Guideline for the management of a Vaginal Birth after Caesarean Section (VBAC)

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Section Headings

1.0 Introduction

For simplicity of language, this guideline will use the term 'women' or 'mother' throughout, and this should be taken to include people who do not identify as women but who are pregnant or who have given birth.

Women with a prior history of one uncomplicated caesarean section require information in order to make an informed decision regarding the mode of birth in subsequent pregnancies, including the option of Vaginal Birth after Caesarean Section (VBAC) or Elective Repeat Caesarean section (ERCS).

The overall caesarean birth rate for England 2020 was 29% (NHS digital). Therefore, the management of subsequent pregnancies including birth planning is an important component of care for a significant number of women who access our services. The consensus of opinion from NICE and the RCOG is that a planned VBAC is a clinically safe choice for the majority of women with a single previous LSCS and would reduce maternal morbidity associated with multiple caesarean births.

This is a woman-centred pathway, ensuring that women receive current evidence based information and have the opportunity to discuss their options in order to make the right choices for themselves and their families.

This information will reflect RCOG Guideline CG45 (2015):
• To facilitate Shared Decision Making
• To identify a plan of care and mode of birth by 30 weeks gestation

2.0 Objective

The guideline aims to outline the management of women choosing a VBAC or ERCS. It provides information for clinicians to use in discussion with the woman about the benefits and risks associated with VBAC versus ERCS and describes ways of providing that information and facilitating discussion.

3.0 Scope

The guideline applies to all medical and midwifery staff working within Maternity services at Barnsley Hospital.

4.0 Main body of the document

4.1 Suitability for planned VBAC

The following women are most suitable for a planned VBAC:

- Singleton pregnancy with a cephalic presentation at ≥ 37+0 weeks gestation who have had a single previous LSCS with or without a previous vaginal birth

VBAC is contraindicated in the following women:

- Previous myomectomy breaching the uterine cavity
- Previous uterine rupture or perforation
- Classical caesarean section scar
- Previous T or J incisions, low vertical uterine incisions or significant uterine extensions at the time of primary caesarean section

- Absolute contra-indications to vaginal birth irrespective of whether there is a uterine scar

Women with the following history will have an individual risk assessment and review if VBAC is being considered. There is uncertainty about the safety and efficacy of planned VBAC in these circumstances and therefore a cautious approach is advised:

- Two or more previous LSCS
- Postdates
- Twin pregnancies
- Fetal macrosomia
- Antepartum stillbirth
- Maternal age >40
- Short interval between this pregnancy and the last delivery (<12 months)
- Obesity (BMI >30)

4.2 Management in the antenatal period

At first contact women should be given or signposted to the RCOG patient information leaflet: Birth after previous caesarean patient information leaflet | RCOG

After receiving the relevant information, the woman will have the opportunity to discuss the options available to them with their Consultant. The risks and benefits of VBAC and ERCS will be discussed (See appendix 1). If the woman remains undecided as to mode of birth or is requesting a ERCS when VBAC is an appropriate option she should be offered referral to the birth in mind service.

Ideally a decision should be reached by the woman with the help and support of the obstetrician/midwife by 30 weeks gestation (in order to facilitate a suitable date for ERCS).

The risks and benefits of VBAC and ERCS will be shared with the woman. See appendix 1-7.

The woman and the clinician will complete the Trust VBAC proforma Add link to sharepoint. This will be filed in the woman's records and recorded on EPR.

The management plan will be recorded in the woman's records and on EPR. The woman will be made aware that any emerging risk factors may change the recommendations made and subsequent management plan.

If a woman with a previous uterine scar goes into labour or requires an induction of labour without a pre-planned consultant discussion regarding mode of birth, the consultant on duty must be contacted so that appropriate discussions can take place with the woman and a decision regarding mode of birth made.

4.3 Induction or Augmentation of labour

The obstetrician will discuss the following information with the woman and document an agreed management plan in the woman's records:

- Whether induction of labour is appropriate
- When to induce the labour
- Method of induction
- Whether augmentation with oxytocin is appropriate following evaluation of risks and benefits

- Frequency of assessments of progress, in particular vaginal examinations and plans for when the VBAC would be discontinued

Women should be informed of the following:

- Uterine rupture is two to three times more likely if labour is induced
- Caesarean section is 1.5 times more likely than with a spontaneous labour
- There is an increased risk of instrumental delivery

4.4 Management of labour

Management of labour will be managed in accordance with the "Guideline for the Management of Intrapartum Care for Healthy Women and Babies" with the following additional requirements:

- Offer continuous fetal monitoring if amniotomy is performed or the woman requires oxytocin
- Gain consent and send bloods for FBC, Group and Save, if appropriate. Do not routinely offer to cannulate women in labour who have had a previous Caesarean section following individualised risk assessment
- Offer Omeprazole 40mg and 20mgs 12 hourly after an individual risk assessment
- Offer a full range of options for pain relief in labour including birth in water
- If requested, Epidural anaesthesia may be provided (staff should be aware that an increased requirement for pain relief despite the epidural may be a sign of impending uterine rupture)
- Offer Regular cervical assessment of progress every 4 hours
- If augmentation is required the decision is made by the Consultant/registrar on call. Syntocinon for augmentation should be used with caution and a discussion with the woman and the consultant must be made prior to making a plan of care

4.5 Management of Elective Repeat Caesarean Section (ERCS)

- ERCS delivery will be conducted after 39+0 weeks gestation unless there is a clinical indication for earlier birth
- Antibiotics should be administered before making the skin incision

4.6 Uterine rupture or complete scar dehiscence

Uterine rupture or complete scar dehiscence is usually characterised by:

- Severe abdominal pain, especially if persisting between contractions
- Acute onset scar tenderness
- Abnormal vaginal bleeding (please note – bleeding may not be evident)
- Haematuria
- Failure to progress
- Marked CTG abnormalities
- Cessation of previously efficient uterine activity
- Maternal tachycardia, hypotension
- Shock
- Maternal collapse with loss of consciousness

- Loss of station of the presenting part
- Change in abdominal contour and inability to pick up the fetal heart at the original transducer site

If any of these signs occur and an Oxytocin infusion is in progress this should be stopped. Immediate delivery by caesarean section is recommended. The consultant must be informed. This will be discussed with the woman and consent must be gained for any intervention.

5.0 Roles and responsibilities

5.1 Midwives

Have a responsibility to work collaboratively with the woman and obstetric staff to ensure the woman has the required information to enable her to make an informed choice.

5.2 Obstetricians

Have a responsibility to work collaboratively with the woman and midwifery staff to ensure the woman has the required information to enable her to make an informed choice.

6.0 Associated documents and references

National Institute for Health and Care Excellence (NICE) Guideline 121. Intrapartum care for women with existing medical complications or obstetric complications and their babies (2019) [online] www.nice.org.uk

National Institute for Health and Care Excellence (NICE). Clinical guideline 190. Intrapartum care: care of healthy women and their babies during childbirth (2014) [online] www.guidance.nice.orguk/cg190

National Institute for Health and Care Excellence (NICE) Clinical Guideline 132 Caesarean Section (2011) [online] www.nice.org.uk

NHS Digital. Maternity Services Monthly Statistics - August 2018, Experimental statistics (2018) [online] www.digital.nhs.uk

Royal College of Obstetricians and Gynaecologists. (2015) Green-top Guideline No.45. [Online] www.rcog.org.uk

Royal College of Obstetricians and Gynaecologists. Green-top Guideline No. 72. Care of Women with Obesity in pregnancy (2018) [online] www.rcog.org.uk

Greater Manchester and Eastern Cheshire SCN, Vaginal Birth After Caesarean Section Guideline (2019) [online] GMEC-VBAC-Guideline-FINAL-V1.0-October-2019.pdf (england.nhs.uk)

7.0 Training and resources

Training will be delivered as outlined in the Maternity Training Needs Analysis. This is updated on an annual basis.

8.0 Monitoring and audit

Any adverse incidents relating to the guideline for VBAC will be monitored via the incident reporting system. Any problems will be actioned via the case review and root cause analysis action plans. The action plans are monitored by the risk midwife to ensure that improvements in care are made. The trends and any root cause analysis are discussed at the monthly risk meetings to ensure that appropriate action has been taken to maintain safety.

The guideline for VBAC will be audited in line with the annual audit programme, as agreed by the CBU. The audit action plan will be reviewed at the monthly risk management meetings on a quarterly basis and monitored by the risk midwife to ensure that improvements in care are made.

9.0 Equality and Diversity

This section is mandatory for all Trust Approved Documents and must include the statement below:

The Trust is committed to an environment that promotes equality and embraces diversity in its performance as an employer and service provider. It will adhere to legal and performance requirements and will mainstream equality, diversity and inclusion principles through its policies, procedures and processes. This guideline should be implemented with due regard to this commitment.

To ensure that the implementation of this guideline does not have an adverse impact in response to the requirements of the Equality Act 2010 this policy has been screened for relevance during the policy development process and a full equality impact assessment is conducted where necessary prior to consultation. The Trust will take remedial action when necessary to address any unexpected or unwarranted disparities and monitor practice to ensure that this policy is fairly implemented.

This guideline can be made available in alternative formats on request including large print, Braille, moon, audio, and different languages. To arrange this please refer to the Trust translation and interpretation policy in the first instance.

The Trust will endeavor to make reasonable adjustments to accommodate any employee/patient with particular equality, diversity and inclusion requirements in implementing this guideline. This may include accessibility of meeting/appointment venues, providing translation, arranging an interpreter to attend appointments/meetings, extending policy timeframes to enable translation to be undertaken, or assistance with formulating any written statements.

9.1 Recording and Monitoring of Equality & Diversity

This section is mandatory for all Trust Approved Documents and must include the statement below:

The Trust understands the business case for equality, diversity and inclusion and will make sure that this is translated into practice. Accordingly, all guidelines will be monitored to ensure their effectiveness.

Monitoring information will be collated, analysed and published on an annual basis as part of Equality Delivery System. The monitoring will cover the nine protected characteristics and will meet statutory employment duties under the Equality Act 2010. Where adverse impact is identified through the monitoring process the Trust will investigate and take corrective action to mitigate and prevent any negative impact.

Appendix 1- Maternal Outcomes/Risks and Benefits from 39+0 weeks gestation (GMEC,2019)

Planned vaginal birth after caesarean	Planned caesarean section
Between 72-75 in 100 (72% - 75%) women who plan a vaginal birth after a caesarean section are able to have one. The same chance as a woman who has not had a baby before. • If a woman has also had a previous vaginal birth, the chance of having another vaginal birth is around 9 out of 10 (90%) • Difficulties with the pregnancy or during labour might mean that a woman needs to have a caesarean section • The rate of instrumental delivery is increased with VBAC (can be up to 39%) • There is a reduced chance of having a vaginal birth if: a woman has a raised Body Mass Index (equal to or over 30); labour is induced; a woman has never had a vaginal birth, if there was previous labour dystocia – which means the cervix stopped dilating past a certain level. Risk increases up to 3-fold if oxytocin is used • 1 in 200 (0.5%) risk of having uterine rupture. Risk increases 2 - 3 times if labour induced • If successful shorter recovery period • Risk of anal sphincter injury 3rd/4th degree tear 5 in 100 (5%, and birth weight is the strongest predictor of this) • Reduced risk of venous thrombosis • Risk of maternal death 4/100 000 • Successful VBAC has the fewest complications and increases likelihood of future vaginal births • Unsuccessful VBAC resulting in emergency caesarean section has the greatest adverse outcomes associated • Around 25 in 100 women (25%) who choose a vaginal delivery will have an unplanned caesarean section during labour • A caesarean section will be performed if there is any immediate danger to a woman or her baby, or if the labour is not progressing	About 98 in 100 (98%) women who plan a repeat caesarean section are able to have one. • Able to plan delivery date however this may change due to clinical circumstances • Small increased risk of placenta previa/accreta and adhesions with successive caesarean /abdominal surgery • Virtually avoids risk of ruptured uterus (0.02%) • Reduces risk of pelvic organ prolapse and urinary incontinence in short term • Option for sterilisation if fertility no longer required. NB this should not be a determining factor for caesarean section. • Risk of bladder ureteric /bowel damage (1/1000) • There is no risk of obstetric anal sphincter injury with ERCS • If a woman goes into labour before her caesarean section date, and labour is advanced by the time she reaches the hospital, it may be safer for the woman and her baby to continue with a vaginal delivery • Around 10 in 100 (10%) women who plan a repeat caesarean section go into labour before their scheduled caesarean section date. Unless a woman is in advanced labour, she should still be able to have a caesarean section if she wishes • Longer hospital stay and recovery • Risk of maternal death with ERCS 13 /100 000 • If BMI is raised there is an increased risk of surgical/venous thromboembolic complications • Anticoagulant is required for CS for 7-10 days for all women • If BMI is raised an anti-coagulant injection should be taken up to 6 weeks post operation

Appendix 2: Infant Outcomes/ Risk and Benefits from 39+0 weeks gestation (GMEC,2019)

	Planned vaginal birth	Planned caesarean section
RDS	• Respiratory distress syndrome. A temporary breathing problem occurring in some mature babies (born after 37 weeks) - happens to less than 1 in 1,000 babies born by vaginal births after caesarean section	• RDS happens to around 4 in 1,000 to 6 in 1,000 babies born by repeat caesarean section and is limited by ensuring the caesarean section is booked for no earlier than the 39th week of pregnancy
Infant death	• The chance of a baby dying during or after a planned vaginal birth after a caesarean section is very small (1/1000, the same risk as a first-time mother giving birth after 39 weeks of pregnancy). The chances of a baby dying are about the same as the chances of that happening during a vaginal birth when a woman gives birth for the first time • Planned VBAC associated with 10/10 000 prospective risk of antepartum still birth beyond 39 +0 weeks • 4/10 000 (0.04%) risk of delivery related perinatal death	• The chance of a baby dying during or just after a planned repeat caesarean section after 39 weeks is virtually nil
HIE	• HIE (hypoxic ischaemic encephalopathy) is 8 times higher in relative terms at VBAC (8/10 000) compared to 1/10 000 at ERCS while absolute risk is minimal	• <1/10 000 risk of delivery related perinatal death or HIE

Appendix 3: Chance of other health problems for the baby (GMEC,2019)

	Planned vaginal birth	Planned caesarean section
Transient Tachypnoea of the Newborn:	• This is a condition where the baby breathes abnormally fast. It may happen if the baby is delivered before the 39th week of pregnancy. Often treated by giving the baby oxygen or antibiotics. It is not life threatening and usually stops after a day or two • Babies with transient tachypnoea may need a short stay in a neonatal unit (NNU) for observation • Occurs in about 26 in 1,000 babies delivered vaginally	• Occurs in about 36 in 1,000 babies delivered by caesarean
Accidental cuts		• Between 7 in 1,000 and 31 in 1,000 babies are accidentally cut by the doctor during caesarean delivery. This is more likely during an unplanned caesarean section (when the waters have gone) than a planned caesarean section • The cuts can occasionally leave scars.

Appendix 4: Chance of serious health problems for the mother (GMEC,2019)

The rates of hysterectomy and co morbidities of thromboembolic disease, transfusion and endometriosis did not differ significantly between planned VBAC V ERCS. It is very rare for a woman to die during childbirth, or from problems related to childbirth, in the United Kingdom. Overall, the numbers are 7 in 100,000 births; the difference between deaths after a planned caesarean section and deaths after a vaginal birth is small enough to be down to chance.

Appendix 5: Chance of other health problems for the mother

	Planned vaginal birth	**Planned caesarean section**
Endometritis	• An infection of the lining of the womb. It occurs in nearly 3 in 100 women (3%) who have a planned vaginal birth after a caesarean section • The condition is treated with antibiotics, and in 90 in 100 (90%) of cases, it clears up within three to four days	• Occurs in nearly 2 in 100 women (2%) who have a planned repeat caesarean section • The condition is treated with antibiotics and usually clears up within one week. Women having a caesarean section are generally given antibiotics when the caesarean section is being carried out
Stress incontinence	• Where urine leaks while coughing, laughing, sneezing, or exercising. This usually improves within a few weeks of giving birth, but sometimes lasts for several months • Having several pregnancies increases a woman's chances of getting stress incontinence • About 12 in 100 (12%) women who have a vaginal birth get stress incontinence	• About 7 in 100 women (7%) who have a caesarean section get stress incontinence • A caesarean section operation won't cause stress incontinence, but being pregnant might
Abdominal discomfort		• About 9 in 100 (9%) women experience continuous wound and abdominal discomfort in the first few months after surgery.

Appendix 6: Hospital stay and home recovery (GMEC,2019)

Planned vaginal birth	Planned caesarean section
• Babies are given a thorough check (neonatal examination) by a nurse, midwife, or doctor within 72 hours of being born • This may be in hospital or at a woman's home if she has been discharged • If a woman had stitches or other problems, recovery could take several weeks. Women should be able to get back to their normal activities, including looking after other children, driving, and normal social activities, as soon as they feel well enough to do so	• The same check-up will be given within 24 hours of being born • Following an uncomplicated CS, mother and baby usually go home within 24 hours • It can take four to six weeks to fully recover from a caesarean section. This can affect ability to drive. The woman is advised to contact her vehicle insurance provider to receive advice for when she can recommence driving • While the wound is healing, a woman should not drive, do strenuous exercise or household chores, lift anything heavier than her baby, or have sex • A woman can start doing these things again once she feels able to do them and they do not cause pain. For some women, this may be in a few weeks. For others, it may be longer • Some women have abdominal pain following a caesarean section. The pain from the caesarean section wound may last six to eight weeks

Appendix 7: Effect on choice in future childbirth (GMEC,2019)

Planned vaginal birth	Planned caesarean section
• Women who choose a vaginal birth are likely to be able to choose either another vaginal birth or a planned caesarean section in future pregnancies • If a woman has a successful vaginal birth this time, her chance of having a successful vaginal birth in the future with a straightforward recovery will be higher. About 94 in 100 (94%) women who have a successful vaginal birth after a caesarean section, have a successful second vaginal birth • If a woman has an assisted vaginal delivery (with forceps or ventouse), the chance that she will need an assisted delivery next time will be much lower • Having an unplanned caesarean section or changing to a planned caesarean section may affect a woman's chances of having a vaginal birth next time • Women who have had two or more prior lower segment caesarean deliveries may be offered VBAC after counselling by a consultant obstetrician. (RCOG 2015)	• Having multiple CS increases the risks of placenta praevia /accreta/adhesions and increases the likelihood of further CS.

Appendix 8
Glossary of terms

- BMI – Body mass index
- CTG - Cardiotocograph
- ERCS – Elective repeat caesarean section
- FBC – Full blood count
- IV – Intra-venous
- LSCS – Lower segment caesarean section
- RCOG – Royal College of Obstetricians and Gynaecologists
- VBAC – Vaginal birth after caesarean

Appendix 9 (must always be the last appendix)
Maintain a record of the document history, reviews and key changes made (including versions and dates)

Version	Date	Comments	Author
1	05/08/2013		
2	03/02/2014		
3	14/12/2015		

Review Process Prior to Ratification:

Name of Group/Department/Committee	Date
Reviewed by Maternity Guideline Group	N/A
Reviewed at Women's Business and Governance meeting	17/03/2023
Approved by CBU 3 Overarching Governance Meeting	22/03/2023
Approved at Trust Clinical Guidelines Group	N/A
Approved at Medicines Management Committee (if document relates to medicines)	N/A

Trust Approved Documents (policies, clinical guidelines and procedures)

Approval Form

Please complete the following information and attach to your document when submitting a policy, clinical guideline or procedure for approval.

Document type (policy, clinical guideline or procedure)	**Guideline**
Document title	Guideline for the management of a Vaginal Birth after Caesarean Section (VBAC)
Document author (Job title and team)	Consultant Obstetrician, BBC Senior Midwife, Maternity Voices Partnership (MVP)
New or reviewed document	Reviewed. Replaces Birth after LSCS or other uterine scar
List staff groups/departments consulted with during document development	Obstetricians, Midwifes, MVP
Approval recommended by (meeting and dates):	WB&G 17/03/2023 CBU3 Governance 22/03/2023
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Key words for search criteria on intranet (max 10 words)	Maternal choice
Key messages for staff (consider changes from previous versions and any impact on patient safety)	
I confirm that this is the <u>FINAL</u> version of this document	Name: Jade Carritt Designation: Governance Midwife

FOR COMPLETION BY THE CLINICAL GOVERNANCE TEAM

Approved by (group/committee): CBU Governance **Date approved: 22/03/23** **Date Clinical Governance Administrator informed of approval: 23/03/2023** **Date uploaded to Trust Approved Documents page: 28/03/2023**