Birth Choices after Caesarean Section

University Hospitals of Leicester NHS Trust

C33/2015

Contents

1. Introduction and Who Guideline applies to

Maternity services in the UK have seen a consistent increase in Caesarean Section. There is a recent recommendation to not quote CS rate as a measurement of performance as it can compromise safety. The implications of Caesarean section for pregnant women and people in subsequent pregnancies are not to be underestimated: risks for both mother and baby, in both the current and potential future pregnancies, should be considered using best evidence available (RCOG 2015).

It is essential that pregnant women and people who have undergone a previous caesarean section receive timely and accurate information about the risk involved with a subsequent pregnancy to enable them to make an informed choice about the mode of delivery. Pregnant women and people who choose to undergo a vaginal birth after caesarean section should be cared for in a consistent and safe manner, minimising any risk that may be involved.

The aim of this guideline is to provide up to date evidence and guidance for professionals to inform pregnant women and people's choice of mode of delivery following a previous Caesarean (CS) and to ensure that their care is optimised. 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.

Philosophy:

It is possible for most pregnant women and people (72-75%) to have a successful vaginal delivery following a previous lower segment caesarean section (LSCS).

This guideline is based on NICE guidance on Caesarean Section and RCOG Green Top guideline on Birth After Previous Caesarean Section; it is aimed at all Health Care Professionals involved in the care of pregnant women and people who have had one or more previous Caesarean Sections. Its purpose is to provide evidence-based information to inform the care of pregnant women and people undergoing planned vaginal birth after previous caesarean section (VBAC).

2. Guideline Standards and Procedures

2.1 Antenatal counselling

All pregnant women and people with 1 prior Caesarean section and no other co-morbidities/risk factors should receive antenatal counselling with discussion of options of VBAC or Elective repeat Caesarean section.

Documented counselling of risks and benefits of VBAC versus Elective Repeat CS (facilitated use of VBAC proforma-Appendix). A review of the previous caesarean delivery, with access to the pregnant woman or persons previous obstetric medical record, should take place.

Antenatal counselling should include options of VBAC or elective LSCS, including success rates and contraindications.

Antenatal counselling:

- The pregnant woman or person should be advised to give birth in a unit with appropriate monitoring, blood transfusion facilities and immediate access to Caesarean section.
- Pregnant women and people should be offered continuous electronic fetal monitoring during labour.
- Pregnant women and people should be informed that overall, the chances of a successful planned VBAC are 72- 76% for pregnant women and people with no prior vaginal birth, and approximately 85-90% for pregnant women and people who have had one or more vaginal delivery as well as a Caesarean Section.
- Pregnant women and people should be informed that the risk of scar dehiscence or rupture is 50:10,000 (1:200 or 0.5%) with VBAC, compared to <2:10,000(<0.02%) with a planned repeat Caesarean Section
- The antenatal counselling of pregnant women and people with a prior Caesarean birth should be documented in the notes. This can be facilitated by using the VBAC pro forma.
- There should be provision of the 'UHL VBAC' patient information leaflet with the consultation. It can also be accessed on UHL YourHealth

2.2 Intrapartum plan

An intrapartum plan should be put in place by 37 weeks gestation for those pregnant women and people wishing to give birth normally

Pregnant women and people who wish to give birth normally should have an intrapartum plan put in place by 37 weeks gestation.

- A final decision for mode of birth should be agreed between the pregnant woman or person and the relevant health professional before the expected / planned delivery date (ideally by 37 weeks of gestation
- The 'VBAC Antenatal Counselling Form', (the intrapartum care plan is on the reverse of this form) including a plan for continuous electronic fetal heart rate monitoring, can be completed and placed in the notes where VBAC is chosen.

- It is the responsibility of the Obstetrician to document the agreed mode of delivery
- The VBAC counselling form can be used to assist counselling of the woman or birthing person.
- All discussions should be clearly documented in the maternity records.

2.3 Planned caesarean section

Pregnant women and people who wish, after appropriate counselling, to have a planned repeat Caesarean section should have a Caesarean section booked for 39 weeks gestation.

If, after appropriate counselling and discussion of risks, the pregnant woman or person wishes an elective repeat Caesarean section, the Caesarean section for 39 weeks gestation should be booked by a Consultant or Registrar on the online booking form.
If counselling in virtual clinic, the consent form will be completed in the preoperative review by consultant Obstetrician or Specialist Trainee.

2.4 Induction of labour

Induction of labour in pregnant woman and people having VBAC requires approval by a Consultant Obstetrician during the pregnancy.

- The obstetrician should provide counselling about prolonged pregnancy and risks of induction of labour in pregnant women and people planning VBAC.

- Spontaneous labour should be encouraged as there is evidence to suggest it is associated with reduced incidence of scar dehiscence as well as a higher rate of successful vaginal birth.

- A membrane sweep at term is NOT contraindicated in women or people with previous Caesarean section, and may reduce the need for formal induction of labour therefore should be;
    - performed at Term by the community midwife, provided there are no other contraindications to a sweep as per IOL guideline.

- An Antenatal plan should be made for pregnant women and people who have chosen to have **VBAC but not IOL:**

    - LSCS should be booked for around Term+7, with the aim for the C/S to be performed in the 41st week gestation in case the pregnant woman or person has not laboured by then. This can be deferred to Term +12 if the pregnant woman or person wishes.

- For pregnant women and people who wish VBAC who are considering IOL, then referral to a consultant-led clinic should be made for 39+0 - 39+6 week's gestation for further counselling and approval.

3. Education and Training

None

4. Monitoring Compliance

What will be measured to monitor compliance	How will compliance be monitored	Monitoring Lead	Frequency	Reporting arrangements
VBAC discussion Performa in notes	Audit of Maternity Notes	Specialist Midwife	Audit in 3 years	LW Lead
Intrapartum Plan by 37 weeks	Audit of maternity Notes	Specialist Midwife	Audit in 3 years	LW Lead
IOL booked after discussion with Consultant	Audit of Maternity Notes	Specialist Midwife	Audit in 3 years	LW Lead

5. Supporting References

1. Caesarean birth (NG192): National Institute for Clinical Excellence, 6 September 2023. National Collaborating Centre for Women's and Children's Health - (2021 last updated 2023)
2. Birth After Previous Caesarean Birth Green-top Guideline No. 45 October 2015

6. Key Words

Elective caesarean, Induction of labour, Uterine scar, VBAC, vaginal birth after caesarean section,

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The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.
As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

DEVELOPMENT AND APPROVAL RECORD FOR THIS DOCUMENT	
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REVIEW RECORD			
Date	**Issue Number**	**Reviewed By**	**Description Of Changes (If Any)**
July 2017	V1	L Harvey	No change
September 2020	V2	A Kulkarni, S Agarwal	Minimal modifications

October 2020	V3	S Agarwal and A Kulkarni	Birth Choices midwife removed as no longer midwifery led clinic. Statistics updated in recommendation 2. Proforma added in (appendix)
November 2023	V4	Agrawal Divya – Higher Specialist & Scott Mabbutt Consultant Maternity guidelines group Maternity governance group UHL Women's Quality & Safety Board	Added statement re-b c/s rate should not be used as a measurement of performance. Added Risk of caesarean section in future pregnancy may be increased & Increase need for pain relief to the VBAC proforma under disadvantages of ELCS 2-hourly vaginal examination when oxytocin in use - removed from the intrapartum care plan

Appendix 1 – VBAC counselling form

University Hospitals of Leicester NHS Trust

Patient Name:
ID:

Parity:
Number of previous CS:
Indication for previous CS:

Prerequisites for VBAC

- ☐ One or two previous CS
- ☐ No previous upper segment incision to uterus
- ☐ No previous uterine rupture
- ☐ No other contraindications to vaginal birth
- ☐ Birth in hospital on delivery suite
- ☐ Continuous FFM in established labour

Leaflets given: VBAC ☐ Elective CS ☐

Advantages of VBAC discussed:

- ☐ 72-75% success after 1 previous CS(with spontaneous onset of labour
- ☐ Avoids risks of planned surgery (VTE, visceral injury etc.)
- ☐ Faster recovery
- ☐ Greater chance of uncomplicated vaginal birth in future

Disadvantages of VBAC discussed:

- ☐ Risk of scar rupture approximately 1:200
- ☐ Risks to the baby with VBAC are comparable to those in first time labour, but higher than with a repeat CS
- ☐ 25% risk of emergency CS in labour (with higher risks than elective CS)
- ☐ 1% increased risk of needing blood transfusion over women having elective CS

Disadvantages of Elective CS at 39 weeks discussed:

- ☐ Reduced risk of scar rupture

Disadvantages of Elective CS discussed:

- ☐ Risk of CS in future pregnancy may be increased
- ☐ Increase risk for pain relief
- ☐ Risk of haemorrhage and blood transfusion
- ☐ Risk of infection (wound, urinary, chest)
- ☐ Risk of thrombosis (DVT/PE)
- ☐ Risk of bowel or bladder injury
- ☐ Risk of hysterectomy (as a life-saving procedure)
- ☐ Risks to baby:
  - Injury (1:100)
  - Breathing difficulty leading to NNU admission (1:10 at 37 weeks, 1:100 at 39 weeks)
- ☐ Longer recovery
- ☐ Implications for future pregnancy: risk of placenta praevia or accreta

Induction of labour (IOL) in the presence of a uterine scar

- ☐ Increased risks of scar complications with IOL or augmentation
  - Mechanical methods: similar to spontaneous labour, but commonly need syntocinon therefore approx 1:100
  - Prostaglandin plus syntocinon 1:50
  - Syntocinon alone 1:100
- ☐ Aim will be ARM +/- Syntocinon; balloon catheter if ARM not possible
- ☐ Obstetric consultant to be involved in all decision making, care plan will be individualised
- ☐ IOL to occur on delivery suite

MOD DECISION: ☐ VBAC ☐ Elective CS

- ***If for VBAC but no spontaneous labour:***
  ☐ IOL if appropriate ☐ Elective CS at …….. weeks
- ***If for Elective CS but presents in spontaneous labour:***
  ☐ Aim for VBAC ☐ Aim for repeat CS ☐ Discuss on admission
- ***If for IOL – Consultant authorising ……***

Date:
Name:
Signature: Designation:

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SUGGESTED INTRAPARTUM CARE PLAN – please individualise; use yellow care plan

Plan for labour

- Intravenous access, FBC, G&S when in labour
- Continuous electronic fetal monitoring in established labour
- Epidural analgesia may be used unless contraindicated
- Senior obstetric assessment before Oxytocin augmentation
- Avoid hyperstimulation
- 4-hourly vaginal examination for women in spontaneous, non-augmented labour
- Routine intrapartum maternal observations unless otherwise specified

- ***Immediate medical review*** **if any of the following occur (or other concerns regarding scar):**

  - Abnormal CTG
  - Severe abdominal pain between contractions
  - Chest of shoulder tip pain, sudden onset of shortness of breath
  - Acute onset scar tenderness
  - Abnormal vaginal bleeding or haematuria
  - Cessation of previously efficient uterine activity
  - Maternal tachycardia, hypotension or shock
  - Loss of station of the presenting part
  - Breakthrough pain despite working epidural

- Any decision for FBS must be discussed with consultant first (FBS generally discouraged in VBAC)

Plan for 3rd stage:

- ☐ Routine active third stage
- ☐ Active third stage plus Oxytocin infusion
- ☐ Other ……

Plan for Baby:

- ☐ Routine care
- ☐ Neonatal review at birth
- ☐ Other ……..

Date:
Name:
Signature: **Designation:**

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