# Birth choices and vaginal birth after Caesarean Section

University Hospitals of Leicester NHS
NHS Trust

C83/2005

## Contents



## 1. Introduction and who the 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, minimizing 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 of their choice regarding mode of delivery following a previous Caesarean (CS) and to ensure that their care is optimised to their needs. This involves careful antenatal discussion about the risks and benefits of vaginal birth after Caesarean (VBAC), elective repeat Caesarean section (ERCS), and careful considered management and observation at the time of labour and birth. Pregnant women and people are informed that they and their birthing partner have a choice re-timing, mode of birth and monitoring.

**Philosophy:**

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

This guideline is based on NICE guidance on Caesarean Section nice.org.uk/guidance/ng192 and RCOG Green Top guideline on Birth After Previous Caesarean rcog.org.uk/gtg_45.pdf ; 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 also to provide evidence-based information to inform the care of pregnant women and people undergoing planned vaginal birth after previous caesarean section (VBAC).

**What's new?**

- Merged 2 guidelines, previously titled Vaginal birth after caesarean section (C83/2005) and Birth choices after caesarean section (C33/2015)
- Actions to follow when requesting to birth in low risk settings.
- Use of telemetry
- Counselling re- balloon IOL & Propess® IOL (including Propess® prescribing)
- Psychological support and Postnatal advice
- Removed reference to performing FBS in the event of CTG abnormalities

**Related documents:**

- Supporting Birth Outside of Trust Guidance in Low Risk Midwifery Birth Settings UHL Obstetrics Guideline.pdf
- Induction and Augmentation of Labour UHL Obstetric Guideline.pdf

## 2. Antenatal care

### 2.1 Referral

- All pregnant women and people who have previously delivered by Caesarean Section should be referred antenatally for review at a hospital antenatal clinic to discuss and plan mode of delivery; the plan should be in place before 37 weeks gestation.

- This should be to the General Obstetric Clinic or the existing specialist clinic if already referred to one.

- This should be done by the community midwife or the antenatal core midwives.

### 2.2 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 - please see Appendix). A review of the previous caesarean delivery, with access to the pregnant woman or person's previous obstetric medical record, should take place.

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

- 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.

- For pregnant women and people who have had a previous caesarean section and wish to consider birthing in a low risk setting, please refer to the Supporting Birth Outside of Trust Guidance in Low Risk Midwifery Birth Settings UHL Obstetrics Guideline.pdf

- Pregnant women and people should be offered continuous electronic fetal monitoring during labour. Discuss utilisation of telemetry monitoring in labour.

- Pregnant women and people should be informed that overall, the chances of a successful planned VBAC are 72-75%, and slightly higher for those who have had one or more vaginal deliveries as well as a Caesarean Section, 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 (in spontaneous labour), compared to <2:10,000(<0.02%) with a planned repeat Caesarean Section

- Pregnant women and people should be informed that an emergency Caesarean section may increase the chances of heavy bleeding needing a blood transfusion, infection (such as intrauterine infection), a longer hospital stay and complications in future pregnancy like placenta praevia and placenta accrete.

- 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 (please see appendix).

- There should be provision of the 'UHL VBAC' patient information leaflet with the consultation. It can also be accessed on UHL YourHealth

### 2.3 Type of previous caesarean section:

- Pregnant women and people with one previous Lower Uterine Segment Caesarean Section should have a discussion regarding the mode of delivery.
- Pregnant women and people with two previous Lower Uterine Segment Caesarean Sections may opt for VBAC. Individual risk factors and personal choice must be taken into consideration and be in discussion with a Consultant Obstetrician.
- Pregnant women and people with a previous Classical Caesarean Section or a history of uterine rupture should be offered a planned repeat Caesarean as there is increased risk of uterine rupture.

### 2.4 Decision regarding mode of birth:

- A final decision for mode of birth should be agreed between the pregnant woman or person and member(s) of the maternity team before the expected/planned date of delivery (ideally by 37 weeks of gestation).
- For pregnant women and people who opt for an elective Caesarean Section, a plan for the event of onset of labour prior to the planned date should be discussed.
- It is the obstetrician's responsibility to counsel the pregnant woman or person and provide the above information
- 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, should 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 and complete the VBAC Antenatal Counselling Form.

## 3. Vaginal Birth After Caesarean Section (VBAC)

### 3.1 Prolonged pregnancy and VBAC

An antenatal plan for post-dates should be made for those who have chosen to have **VBAC;** For pregnant women and people who wish VBAC who are considering IOL, referral to a consultant-led clinic should be made for 39+0 - 39+6 week's gestation for further counselling and approval. This should include discussion regarding the risks of stillbirth once the pregnancy is post-dates (please refer to the Induction and Augmentation of Labour UHL Obstetric Guideline, section 2.2)

- 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 pregnant women and people with previous Caesarean section, and may reduce the need for formal induction of labour (IOL) therefore should be;
    - Performed from 39 weeks by the community midwife, provided there are no other contraindications to a sweep as per IOL guideline.

- Pregnant women and people may be offered induction of labour as long as they have been carefully counselled (and this has been fully documented) by a senior obstetrician.

- For those who wish to have an IOL, an individualised care plan should be made by a Consultant Obstetrician in the notes including the counselling that has taken place and whether prostaglandins may be used.

- Induction of labour may be offered for obstetric reasons, however both the pregnant woman or person and the health care professional need to be aware of an increased risk of scar dehiscence/rupture (1 in 50 if labour is induced using Prostaglandins, 1 in 100 where labour is induced with oxytocin without Prostaglandins). Risk with balloon induction is same as spontaneous labour but often need oxytocin and thus risk is 1 in 100. When counselling regarding balloon induction, this should be mentioned.

- The intervention of choice should be foley's balloon induction or artificial rupture of membranes +/- oxytocin. Where this is not possible, birthing women and people may request the use of Propess® rather than caesarean section.

- Propess® should only be used after agreement by a named obstetric consultant and the patient should be specifically informed that this is an unlicensed use of the drug (as per Trust guidelines on unlicensed drugs) as well as the increased risk of uterine rupture and decreased rate of vaginal delivery. The consultant obstetrician must carefully assess and counsel the birthing woman or person, taking into account their individual history and requests.

- **Propess® indication and use must be discussed with a consultant obstetrician and clearly documented for those who have had major uterine surgery. Propess® can only be prescribed by ST3 or above, following the consultant discussion.**

- Induction of labour in pregnant women and people must be performed and monitored on a medical / combined care unit with access to electronic fetal monitoring, a blood bank and theatre facilities.

- The pregnant woman or person should be monitored on Delivery Suite once in active labour as per Induction and Augmentation of Labour UHL Obstetric Guideline.pdf.

- Pregnant women and people not wishing to have IOL should be booked for elective caesarean section 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.

- Where induction is not appropriate, the appropriate paperwork for the caesarean section should be completed and a pre-operative appointment should go ahead.

### 3.2 Planned caesarean section

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

### 3.3 Labour prior to elective caesarean section

A plan should be made antenatally for pregnant women and people who have chosen to have an elective Caesarean Section but who then go into labour prior to the booked date for the Caesarean Section.

- A plan should be made antenatally and documented in the notes by the Obstetrician discussing modes of delivery.

- The pregnant woman or person should be informed that if they present in early labour prior to the booked date for Caesarean Section an emergency Caesarean Section will be performed or an option may be given to attempt VBAC in the absence of other contraindications.

- However, the pregnant woman or person should be informed about the possibility of delay in carrying out an emergency Caesarean Section, which will be prioritised based on maternal and fetal wellbeing.

- The pregnant woman or person should be informed that if they present in advanced labour, the risks of emergency Caesarean Section in the second stage may outweigh the risks of vaginal delivery.

## 4. Intrapartum care

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

- Where a pregnant woman or person presents in early labour, they should be reviewed by an ST3 registrar or above. A management plan including frequency of observations and auscultation of the fetal heart before labour is established should be documented by the reviewer in the health record.

- It is the midwife's responsibility to notify medical staff of the pregnant woman or person's admission, follow any subsequent care plan, support through labour, record observations and observe for signs of dehiscence and refer to medical staff where any deviations from the norm are noted

- It is the obstetrician's responsibility to make the initial assessment and plan for labour (which may be a review of notes and agreement with the VBAC personal Intrapartum Care Plan, or further detailed review in person as required). It is good practice to reconfirm and document the patient's understanding of the risks associated with VBAC, particularly when proceeding with induction or augmentation of labour.

### 4.1 Intrapartum care and observations:

- Abdominal palpation on admission / onset of labour

- Intravenous access, FBS, G&S
- Continuous electronic fetal heart rate monitoring as per Fetal Heart Rate Monitoring in Labour guideline
- Epidural anaesthesia is not contraindicated
- 'Routine' observations in labour as per Intrapartum care guideline unless otherwise requested

Continuous and consistent Intrapartum Care should be provided to enable early detection and management of scar dehiscence or rupture.

Early diagnosis of uterine scar rupture followed by expeditious laparotomy and resuscitation is essential to reduce associated morbidity and mortality in mother and infant. There is no single pathognomonic clinical feature that is indicative of uterine rupture but the presence of any of the intra/peripartum concerns listed below should raise the concern of the possibility of this event:

  - abnormal CTG
  - severe abdominal pain, especially if persisting between contractions
  - breakthrough pain despite working epidural
  - chest pain or 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

- The presence of any of the above signs associated with uterine rupture must be immediately reported to medical staff:
- It is the obstetrician's responsibility to act on any request for review by the midwife
- CTG concerns are considered to be one of the first signs of impending uterine rupture. In the event of CTG abnormality a full clinical review must take place.
- There should be close and critical review of the progress of spontaneous labour.
- Vaginal examinations should be offered every 4 hours during the active phase of labour to detect any delay in progress as soon as possible. Any delay should be promptly reported to the ST3 registrar or above.

### 4.2 Oxytocin augmentation

If Oxytocin augmentation is used caution needs to be exercised.

- Undertake only after discussion with the Consultant Obstetrician, including the decision to augment as well as an individualised management plan for review of subsequent progress and when to abandon augmentation.
- Although augmentation is not contraindicated it should be performed following careful obstetric assessment by a ST3 registrar or above and maternal counselling.
- Oxytocin augmentation should be titrated such that it should not exceed the maximum rate of contractions of four in 10 minutes (contractions more than 4 in 10 min have been associated with uterine rupture.)

- 4 hourly cervical assessments should be offered to show adequate progress, thereby allowing augmentation to continue (unless individualised plan states otherwise).

- Pregnant women and people should be informed that oxytocin augmentation for delay in first or second stage of labour reduces the chances of another caesarean section but increases the risk of uterine rupture and chance of an instrumental birth.

## 5. Immediate post natal care

Routine digital palpation / routine examination of the previous scar should NOT be performed after a vaginal delivery**.** This may only necessary if there is persistent vaginal bleeding

### 5.1 Psychological support and postnatal advice

Postnatal women and people should be counselled regarding birth details and a plan going forward for immediate care and future pregnancies. It should be documented clearly in notes regarding any implications for future births. There should be a plan documented for management for any complications if they happen, and the postnatal woman or person should be informed. Referrals for any further support should be made, if required.

## 6. Education and Training

No new skills required in order to implement this guideline

## 7. Monitoring & audit criteria

| 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 |

## 8. References

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## 13. Keywords

Classical Incision, Lower segment caesarean section, Scar dehiscence, Uterine rupture, VBAC

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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.**

**EDI Statement**

We are fully committed to being an inclusive employer and oppose all forms of unlawful or unfair discrimination, bullying, harassment and victimisation.

It is our legal and moral duty to provide equity in employment and service delivery to all and to prevent and act upon any forms of discrimination to all people of protected characteristic: Age, Disability (physical, mental and long-term health conditions), Sex, Gender reassignment, Marriage and Civil Partnership, Sexual orientation, Pregnancy and Maternity, Race (including nationality, ethnicity and colour), Religion or Belief, and beyond.

We are also committed to the principles in respect of social deprivation and health inequalities.

Our aim is to create an environment where all staff are able to contribute, develop and progress based on their ability, competence and performance. We recognise that some staff may require specific initiatives and/or assistance to progress and develop within the organisation.

We are also committed to delivering services that ensure our patients are cared for, comfortable and as far as possible meet their individual needs

| **DEVELOPMENT AND APPROVAL RECORD FOR THIS DOCUMENT** | | | |
|---|---|---|---|
| **Original Author:**<br>P McParland Consultant Obstetrician , L Harvey Midwifery Matron and Named Midwife for Safeguarding , S Hill and H Spinks-Essam Midwives | | | Executive lead<br>Chief Medical Officer |
| **Reviewed by:** | Agrawal Divya – Higher Specialist & Scott Mabbutt Consultant | | |
| **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<br>Maternity guidelines group<br>Maternity governance group<br>UHL Women's Quality & Safety Board | Added statement re- c/s rate should not be used as a measurement of performance.<br><br>Added Risk of caesarean section in future pregnancy may be increased & Increase need for pain relief to the VBAC proforma under disadvantages of ELCS<br><br>2-hourly vaginal examination when oxytocin in use - removed from the intrapartum care plan |
| June 2024 | V5 | L Taylor<br>C Roy<br>Maternity guidelines group<br>Maternity governance group<br>UHL Women's Quality & | Added signpost statement and hyperlink to the augmentation & induction of labour guidance when discussing risks of stillbirth and prolonged pregnancy.<br><br>The rest of the guidance has not been reviewed at this time. |

| | | | |
|---|---|---|---|
| | | Safety Board | |
| November 2024 | V5 | Divya Agrawal- Higher Specialist<br>Maternity guidelines group.<br>Maternity governance group<br>UHL Women's Quality & Safety Board | Combined Birth Choices after caesarean section C33/2015 & Vaginal birth after caesarean section C83/2005<br>Added reference to;<br>Action to follow when requests to birth in low risk settings.<br>Use of telemetry<br>Counselling re- balloon IOL & Propess IOL & Propess prescribing<br>Psychological support and PN advice<br>Removed reference to performing FBS in the event of CTG abnormalities |

# Appendix 1: VBAC counselling form



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 oxytocin therefore approx 1:100
  - Prostaglandin plus oxytocin 1:50
  - Oxytocin alone 1:100
- ☐ Aim will be ARM +/- Oxytocin; balloon catheter if ARM not possible
- ☐ Obstetric consultant to be involved in all decision making, care plan will be individualised
- ☐ Administration of Propess® must be an Obstetric Consultant discussion
- ☐ 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:



Title: Birth Choices and vaginal birth after caesarean Section
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Trust Ref No: C83/2005

## Appendix 2: Intrapartum care plan

University Hospitals of Leicester NHS Trust

**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, consider use of telemetry
- 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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