breath
- No progress/inadequate progress in labour
- In-coordinate uterine action in active labour or cessation of contractions
- Changes of the uterine shape
- Loss of station of the presenting part (disengagement of presenting part)
- If pain does develop an atypical pattern, particularly with unusual radiation (such as to the shouldertips), or pain previously controlled by analgesia (epidural or otherwise) which becomes more severe, then complete clinical reassessment is required by a Senior Registrar or Consultant

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