VAGINAL BIRTH AFTER CAESAREAN SECTION

Introduction

This guideline will consider the management of a woman who elects for vaginal delivery after 1 previous caesarean section.

Antenatal care

A woman who has had 1 or more previous LSCS should be referred to a consultant team for antenatal booking. At that time, the reasons for the previous operation will be reviewed to exclude any recurrent issue. If the woman delivered in another unit, it may be appropriate to contact them for further information.

If the woman has had 2 or more LSCS, then she is usually advised to have a further LSCS in the current pregnancy. If she has had 1 previous LSCS with no obstetric issues, then she can usually be offered either vaginal birth after caesarean (VBAC) or elective LSCS. The women opting for VBAC will need to have a hospital delivery, unless special arrangements have been made in exceptional circumstances after discussion with the Consultant obstetrician, senior midwife and the woman.

VBAC	Elective LSCS
Success rate 72% (HH figs 2009)	Risk of bleeding / transfusion / infection / thrombosis
IV access / FBC / G&S	Risk of injury to other viscera
Continuous CTG in labour	Prolonged recovery time
Scar rupture 0.5%	Future pregnancy
Quicker recovery time	

The woman should be given the Patient Information Leaflet on VBAC at the booking visit. Provided there are no other obstetric/medical/social concerns, further antenatal care can be with the midwife or GP until 36 weeks.

The woman should be made a follow-up appointment at 36 weeks for the Consultant led antenatal clinic to confirm her decision. At that time, a date is arranged for ≥ 39/40 if she elects for LSCS. Also document plan for labour should this commence earlier than the planned LSCS date, namely whether the woman would then consider VBAC if appropriate or need an emergency LSCS.

If she chooses VBAC, an appointment for 40-41 weeks should be offered in case spontaneous labour has not occurred and a plan of care will be made. With informed consent, she can be offered a cervical sweep and review at 40+10 weeks for possible ARM/IV syntocinon or elective LSCS depending on findings at vaginal examination. If the plan is made for induction, the consultant must be informed. Use of prostaglandins is a consultant decision because of the increased risk of scar rupture. Instructions should be documented on the LW page of the hand held notes.

Having made a decision for VBAC, the woman will be advised to inform the Labour Ward that she has previously had a LSCS when she contacts them in early labour.

Care in labour

Having been admitted to LW by the midwife, a SpR should review the woman at the earliest opportunity. IV access must be sited and FBC and G&S sent to haematology. Oral ranitidine 150mg should be given every 6 hours and intake restricted to clear

fluids. Once in established labour, a continuous CTG is advised since an abnormality may indicate scar rupture. A fetal scalp electrode should be used if there are difficulties with abdominal monitoring, in particular during the siting of regional anaesthesia. Monitor and document in the active phase of labour:

- maternal pulse every 30 min
- blood pressure every 30 min
- PV loss
- abdominal pain intermittent or constant

In a case of slow progress once in established labour, a SpR should perform abdominal and vaginal examinations to decide whether IV syntocinon is appropriate, and the CTG must be reviewed. Use of syntocinon must be following discussion with the on call Consultant and a plan should be made for the timing of subsequent examinations.

Audit:

VBAC should be audited at least every 3 years, depending on departmental data, with particular reference to

- documented individual management plan for labour
- documented plan for the monitoring of the fetal heart in labour

This audit should be multidisciplinary in process, review of results and monitoring of subsequent action plan.

References:

1. NICE Guideline, Sept 2007: Intrapartum Care – Care of healthy women and their babies during childbirth.
2. NICE guideline April 2004: Caesarean Section
3. National Sentinel CS Audit. RCOG Clinical Effectiveness Support Unit October 2001
4. Cochrane Library October 2004
5. NICE guideline May 2001: Electronic Fetal Monitoring
6. A Guide to Effective Care in Pregnancy and Childbirth. Enkin M et al 2000