

VAGINAL BIRTH AFTER CAESAREAN SECTION (VBAC)

KEY DETAILS:			
Description:	Guideline to assist safe vaginal birth after previous caesarean section.		
Document Type:	Guideline		
Document Keywords:	VBAC, Caesarean section, maternal choice, elective, vaginal birth, induction, consultant, day unit, post dates, scar rupture		
Main areas affected:	Antenatal counselling and clinic, hospital and community. Intrapartum care.		
Date document valid from:	November 2009		
Document review due date:	3 years		
Final Validating group and any other group consulted:	1. Clinical governance Steering Group		
Author (title/position in Trust)	Michael Heard. Revised: Lisa Birkett, Catherine Houlder, Jo Holland.		
Accountable Officer/Executive(s):	Dr Keith Foote, Family services Divisional Clinical Director		
Material suitable for publishing on:			
Trust Intranet: (Trust Staff Only):	YES		
Extranet (NHS Community):	NO		
Internet (Public):	NO		
Is this a priority document required for an external assessment or accreditation?		YES	
AUDIT TRAIL:			
Current status or final agreed document:	Approved	Date sent to Library for archiving:	
Date doc. loaded on Trust Intranet:		Date archived:	
Date(s) Reviewed (if applicable):	12-10	Version number:	
Date of planned review:	01-14	Date of disposal:	25 years
Details and dates of most recent review: (Outline main changes made to document)	<ol style="list-style-type: none"> 1. New policy in line with new information leaflet. 2. Review and approved by MSSG 18-12-09 3. Needs review with in 2010 with NHS toolkit. 4. Approved MSGG 08-01-10 5. Introduction of Midwifery led birth choices clinic January 2011, with review of guideline by midwifery leads 6. Review by Consultants 09-12-10 and MSGG 10-12-10. 		

INTRODUCTION

The aim of this guideline is to provide up to date evidence to support women's choice of mode of delivery following a previous caesarean (CS) and to ensure that their care is optimised resulting in a successful and safe outcome for both mother and baby.

This involves careful antenatal discussion about the risks and benefits of vaginal birth after caesarean (VBAC) and elective repeat caesarean section (ERCS) and careful considered management and observation at the time of labour and birth.

CLINICAL MANAGEMENT

Antenatal Management

All women with a previous uterine incision must be referred for shared antenatal care.

All women should be given the VBAC information leaflet at booking and community staff should aim to facilitate discussion about options prior to central review.

All women who have had a caesarean section and are suitable for a VBAC in their next pregnancy, will be given information stating this prior to discharge home from the postnatal ward.

Central review can be:

All women who do not have any additional risk factors will be seen at the Midwife-Led Birth Choices Clinic at around 21 weeks gestation.

All women will remain under Consultant led care and will attend a Consultant Antenatal appointment at around 34 weeks gestation. The final management plan will be agreed by a senior obstetrician and documented on the VBAC proforma in the hospital notes.

The final management plan must be agreed by a senior Obstetrician and documented in the VBAC proforma in the notes.

Encouraging women towards a vaginal birth is appropriate if there are no other risk factors, but as a unit we will agree to a planned ERCS, if after counselling, by the Midwife and Obstetrician, Caesarean section is the preferred option. Encouraging VBAC is a central action point in reducing caesarean section rates.

ANTENATAL DOCUMENTATION (see appendix 1)

It must be clearly documented in the woman's notes that appropriate discussion of the risks and benefits of VBAC and ERCS has been undertaken. This discussion should be balanced and it must be recorded that the information booklet has been given to the woman.

Counselling must cover:

- The likely success of vaginal birth; overall chance 75%; where women have had a vaginal delivery before 90%; where all risk factors are present 40%.

- The overall risk of uterine rupture – 0.7%
- Associated fetal and maternal risks associated with both options
- Discussion and agreement of an individual birth plan, including final decision of mode of delivery.
- Documentation of plans should labour start early or additional risk factors be present at the onset on labour.
- Documentation on the plan for monitoring the fetal heart in labour
- Complete the proforma (appendix 1) and file in notes

ELECTIVE REPEAT CAESAREAN SECTION

If an elective CS is agreed, this should be performed as an elective procedure at 39 weeks. Delivery before this time must be after a Consultant discussion about the increased risk of neonatal admission. MRSA screening should be in line with the current Trust policy

Should spontaneous labour commence prior to this date, the clinical situation will be fully assessed and an individual management plan made. This should be discussed with the Obstetric Consultant if there is any doubt about the most appropriate route of delivery.

PLANNED VBAC

In general a spontaneous onset of labour should be awaited. If there is an indication for induction, then this must be a Consultant decision.

In post dates pregnancies, the Day assessment unit should be used as a triage point from term +7 days. The risks will be reassessed and a new management plan made.

INDUCTION OF LABOUR

Induction of labour will be considered for the usual obstetric indications. There are few good quality studies about the benefits and risks of induction of labour in women who have had a prior CS. One study suggests that the chances of requiring an emergency CS after induction of labour with Prostin in women with a prior CS is 33% compared to 19% who labour spontaneously. The risk of uterine rupture is also higher with induction with Prostin; about 2% compared with 0.5% when labour commences spontaneously. In view of these increased risks, the indication to undertake induction should only be made by a Consultant Obstetrician.

Women who are undergoing induction of labour with a previous CS should be considered high risk and managed on labour ward.

INDUCTION OF LABOUR FOLLOWING PRE-LABOUR RUPTURE OF MEMBRANES (PROM)

A Consultant Obstetrician should make the decision and method for induction of labour with PROM in the presence of a uterine scar with the woman. The guideline for augmentation of labour should be followed.

INTRAPARTUM MANAGEMENT

Diagnosis of labour

The diagnosis of labour should be made in the same way as for women without a uterine scar. Women can be triaged on the phone in the usual way with the same advice given for mobilising, eating and drinking and pain management at home. Women in the latent phase of labour should be encouraged to remain at home until they are in established labour. Women in the latent phase of labour do not require constant electronic fetal monitoring (EFM). If, on admission, the woman is diagnosed as being in the latent phase of labour she can go to return when labour has established. As with all women, careful guidance must be given about indications for readmission, including clear documentation. An admission CTG is not necessary in the latent phase of labour as these women are to be treated as normal labourers at this stage.

Admission in established labour.

It is recommended that women who wish to have a VBAC should be admitted and cared for on the main labour ward. On admission the lead midwife should undertake a further discussion of the birth plan with the woman, and care should proceed appropriately.

Investigations and intravenous access

Samples for full blood count and group and save should be sent to the laboratory once established labour is diagnosed. Cannulation is only required in the presence of additional risk factors not as routine practice and they should be removed as soon as possible.

Diet and prophylactic antacids

Women should be advised to eat a light diet and keep well hydrated in the latent phase of labour. It is recommended that in established labour oral intake should be restricted to clear fluids. Prophylactic Ranitidine 150 mgs should be given orally 8 hourly for the duration of the labour.

Electronic fetal monitoring in labour.

Continuous electronic fetal monitoring (EFM) is advised for all women having a VBAC. A scar rupture is one of the few Obstetric emergencies where preceding fetal heart rate abnormalities may not be present. The acute fetal compromise so often seen in this situation demands emergency action and valuable time is lost if there is further delay introduced with intermittent monitoring. If a woman declines this level of monitoring, clear documentation of the discussion must be made and the senior Obstetrician informed.

Monitoring can be external or via a fetal scalp electrode. Internal monitoring is mandatory if there is any difficulty in obtaining a reliable external trace. Internal monitoring with telemetry is very effective in maximising maternal mobility and ensuring accurate fetal heart monitoring.

Scar rupture

Signs: The CTG is not always abnormal but any unexpected change in the tocograph reading or acute fetal heart rate changes should trigger Obstetric review., other signs include:

Severe abdominal pain, especially persisting between contractions; chest or shoulder-tip pain; sudden onset of shortness of breath; acute onset scar tenderness; PV bleed or haematuria;

cessation of previously effective uterine contractions; maternal tachycardia, hypotension or shock; loss of station of the presenting part.

Analgesia in labour:

The indications for analgesia in women having a VBAC are the same as for any woman in labour. All of the usual options for analgesia are available for women having a VBAC. For women wanting to use the birthing pool a plan should already have been agreed and documented in the hospital notes. If this is not present discussion should be held with the Senior Obstetrician. Epidural anaesthesia is not contraindicated in women having a VBAC, as it does not hinder the diagnosis of uterine rupture; pain alone is not a reliable indicator, however, a sudden increase in pain or analgesia requirements may be an indicator and close observation for other signs would be required. Women should be aware that epidural anaesthesia might not rule out the need for a general anaesthetic in the unlikely event of sudden fetal or maternal compromise.

Progress in labour

Once the diagnosis of established labour has been made the partogram should be commenced. Vaginal examinations should be undertaken in accordance with the normal recommendations unless there are other indications. If a diagnosis of poor progress is made discussion should be held with the Senior Midwife on labour ward and the Obstetrician on call as appropriate. If poor progress is diagnosed and IV access has not already been established, this is an appropriate time for cannulation.

Augmentation in labour

There is an increased risk of an emergency CS when labour is augmented with oxytocics. There is also an increased risk of uterine rupture; about 1% with augmentation compared to about 0.5% without. Any woman who is to undergo augmentation must be informed of these risks and that discussion should be clearly documented in her notes. Although not contraindicated, augmentation of labour in a woman having a VBAC must proceed with caution. The decision to undertake augmentation must only be made by a Consultant. There must be clear documentation in the notes to support the diagnosis of dysfunctional uterine activity and the absence of mechanical obstruction.

Second stage of labour

Although there is no good data on the optimal length of the second stage of labour in the presence of a uterine scar, it is accepted practice that the length of the second stage should not be outside an hour of active pushing. This is because of the potential for scar rupture in the face of the raised intrauterine pressure associated with the active phase of the second stage of labour. In women with epidural analgesia there is evidence that delayed pushing will help reduce the risk of instrumental delivery. Therefore, pushing can be delayed for one hour, assuming there are no other indications for immediate delivery, e.g. abnormal or suspicious EFM.

Uterine rupture

All women with a previous scar should be carefully monitored for symptoms and signs of uterine rupture. These warning signs include poor progress in labour (i.e. less than 0.5cm per hour as per NICE Guidelines for normal labour), an abnormal CTG (both in contraction and heart rate changes), severe abdominal pain, especially persisting between contractions; chest or shoulder-tip pain; sudden onset of shortness of breath; acute onset scar tenderness; PV bleed or haematuria; cessation of previously effective uterine contractions; maternal tachycardia, hypotension or shock; loss of station of the presenting part. However, these are poor indicators and scar ruptures can occur suddenly and without warning and all staff should remain vigilant.

In the event of a suspected uterine rupture immediate (category 1) CS should be performed, usually under general anaesthesia. The Consultant Obstetrician on call should be informed and attend.

Continuous monitoring should continue for as long as possible. Urgent urinary catheterisation should be performed, as the bladder is often adherent in these cases.

Cord gases must be taken. A Datix risk notification form must be completed.

1. TRAINING

See training needs analysis

2. STANDARDS, MONITORING AND COMPLIANCE

Antenatal management

- Patient Information leaflet given
- Discussion and documentation of individual management plan for labour, to include plan for fetal monitoring.
- Midwife led Birth Choices Clinic and Consultant antenatal clinic attendance
- Induction of labour: decision made by Consultant Obstetrician.

Process: Annual notes review to assess compliance of above standards

Review through maternity risk management forum, labour ward forum and annual governance review.

Ongoing risk reporting through trust matrix and individual case review of scar rupture, depending on grading by risk team.

Birth Choices Clinic audit undertaken annually of birth outcomes.

BACKGROUND INFORMATION

Risks and benefits of VBAC and ECRS

The following information may help inform antenatal discussion.

9% of women giving birth in England and Wales have had a previous CS.

The statistics show that the majority of women who attempt a VBAC will achieve a vaginal birth.
The overall rate is about 75%.

For women who have already had a vaginal birth, especially a VBAC, their chances of a successful VBAC are up to 90%.

In a woman who has all of the following risk factors:

Induction of labour in this pregnancy
No previous vaginal births
BMI >30
Previous CS with cephalo-pelvic disproportion

The chance of a successful VBAC is reduced to 40%.

The main concern for women who have already had a CS is uterine rupture. This is defined by NICE as symptomatic rupture of the uterine muscle, requiring surgical repair, or the extrusion of fetal parts. The chance of uterine rupture for women attempting a VBAC is 0.7%, which is the figure that has been accepted by the RCOG. This figure is comparable to the risk of a shoulder dystocia occurring (1.1%) or a cord prolapse (up to 0.6%) as quoted by the RCOG. In addition the probability of requiring an Emergency CS for other reasons (Fetal distress, cord prolapse, APH) in *any* woman giving birth is up to 30 times more likely than the risk of uterine rupture with VBAC labour (Enkin, 2000).

Uterine rupture, with prompt identification and urgent operative delivery, still carries a significant risk to the mother and baby. Maternal death from uterine rupture occurs in less than 0.001% of cases. When uterine rupture does occur there is a risk of perinatal mortality or severe metabolic acidosis (i.e. pH of <7.0 in 33% of term cases). Prompt recognition and action if rupture is suspected will reduce the risks even further.

Early diagnosis of uterine rupture is vital, reinforcing the need for continuous intrapartum care for women having a VBAC. However an abnormal CTG trace is only present in 55-87% of cases, therefore, the CTG trace must not be solely relied upon for reassurance of maternal and fetal wellbeing with regard to uterine rupture.

The risk of perinatal mortality is slightly increased with VBAC (0.2%) compared to ERCS (0.1%).
The absolute risk of perinatal death related to VBAC is comparable to the risk for nulliparous women.

Advantages of successful VBAC

Risks of neonatal respiratory problems are reduced.

The overall risks of the neonate developing respiratory problems with delivery by ERCS are about 4% (3.5-3.7%); compared to VBAC at about 1% (0.5-1.4%) The risk with ECRS can be reduced by delaying delivery until 39 weeks to approximately 2.4% with the use of steroids (Stutchfield et al, 2005).

Risks of maternal post-delivery infection are reduced.

The overall risk of developing a delivery related infection, up to three months after a caesarean section, is 17% (Horey et al, 2008). Studies comparing infection rates have established that the chances of infection after an ERCS, at about 8% (6.4-9.3%) are higher than after a VBAC, at about 6% .

ERCS will require a longer stay postnatally than a successful VBAC without maternal or neonatal complication. There is also an increased incidence of re-admission with ERCS.

Risks of problems in future pregnancies increases after ERCS.

The following risks are significantly higher with increasing numbers of CS: placenta accreta; bladder injury; bowel or ureter injury; ileus; need for post operation ventilation; ICU admission; hysterectomy; the need for blood transfusion of over 4 units; duration of operation time and hospital stay increase.

The risks of placenta praevia in the next pregnancy is approximately doubled from about 0.5% (0.2-0.5%) after a vaginal birth to about 1% (0.4-0.8%) after a caesarean

Women who have a vaginal birth are more likely to breastfeed than those who have a caesarean. CS is known to reduce rates of breastfeeding initiation and overall duration of breastfeeding. There is no specific data comparing breastfeeding rates between VBAC and ERCS.

There has been found to be a five-fold increased risk of thromboembolism with caesarean delivery (about 1%) compared to vaginal delivery (about 0.2%)

VBAC is more cost effective than ERCS (according to studies carried out in the United States). It is suggested that attempted VBAC is more cost effective, even when offset with the higher cost of unsuccessful VBACs resulting in an emergency caesarean section.

Advantages of ERCS

The risk of Hypoxic Ischaemic Encephalopathy (HIE) with a successful VBAC is comparable to the rate in a nulliparous woman. The risk of HIE with an unsuccessful VBAC and a uterine rupture is 0.1% . The only way for the risk of HIE to be completely avoided is for all women to undergo an Elective CS.

The risk of perinatal morbidity is reduced with ERCS. The risk of delivery related trauma to the neonate, such as subdural haematoma or Erb's palsy, is reduced with ERCS but only to 0.1 to 0.4%. There are increased chances of suspected and proven sepsis in the neonate with VBAC (5% and 1% respectively) than with ERCS (2% and 0.1% respectively).

The risk of urinary incontinence is increased in all pregnant and postnatal women, however it remains debatable whether this is attributable to the pregnancy itself or the mode of delivery (Swift, 2008).

The increased risks inherent with unsuccessful VBAC resulting in an emergency CS, listed below, are avoided. The following statistics are of some use as women and clinicians need to make decisions based on what might happen. However, it is important to keep in mind the individual woman's chances of successful VBAC based on her circumstances and the statistics quoted above.

The risk of uterine rupture with an unsuccessful VBAC (2.%), which will result in an emergency CS, is much higher than with a successful VBAC (0.1%)

The risk of hysterectomy is higher with unsuccessful VBAC (0.5%) than successful VBAC (0.1%)

The risk of blood transfusion is increased with unsuccessful VBAC (3%) than with successful (1%)

The risk of endometritis is greatly increased with an emergency CS (8%) compared to successful VBAC (1%)

There are increased risks of neonatal morbidity with emergency CS, including increased hospital stay, slightly increased risk of developing respiratory illness and increased risks of suspected and proven sepsis

No Significant Difference with successful VBAC and ERCS

Maternal mortality

The need for hysterectomy

Rates of genital tract injury i.e. extension of the uterine incision or cervical lacerations

The incidence of dyspareunia (pain on sexual intercourse) at three months after birth

The rate of faecal incontinence at three months after birth

The rate of postnatal depression or post-traumatic stress disorder

More than one previous CS and other non-lower segment incisions

Success rates of VBAC after two previous LSCS are about 70%, which is similar to after only one. There was no significant difference in the rates of uterine rupture with two previous caesareans (1%) compared with one. However, this figure was based on a study of a small number, therefore the validity of the statistic is questionable. It is generally accepted there is a small increase in risk in this situation.

The risk of hysterectomy is three times more likely and the need for blood transfusion twice as likely after VBAC following two or more LSCS.

Previous high vertical classical caesarean section carries a risk of uterine rupture with VBAC of up to 9%.

All women in these more complex categories should be advised to have an ERCS. If a VBAC is requested, an individual management plan must be drawn up with the Consultant.

6. REFERENCES

Royal College of Obstetricians and Gynaecologists. (2007). Birth after Previous Caesarean Section. London: RCOG. Available at: www.rcog.org.uk

Blanchette H, Blanchette M, McCabe J, Vincent S. 2001. Is vaginal birth after caesarean safe? Experience at a Community Hospital. American Journal of Obstetrics and Gynecology. Volume 184. Pages 1478-87. Carli G, Reiger I, Evans N.

Cost effectiveness of a trial of labour after a previous Caesarean. Obstetrics and Gynaecology. Volume 97, issue 6, pages 932-941. DiMaio H.; Edwards R.K.; Euilano T.Y.; Treloar R.W.; Cruz A.C. 2002.

Vaginal Birth after Caesarean: an historic cohort cost analysis. American Journal of Obstetrics and Gynaecology. Volume 186, issue 5, pages 890-892. Dodd JM, Crowther C, Hillier J, Haslam R, Robinson J. 2007.

Birth after caesarean study – planned vaginal birth of planned elective repeat caesarean for women at term with a single previous caesarean birth: protocol for a patient preference study and randomised trial. Biomed Central – Pregnancy and Childbirth. Volume 7, Issue 17. Pages 1-9. Guise JM, Hashima J, Osterweil P. 2005.

Evidence-based vaginal birth after Caesarean section. Best Practice and Research Clinical Obstetrics and Gynaecology. Vol 19. Pages 117–30. Guise JM, McDonagh MS, Osterweil P, Nygren P, Chan BK, Helfand M. 2004.

Systematic review of the incidence and consequences of uterine rupture in women with previous caesarean section. British Medical Journal. Volume 329. Pages 19-25. Guise JM, McDonagh MS, Hashima J, Kraemer DF, Eden KB, Berlin M, Nygren P, Osterweil P, Krages KP, Helfand M. 2003.

Vaginal birth after caesarean. Volume 1: evidence report and appendices. Agency for Healthcare Research and Quality. Page 211. Gyamfi C, Juhasz G, Gyamfi P, Stone JL. 2004.

Increased success of trial of labour after previous vaginal birth after caesarean. Obstetrics and Gynaecology. Vol 104. Pages 715-9. Hook B, Kiwi R, Amini S, Fanaroff A, Hack M. 1997.

Neonatal morbidity after elective repeat caesarean section and trial of labour. Paediatrics. Volume 100, Issue 3. Pages 348-53. Horey D, Weaver J, Russell H. 2008.

Information for pregnant women about caesarean birth (review). The Cochrane Collaboration. Issue 2, 2008. Jolly J, Walker J, Bhabra K. 1999.

Subsequent obstetric performance related to primary mode of delivery. British Journal of Obstetrics and Gynaecology. Volume 106. Pages 227- 32. Landon MB, Spong C, Thom E, Hauth JC, Bloom SL, Varner MW. 2006.

Risk of uterine rupture with a trial of labour in women with multiple and single prior caesarean delivery. *Obstetrics and Gynaecology*. Vol 108. Pages 12-20. Landon MB, Spong C, Leveno K, Varner M, Rouse D, Moawad A, Caritis S, Harper M, Peaceman A, Gersnoviez M. 2005.

The MFMU Caesarean Registry: Impact of fetal size on trial of labour success for patients with previous caesarean for dystocia. *American Journal of Obstetrics and Gynaecology*. Volume 195, Issue 4. Pages 1127 - 1131. Landon MB et al 2004.

Maternal and perinatal outcomes associated with a trial of labour after prior caesarean section. *New England Journal of Medicine*. Vol 351. Pages 2581-9. Lindqvist P, Dahlback B, Marsal K. 1999.

Thrombotic risk during pregnancy: A population study. *Obstetrics and Gynaecology*. Volume 94. Pages 595-9. Liston FA, Allen VM, O'Connell CM, Jangaard KA. 2008.

Neonatal outcomes with caesarean delivery at term. *Archives of Disease in Childhood – Fetal and Neonatal Edition*. Volume 93, Issue 3. Pages 176-82. Lydon-Rochelle M, Holt V, Easterling T, Martin D. 2001.

Risk of uterine rupture during labour among women with a prior caesarean delivery. *The New England Journal of Medicine*. Vol 345, issue 1. Pages 3-8. Macones GA, Cahill A, Pare E, Stamilio DM, Ratcliffe S, Stevens E. 2005.

Obstetric outcomes in women with two prior caesarean deliveries: is vaginal birth after caesarean delivery a viable option? *American Journal of Obstetrics and Gynaecology*. Vol 192. Pages 1223-8. Makoha FW, Felimban HM, Fathuddien MA, Roomi F, Ghabra T. 2004.

Multiple caesarean section morbidity. *International Journal of Gynaecology and Obstetrics*. Vol 87. Pages 227- 32.

National Institute for Health and Clinical Excellence. (2004). *Caesarean Section: Full Guideline*. RCOG Press, London. Pasupathy D, Smith G. 2008.

Neonatal outcomes with caesarean delivery at term. *Archives of Disease in Childhood-Fetal and Neonatal Edition*. Volume 93. Pages 174-5. Pfenninger J, Bachmann D, Bendicht Wagner P. 2001.

Survivors with bad outcome after hypoxic-ischaemic encephalopathy: full-term neonates compare unfavourably with children. *Swiss Medical Weekly*. Volume 131. Pages 267-72. Rageth JC, Juzi C, Grossenbacher H. 1999.

Delivery after previous caesarean: a risk evaluation. *Obstetrics and Gynaecology*. Vol 93. Pages 332-7. Richardson BS, Czikk MJ, daSilva O, Natale R. 2005.

The impact of labour at term on measures of neonatal outcome. *British Journal of Obstetrics and Gynaecology*. Vol 192. Pages 219-26. Smith GC, Pell JP, Cameron AD, Dobbie R. 2002.

Risk of perinatal death associated with labour after previous caesarean delivery in uncomplicated term pregnancies. The Journal of the American Medical Association. Vol 287. Pages 2684-90. Thomas J, Paranjothy S, Royal college of Obstetricians and Gynaecologists Clinical Effectiveness Support Unit. 2001.

The National Sentinel Caesarean Section Audit Report.
London, RCOG Press.
Villar J et al 2006.

Caesarean delivery rates and pregnancy outcomes: the 2005 WHO global survey on maternal and perinatal health in Latin America. Lancet. Vol 367, issue 9525. Pages 1796-7. Wen SW, Rusen ID, Walker M, Liston R, Kramer MS, Baskett T. 2004.

Comparison of maternal mortality and morbidity between trial of labour and elective caesarean among women with previous caesarean delivery. American Journal of Obstetricians and Gynaecologists. Vol 191. Pages 1263-9.

Swift, S.E., *Epidemiology of Pelvic Organ Prolapse and Urinary Incontinence* IN Bent, A.E., Cundiff, G.W., Swift, S.E., *Osteergard Urogynaecology and Pelvic Dysfunction* 6th Ed. 2008 Wolfes Kluwer, Philadelphia. Pg 27-38.

Enkin, M., *Labor and Birth after previous caesarean section* IN Enkin, M., Keirse, M.J.C., Neilson, J., Crowther, C., Duley, L., Hodnett, E., Hofmeyr, J., *A Guide to Effective Care in Pregnancy and Childbirth* 3rd Ed. 2000. Oxford University Press, Oxford. Pg 359-371.

Stutchfield, P., Whitaker, R., Russell, I. Antenatal Betamethasone and Incidence of Neonatal Respiratory Distress after Elective Caesarean CS: Pragmatic Randomised Trial. ASTECS Study. *BMJ* 2005; 331:662.

Management plan for women who have had previous caesarean section/s.

Birth Choices Clinic Midwife:.....

Obstetric Consultant:

Affix Label

Suitable for Birth Choices Clinic? Yes ☐ No ☐ If not, reason.....

If No, refer to Consultant. Date of referral..... signed.....

VBAC leaflet received? ☐ If not received, post with appointment letter.

Review of previous pregnancy / labour. ☐

Risks and benefits of VBAC discussed. ☐ Risks and benefits of ERCS discussed. ☐

Birth Choice Preference: VBAC / ERCS

Planned VBAC

Area discussed	Tick	Comments
Managing early labour at home		
Fetal Monitoring		
Analgesia (inc. use of pool & mobilisation etc)		
Labour care (inc. nutrition, hydration and cannulation)		
Management of postdates / IOL		

Planned ERCS

Date for ERCS booked.		Date:
Blood forms given		Date:
Premeds given		Date:
Plan if labour starts prior to ERCS.		