MATERNITY UNIT
GUIDELINE:

VAGINAL BIRTH AFTER CAESAREAN SECTIONS (VBAC)

SCOPE:
All midwives and obstetricians working in the maternity unit at Gisborne Hospital.

AUTHOR:
Midwifery Education & Quality Co-ordinator.

PURPOSE:
To assist midwives and obstetrician in counselling women who have previously had a caesarean section, in order for the woman to make an informed choice as to the mode of subsequent birth.

To provide guidance on caring for a woman in labour who chooses to birth vaginally following previous caesarean section (CS).

DEFINITIONS:
Vaginal birth after caesarean section (VBAC).

GUIDELINE:
It is now widely accepted that vaginal delivery may be attempted unless the indication for the previous CS recurs, the present pregnancy is complicated by another condition that warrants delivery by caesarean section or a high risk uterine incision was made.

It is the responsibility of the Lead Maternity Carer (LMC), in conjunction with the obstetrician, to inform the woman and her partner of the benefits and risks of VBAC.

Every woman should be debriefed following her first and any subsequent CS to discuss the reason for her CS and her chances of achieving a VBAC in future pregnancies including the risks and benefits of VBAC and her intended size of family.

Benefits
- 60-80% of women who plan a VBAC are successful.
- Following VBAC women experience a faster recovery with fewer limitations and shorter hospital stay.
- Breastfeeding is more likely to be initiated in the first hour after birth leading to a longer duration of breastfeeding.

Risks
- 20-40% of women who plan a VBAC will require an unplanned caesarean section in labour.
- The risk of blood loss, infection, and blood clots are higher in an unplanned caesarean section versus a scheduled caesarean section.
- Uterine scar rupture.
- At least one consultation with the obstetrician, the LMC, the woman and her whanau should be recommended during the pregnancy, preferably around 20 weeks gestation so that the woman has the opportunity to consider all options and make an informed decision by 36 weeks gestation.
- While women electing VBAC require the highest level of care that they are able to receive and accept, willingness of a healthcare provider to administer care in risk-prone circumstances cannot be misinterpreted as de facto support for sub-standard care.
- The woman’s clinical records documenting her CS are to be made available at the time of consultation – if she birthed at another unit, this is to be arranged by the LMC.
- Informational materials, including the RANZCOG treatment information pamphlet ‘Vaginal birth after caesarean section’ should be given to the woman prior to the consultation with the specialist.
- Women should be informed that Gisborne Hospital does not provide immediate access to obstetric, paediatric, anaesthetic and operating theatre personnel as recommended by the RANZCOG guidelines and the New Zealand Guidelines Group. In the event of an obstetric or neonatal emergency, there may be a delay in care that could affect outcome.

Contraindications/Relative Contraindications to Trial of Labour
- Previous classical or low vertical uterine incision
- More than one previous caesarean section
- Less than 18 months since the previous caesarean section
- Morbid maternal obesity
- Fetal EFW > 4 kg.

Factors that increase the success rate of VBAC
- Prior vaginal delivery
- Spontaneous onset of labour

Management of labour
- Woman for trial of labour should be advised to come into the Maternity Unit at the onset of established labour.
- On admission to the unit the LMC will:
  1. Assess the woman - abdominal palpation, baseline observations, urinalysis, auscultate fetal heart, vaginal examination – all to be documented in the woman’s clinical records
  2. Perform an admission CTG
  3. Intrapartum care should have been discussed with the obstetrician, the LMC and whanau and an agreed care plan entered into the woman’s clinical notes by the obstetrician and LMC
  4. If there are any concerns about fetal or maternal well-being at any time, the obstetrician is to be notified promptly.
  5. Cannulate for IV access, draw blood for CBC and Group and Hold, and send to laboratory.
• In active labour (i.e. regular painful contractions and >6cms dilated) there should be regular (at least every 4 hours) vaginal examinations to assess progress – i.e. dilatation of the cervix, position of the fetus and descent of the presenting part. The cervix should dilate at least at 1cm per hour in the active phase of labour.

• Continuous electronic foetal monitoring is advised in established labour, and must include both contractions and fetal heart monitoring. A cordless CTG monitor is available for this purpose so that the woman may still mobilise if a good trace can be obtained. Inform the woman that remaining active increases her chances of having a vaginal birth.

• Use of the birthing pool is not contra-indicated for VBAC and can promote active birth but a discussion on its use and fetal monitoring should have been included during the antenatal period between the LMC and the woman. If she chooses to use the birthing pool then the cordless CTG monitor can be used as this is waterproof.

• Epidural analgesia may be considered if requested and anaesthetist available.

• Medical induction of labour and augmentation of labour with Syntocinon should be undertaken with caution and great care as studies have shown these to increase the risk of uterine rupture.

Management of Second Stage
Plan to avoid a prolonged expulsive phase. Passive descent may be considered prior to active pushing commencing. Encourage upright positions and avoid use of bed.

• Second stage should not exceed an hour in duration without obstetric consultation unless birth is imminent.

Signs of possible scar rupture – (NB: SCAR RUPTURE MAY BE SUBTLE/SILENT)
• Fetal heart rate abnormality (the most common sign)
• Vaginal bleeding
• Cessation of labour
• Haematuria
• Ascent of presenting part (loss of station)
• Pain not controlled by epidural
• Lower abdominal tenderness – classically suprapubic pain and diaphragmatic pain, but note scar pain and tenderness is an unreliable sign
• Failure to progress in labour especially in the second stage
• Maternal tachycardia

The possibility of unrecognised scar rupture must be considered if:
• Fetal heart rate is abnormal during labour
• Bleeding continues following the birth despite a well contracted uterus.
• The mother suffers from unexplained symptoms of shock.

Be cautious if fetal or maternal observations show any sign of deviating from the normal at any time.
Management of Third Stage
VBAC increases the risk of postpartum haemorrhage and active management of the third stage is recommended.

ASSOCIATED DOCUMENTS:
- Maternity guideline – use of syntocinon
- Maternity guideline – obstetric and neonatal emergencies
- Maternity guideline – ruptured uterus
- Maternity guideline – intrapartum fetal heart rate assessment and monitoring
- Maternity guideline – Use of birth pool
- Appendix 1 – Consent for Vaginal Birth after Caesarean Section (VBAC)
- Appendix 2 – RANZCOG Vaginal Birth after Caesarean Section: A Guide for Women

REFERENCES:
- Maternity Services – Notice Pursuant to Section 88 of the New Zealand Public Health and Disability Act 2000. 1 July 2007
- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists Planned Vaginal Birth After Caesarean Section (Trial of Labour) (C-Obs 38); July 2013
- New Zealand Guidelines Group: Care of Women with Breech Presentation or Previous Caesarean Section Birth; Nov 2004

Date of Approval: 04/05/2015
Next Review Date: 04/05/2018