Vaginal birth with uterine scar (VBAC or trial of scar)

Definition
Women may have a uterine scar from:

- Previous caesarean section
- Previous uterine surgery e.g. myomectomy
- Previous uterine perforation

Antenatal management

- Women with a uterine scar should be booked for consultant care and advised to have a hospital birth.
- Women who have had a previous lower segment caesarean section (LSCS) should discuss vaginal birth after caesarean section (VBAC) and elective LSCS with the midwifery and obstetric team.\(^1\,^2\,^3\)
- Provide the VBAC information leaflet.\(^1\)
- Review the records and circumstances of previous delivery or surgery, especially if there is doubt about the nature of the previous scar.
- Discuss the overall chances of a successful VBAC and how the woman’s individual circumstances influence this.
- VBAC is contraindicated in\(^1\):
  - Previous uterine rupture
  - Previous classical caesarean section involving the whole length of the uterus
  - Three or more previous caesarean sections
- Women with two previous caesarean sections should be given the risks and benefits of both vaginal birth and caesarean section including an increased risk of hysterectomy and blood transfusion following VBAC.\(^1\) The lack of reliable current evidence for dehiscence rates should be explained.\(^4\) Current practice is to recommend caesarean section. Women requesting VBAC following two caesareans sections must be seen by a consultant obstetrician.
- Induction of labour may be considered on an individual basis by the woman’s named consultant. Women should be informed of the increased risk of uterine rupture with induction of labour. A postdates plan should be made with involvement of the consultant including:
  - details of the discussion
  - the method of induction to be used
  - the frequency of assessment in labour
  - the circumstances under which emergency LSCS would be recommended

On admission in spontaneous labour
The admission procedure should be according to the usual Care of women in labour guidelines. In addition:

- Have a lower threshold for admission in the latent phase of labour
- Continuous electronic fetal monitoring (EFM) in established labour\(^1\,^6\,^7\)
Inform the obstetric registrar of admission.

**First stage of labour**

When labour is established a partogram should be commenced and the usual Care of women in labour followed. In addition:

- Antacids should be given 6 hourly
- Advise the woman to have a 16G intravenous cannula sited and bloods taken for FBC and group and save serum
- Inform the coordinator and obstetric registrar of progress.

Assessment of the progress of labour should be by at least 4 hourly vaginal examination to determine descent and cervical dilatation, ideally by the same person. If descent is poor and/or cervical dilatation is less than 1 cm per hour, the obstetric registrar should be informed and assessment may be required more frequently. The reason for the previous LSCS should be considered when assessing progress.

Observe maternal condition for scar tenderness or fresh PV bleeding and report any concerns to the coordinator and obstetric registrar.

If the CTG is pathological, FBS is not appropriate and delivery should be expedited by caesarean section.

**Analgesia**

Analgesia options are as for all labouring women. The use of the pool must be discussed on an individual basis, see The use of the pool for labour and birth guideline.

**Second stage of labour**

- Inform the coordinator and registrar
- Regardless of the mode of analgesia allow a maximum of one hour for descent of the head. If, after 1 hour of passive second stage, the head is above +1 to the ischial spines the obstetric registrar should be informed and review the woman for a further plan of action.
- Regardless of the mode of analgesia allow a maximum of one hour for active pushing before referring to the obstetric registrar.
- Progress should be good throughout. If progress is slow, the registrar should be informed and review the woman for further plan of action.
- If the CTG is pathological, FBS is not appropriate and delivery should be expedited by immediate operative vaginal birth or by caesarean section.

**Augmentation of Labour**

- The registrar must review the woman prior to augmentation with syntocinon in labour.
- The decision to initiate augmentation must be discussed with the consultant obstetrician and a clear management plan documented in the woman’s notes.
- Progress of labour should be reviewed at least 2 hourly by the registrar when augmentation is in progress.

**Prelabour spontaneous rupture of membranes (PROM)**

- Initial management should be according to the guideline for Prelabour rupture of membranes at term.
- Fetal wellbeing should be assessed by EFM for a minimum of 20 minutes.
- The woman should be reviewed by the obstetric registrar and a plan of care documented in the notes. If she meets the criteria for conservative management,
management should follow guideline for Prelabour rupture of membranes at term. 

- If she does not meet the criteria for conservative management, requests earlier augmentation or has not laboured spontaneously after 24 hours, her care must be discussed with a consultant obstetrician to decide whether or not the labour should be induced with syntocinon.

**Monitoring/audit**

This guideline will be subject to three yearly audit and results presented to the department clinical audit meeting. Action plans will be monitored at the department clinical audit meeting.

**Auditable standards**

All women with a uterine scar receive referral for consultant led care
All women with a uterine scar receive the VBAC leaflet
All women undergoing VBAC receive continuous EFM in established labour
Any woman with a uterine scar receiving syntocinon has been reviewed by the obstetric registrar and discussed with the obstetric consultant

**Equality and diversity assessment**

Compliance confirmed and documented at guidelines steering group 22.4.09

**References**

1. RCOG green top guideline no. 45. Birth after previous caesarean birth. Feb 2007

Devised by Bayo Lawal, Michelle Chuter and Tracy Meldrum. (2003)
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