University Hospitals of North Midlands NHS
NHS Trust

Achieving Sustainable Quality in Maternity Services

ASQUAM

Guideline for Vaginal Birth after Caesarean Section (VBAC)

Amalgamating and superceding Midwife-Lead VBAC v2 and VBAC v10

Date of Ratification:	14/6/22
Date of Next Review:	3 years
Ratified by:	Maternity Forum Sub-Group Obstetric Guideline Group
Author:	Consultant Obstetrician and Gynaecologist Community Team Leader

VERSION CONTROL SCHEDULE

Version	Date	Author	Comments
1	1997	Mr R B Johanson Consultant Obstetrician	New guidance
2	1999	Mr R B Johanson Consultant Obstetrician	
3	2005	Sr L Dudley Mr P Young Consultant Obstetrician	
4	2009	Dr N Siraj, SPR Obstetrics & Gynaecology	
5	2011 – June	Miss R Indusekhar Consultant Obstetrician/Guideline Lead Mrs D Turner Community Midwife Team Leader	In line with CNST standards issued January 2011
6	2011 – Dec	Miss R Indusekhar Mrs D Turner,	Section added: 4. Decision for trial of VBAC at UNHS. • Any issues discussed and evaluations concluded will help influence a individual management plan for the place of labour and intrapartum management. This plan must be clearly documented within the medical records. A patient information leaflet should be provided with the consultation (see appendix 1) **and it should be documented in the woman's health records that this has been given to her.**
7	2012	Miss R Indusekhar Mrs D Turner	**Changes include: addition to sentence shown in bold** **4. DECISION FOR TRIAL OF VBAC AT UHNS** **Document antenatal discussion and the mode of delivery** Any issues discussed and evaluations concluded will help influence a individual management plan for the place of labour and intrapartum management. This plan must be clearly documented within the medical records. A patient information leaflet should be provided with the consultation (see appendix 1) **which informs the woman that her baby will be continuously monitored during labour** and it should be documented in the woman's health records that this has been given to her. Appendix 1 – Patient information leaflet updated – first sentence has been made bold. A copy of the updated leaflet will be circulated after ratification and old versions taken out of circulation **What happens in a VBAC?** Labour after a previous caesarean section is managed like any other labour but your baby will be continuously monitored. We will take blood specimens so that we are able to cross-match blood quickly if problems arise.
8	2013 - July	Miss R Indusekhar Mrs D Turner	All of the above guideline have been updated with minor changes to the audit table in line with recommendations made by the CNST assessor in preparation for the Level 3 assessment in November 2013.
9	2013 - Oct	Miss R Indusekhar Mrs D Turner	Change made - additional sentence included **4. Decision For Trial of VBAC At UHNM** • Any issues discussed and evaluations concluded will help influence a individual management plan for the place of labour and intrapartum management. This plan must be clearly documented within the medical records. A patient information leaflet should be provided with the consultation (see Appendix 1) which informs the woman that her baby will be continuously monitored during labour. Documentation should indicate that either the patient information leaflet has been given or that the plan for fetal monitoring during labour has been discussed. Reviewed by pharmacist – syntocinon changed to read oxytocin.
10	2016	Dr J Chan Consultant Obstetrician/Guideline Lead	Patient information changed in line with VBAC clinic guideline.

11	2022 – DRAFT 14/6/22	Reviewed and updated by: C Cole Birth Choices Midwife for VBAC	Full review undertaken Please note that this guideline is an amalgamation of the Midwife-Lead VBAC Clinic v2 guideline and VBAC guideline v10

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1. PURPOSE AND SCOPE

The purpose of the guideline is to outline the antenatal and intrapartum care pathway for women who have undergone a previous caesarean section.

2. DEFINITIONS

Vaginal Birth after Caesarean (VBAC)
VBAC stands for 'vaginal birth after Caesarean'. It is the term used when a woman gives birth vaginally after having a caesarean birth in the past.

Elective Repeat Caesarean Section (ERCS)
An elective repeat Caesarean birth is a planned Caesarean birth which is usually scheduled from 39 weeks gestation.

3. ANTENATAL CARE SCHEDULE

The antenatal care schedule should comply with that recommended by the NICE antenatal care guideline and local antenatal care guidelines with specific reviews as shown in Appendix 2.

Some women with a history of previous Caesarean birth and in the absence of risk factors, can stay under the care of the birth choices midwife during the antenatal period with a referral to a consultant obstetrician for a post dates care plan from 40 weeks gestation if they have not delivered, or if any medical or obstetric complications arise during pregnancy. Please see appendix 1 to establish which women are eligible to stay under the care of the Lead Midwife for VBAC at the booking appointment.

Upon establishing the care pathway please refer the woman to either the ANC for an appointment to see a consultant/obstetrician ST3 or more senior or to the Birth Choices clinic for an appointment with the lead midwife. Women booked under the care of the lead midwife do not need to be seen in an obstetric clinic as well, unless any medical or obstetric complications arise during pregnancy.

4. ANTENATAL COUNSELLING

All professionals providing antenatal care have a duty to support women in their choices. Senior doctors and the lead midwife are responsible for discussing birth choices with individual women, and documenting this discussion in the VBAC wizard and management plan within the online notes. This incorporates checklists that are recommended by the RCOG and facilitates best practice in antenatal counselling, shared decision making and documentation.

A final decision for mode of birth should be agreed upon by the women and members of the maternity team before the expected due date/planned date of birth, ideally before 36 weeks of gestation.

When an ERCS is agreed there should be a documented discussion/plan in place for the event of labour starting.

All women should be referred to the birth after Caesarean section information leaflet (within my pregnancy notes) at the booking appointment. Alternatively the Royal College of Obstetricians and Gynaecologist patient information leaflet "Birth after previous caesarean" available at https://www.rcog.org.uk/for-the-public/browse-all-patient-information-leaflets/birth-after-previous-caesarean-patient-information-leaflet/

5. WOMEN WHO HAVE HAD 2 OR MORE CAESAREAN BIRTHS

Women who have had two or more prior lower segment Caesarean deliveries may be offered VBAC after counselling by a Consultant Obstetrician and being fully informed on the increased risks. This should include:

- Risk of uterine rupture (1.36%)
- Risk of hysterectomy (56/10,000 compared with 19/10,000)
- Blood transfusion (1.99% compared with 1.21%)

VBAC success rates have shown similar rates 62-75%; however, it should be noted that half of the women with 2 previous CS had also had a previous vaginal birth.

6. SUITABILITY FOR PLANNED VBAC

Planned VBAC is appropriate for and may be offered to the majority of women with a singleton pregnancy of cephalic presentation at 37+0 weeks or beyond. Evidence suggests that planned VBAC is a safe and appropriate mode of birth for the majority of pregnant women who have had a single previous lower segment Caesarean birth, with or without a history of previous vaginal birth.

7. CONTRAINDICATIONS TO VBAC

• Previous classical Caesarean birth due to the high risk of uterine rupture.

• Women with previous inverted T or J incision, low vertical uterine incisions or significant inadvertent uterine extension at the time of primary Caesarean.

• Previous uterine rupture – reported risk 5% or higher of recurrent uterine rupture with labour.

• The presence of contraindications to labour such a placenta praevia.

8. FACTORS INFLUENCING THE INCREASED RISK OF UTERINE RUPTURE

An individualised assessment of the suitability for VBAC should be made in women with factors that increase the risk of uterine rupture. Due to limited data there is uncertainty of how to incorporate this information in antenatal counselling and therefore the presence of these risk factors does not always contraindicate VBAC. However, such factors may be considered during the decision making process, particularly if considering induction or augmentation of VBAC labour.

- Short birth term interval (less than 12 months)
- Post-dates pregnancy
- Maternal age of 40 years or more
- Obesity
- Lower pre-labour Bishop score
- Macrosomia

9. RISKS AND BENEFITS OF OPTING FOR VBAC VERSUS ERCS FROM 39 WEEKS OF GESTATION

Please see Appendix 2 for more information.

Women should be made aware that successful VBAC has the fewest complications.

The greatest risk of adverse outcomes occurs in a trial of labour resulting in an emergency CS.

VBAC is associated with an approximately 1 in 200 (0.5%) risk of uterine rupture.

ERCS is associated with an increased risk of placenta praevia and/or accreta and of pelvic adhesions complicating any future abdominopelvic surgery.

There is an increase in neonatal respiratory morbidity when ERCS is performed before 39 weeks.

9.1. What is the likelihood of VBAC success?

The overall success rate is 72-75% in planned VBAC**.**

9.2 Factors improving the success rate of VBAC

- Previous vaginal birth is the single best predictor associated with a success rate of 85-90%. This is also associated with a reduced risk of uterine rupture.
- Spontaneous onset of labour
- Favourable cervix for induction (higher Bishop score)
- One to one care in labour
- Greater maternal height
- Maternal age less than 40 years
- BMI less than 30
- Gestation of less than 40 weeks
- Infant birth weight less than 4kg
- Previous failed induction of labour (IOL)

Successful VBAC is more likely among women with previous Caesarean for:

- Fetal malpresentation 84%
- Labour dystocia 64%
- Fetal distress 73%
- Previous unsuccessful instrumental birth 61%

10. INDIVIDUAL MANAGEMENT PLAN FOR LABOUR

Early Labour

All women should be advised to present in labour at the earliest sign of labour for careful assessment. It is important that women are looked after in hospital in early labour because uterine rupture can occur at this time as well as in later labour.

Management of women in established labour

Women who present with an unplanned labour and a history of previous Caesarean birth should have a discussion with an experienced obstetrician to determine feasibility of VBAC.

Women should be advised that planned VBAC should be conducted on the labour ward; where continuous intrapartum care and monitoring with the resources available for immediate Caesarean birth if needed.

Epidural is not contraindicated in a planned VBAC and equally is not a requirement due to the fact the woman has had a previous CS.

All women in established VBAC labour should be advised and recommended:

- Continuous electronic fetal monitoring (telemetry may be offered)
- Supportive one-to-one care
- Support the use of hydrotherapy if continuous monitoring can be performed using telemetry.
- Monitoring of maternal symptoms and signs in line with the care of women in labour guideline

• Regular (no less than 4-hourly) assessment of their progress in labour

• In the event of any delay in progress, decision for augmentation or other intervention should be discussed with the consultant on call.

• Staff must be aware and be alert to signs of scar dehiscence/rupture which is detailed below:

• Symptoms and signs of scar dehiscence/rupture (NB scar dehiscence may be "silent")

1) Persistent CTG abnormalities.
2) Vaginal bleeding.
3) Uterine scar tenderness.
4) Pain between contractions.
5) Cessation of contractions.
6) Pain "breaking through" epidural analgesia or excessive epidural requirements.
7) Loss of station of the presenting part
8) Change in abdominal contour
9) Maternal tachycardia, hypotension, shock.
10) Palpation of fetal parts outside the uterus.
11) Haematuria.

11. HOW SHOULD WOMEN WITH A PREVIOUS CAESAREAN BIRTH BE ADVISED REGARDING AN INDUCTION OR AUGMENTATION OF LABOUR?

Women should be informed of the two-to-three fold increased risk of uterine rupture and around 1.5 fold increased risk of Caesarean birth in induced and/or augmented labour compared with spontaneous VBAC labour.

An obstetrician ST3 or more senior should discuss the following with the woman and document a management plan within the online notes:

- The decision to induce labour
- Proposed method of induction
- Decision to augment labour with oxytocin
- Time intervals for serial vaginal examinations and the selected parameters of progress that would necessitate discontinuing VBAC. These should be determined by the woman's history, for example a woman who has laboured to fully dilated before can be expected to progress more rapidly in labour than a woman who has never laboured. All women whose uterus is contracting regularly with oxytocin augmentation should be reviewed by an obstetrician ST3 or more senior at least every 4 hours. Consideration should be given to vaginal examinations more frequently than every 4 hours to ensure continual and on-going progress of labour'

The final decision should always be confirmed with a consultant obstetrician.

Induction of labour using mechanical methods such as amniotomy or foley catheter is associated with lower risk of scar rupture compared with induction using prostaglandins.

Please refer to ASQUAM guidelines: "induction of labour" and "Oxytocin use in labour" (current versions on intranet).

12. PRELABOUR RUPTURE OF MEMBRANES

• Initial management should be according to the guideline for 'prelabour rupture of membranes at term'.
• Fetal wellbeing should be assessed by EFM (Electronic Fetal Monitoring) for a minimum of 20 minutes.

• The woman should be reviewed by the obstetric registrar and a plan of care documented in the notes. If she meets the criteria for conservative management, management should follow guideline for 'prelabour rupture of membranes at term'.

• If she does not meet the criteria for conservative management, requests earlier augmentation or has not laboured spontaneously after 24 hours, her care must be discussed with a consultant obstetrician to decide whether or not the labour should be induced with oxytocin.

There must be a documented plan for labour should labour not commence as planned which may include booking of an elective repeat C/S at 42 weeks gestation, if spontaneous labour has not occurred prior to the given date.

13. MULTIDISCIPLINARY MONITORING AND AUDIT

The need to monitor/audit the standards set out below will be considered alongside other Directorate requirements and prioritised accordingly. The Directorate Clinical Audit programme is drafted by the Directorate Clinical auditor, in liaison with clinical staff, and approved by the Directorate.

Element to be monitored	Lead	Tool	Frequency	Reporting arrangements	Acting on recommendations and lead(s)	Change in practice and lessons to be shared
Guideline content	Guideline Co-ordinator	Guideline Review	Every three years	Maternity Forum Subgroup: Guideline Meeting	Required changes to practice will be identified and actioned with the release of the updated guideline.	Required changes to practice will be identified and actioned with the release of the updated guideline.
Clinical standards within guideline	Directorate Clinical Auditor	Clinical Audit	As required in relation to other Directorate priorities	Directorate Business, Performance and Clinical Governance Meeting	Required actions will be identified and completed in a specified timeframe as per the audit action plan.	Required changes to practice will be identified and actioned within a specific timeframe as per the audit action plan and, in addition, lessons will be shared with relevant stakeholders as per audit action plan.

References

1 Clarkson C & Newburn M. (2005) Evidence based briefing: vaginal birth after caesarean section (VBAC) – Part 1. New Digest (31): 19-22

2 Fitzpatrick K, Kurinczuk JJ, Alfirevic Z, Spark P, Brocklehurst P, et al. (2012) Uterine Rupture by intended Mode of Delivery in the UK: A National Case-Controlled Study.UK Obstetric Surveillance System. PLoS Med 9(3) e1001184

3 Landon et al. Risk of uterine rupture with a trial of labor in women with multiple and single prior ceasarean delivery. (2006). Obstetrics and Gynaecology. Jul;108(1):12-20

4 Lesley, J. (2004) Birth After Caesarean. Available from: www.aims.org.uk.

5 National Collaborating Centre for Women and Children's Health (2004) Caesarean Section: Clinical Guideline 13. London. RCOG. Available from: https://www.rcog.org.uk/globalassets/documents/guidelines/research--audit/nscs_audit.pdf

6 National Institute of Clinical Excellence (2019) Intrapartum care

7 NICE Clinical Guideline (2011) Caesarean section. Available from: http://www.nice.org.uk/nicemedia/live/13620/57163/57163.pdf.

8 RCOG green top guideline no. 45. Birth after previous caesarean birth. October 2015.
Available:
https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_45.pdf

9 Smith G.C.L., Pell J.P., Pasupathy D., Dobbie R. (2004) Factors predisposing to perinatal death related to uterine rupture during attempted vaginal birth after caesarean section. BMJ. 2004 Aug 14;329 (7462):375.

10 Thomas J., Paranjothy S. (2001) Royal College of Obstetricians and Gynaecologists Clinical Effectiveness Support Unit. The National Sentinel Caesarean Section Audit Report. London. RCOG

11 Yentis S.M., (ed) (2001) Analgesia, Anaesthetic and Pregnancy. A Practical Guide. Cambridge. Cambridge University Press.

Appendix 1 - Birth Choices/VBAC Clinic

The Birth Choices clinic has been instigated to provide high quality evidence based, standardised information to women with a history of previous Caesarean birth. Discussing their birth options including the benefits and risk of those options, allowing them to make an informed choice about their mode of delivery.

Women can be referred to the Birth Choices Clinic via the VBAC door within K2 once the booking has been completed and the woman advised to review the birth options after caesarean section information leaflet within my pregnancy notes. Once the referral has been received all women will be given an appointment at around 20 weeks of pregnancy, to review previous delivery details and for further discussion around their choices including the individualised benefits and risks. For those women who are undecided about their mode of birth, a further telephone consultation will be offered for 28-34 weeks, to establish a Mode of Delivery.

Those women identified as:

- Having a previous Caesarean Birth outside of the UK
- Requiring an interpreter
- Women who do not know the reason for their previous Caesarean Birth
- Identified as having Tokophobia

Will be offered a face to face appointment earlier than 20 weeks to establish whether the criteria for VBAC is met with the use of an interpreter if required, and to allow time to discuss issues surrounding their previous birth with a possible referral to the Lotus Service/ Perinatal Mental Health. If unable to make a decision regarding Mode of Delivery a further appointment will be offered 28-34 weeks gestation.

If a decision to aim for a VBAC is made a follow up appointment will be offered with a consultant after 40 weeks of pregnancy where they can have a discussion about IOL/ERCS and offered a cervical sweep if appropriate.

If following review of the records, there is an obvious contraindication to VBAC, or if the patient requests an ERCS, then an ERCS will be arranged from 39 weeks gestation. If no antenatal problems are anticipated, then there is no clinical reason why the women need attend the hospital again until the pre-operative assessment clinic visit.

For those women who are requesting an Elective Caesarean for other reasons a referral to the birth choices clinic can be made and a face to face appointment offered as soon as possible to discuss the reasoning for this request and enabling a timely referral to other relevant services if required.

Women who are choosing to deliver outside of the guidance for example requesting to deliver on the midwife birth centre or at home can be referred to the birth choices clinic for an in depth discussion around the benefits and risks associated with their choice for delivery. There will be a detailed consultation added to the online notes along with a management plan.

Women choosing to deliver on the MBC will be added to the birth choices folder within MBC following a discussion with the manager.

For those choosing to deliver at home, a consultant appointment will be offered for further discussion, if this is declined the community midwife will be informed to complete the home birth assessment tool.

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Appendix 2 - Previous or Planned Caesarean Section Pathway

Name and Hospital Number or Patient information Sticker

Name and grade of person completing form:	Date:
	Initial preference for delivery
Gravida: Para:	C/S VBAC Undecided
Current Gestation:	Reasons:
Booking BMI:	
Number of previous Caesarean births:	
Number of Previous vaginal births:	
Desired family size	

Obstetric History (First Appointment)

Previous CS details: Elective Emergency Cervical dilatation cm (if applicable)

Reason for previous CS:

Complications (eg PPH, wound infection):

Other previous abdominal surgery:

Medical conditions relevant to surgery/anaesthetic

Any contraindications to labour and vaginal birth?

- Uterine incision other than lower transverse
- Uterine surgery breaching cavity
- Previous uterine rupture
- Other (Please specify)

Any Tocophobia Yes No
Any trauma/shock or fear about labour/birth Yes No

Women Choosing or Considering VBAC (first Appointment)

Information page (see page**) reviewed with woman:	Yes	No
Approximate likelihood of successful VBAC discussed?	Yes	No
VBAC management plan for labour discussed:		
• Hospital birth on delivery suite	Yes	No
• Continuous electronic fetal monitoring	Yes	No
Post term appointment arranged?	Yes	No

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Women Choosing or Considering Caesarean Birth (first appointment)

Reason for requesting CS:

Alternatives discussed (if applicable)	Yes	No
Plan for labour before CS discussed?	Yes	No
Informed Elective CS performed at 39/40	Yes	No

Notes:

28-36/40 Mode of Birth Discussion.

Name and grade of person completing form: Date
Gestation

Current preferences for Delivery: VBAC Caesarean

If planning a Caesarean Birth

Gestation/Date of planned CS

Management plan for spontaneous labour before CS date e.g trial of VBAC or EMCS

If planning a VBAC

Consultant appointment arranged for 40-41/40: Date:

Post Dates Discussion for those planning a VBAC
Name and Grade of person completing the form:

Date: Gestation:

Preferred management ELCS IOL

Risks of IOL in VBAC discussed? Yes No

Method of IOL Mechanical Prostaglandins ARM Oxytocin

Management Plan documented within online notes? Yes No

Prescription Chart Complete? Yes No

VBAC – Advantages

- Quick Recovery
- Less risk for future pregnancies
- Shorter hospital stay
- Fewer breathing problems

Chance of successful VBAC:

- Single previous CS, no vaginal birth – 3 out of 4 women (72-75%
- Single previous CS, at least 1 previous vaginal birth 9 out of 10 women 85-90%

Unsuccessful VBAC more likely if:

- Induced labour
- BMI >30
- Previous CS due to unsuccessful induction
- Previous CS for slow progress in labour

If all of these risk factors present, chance of successful VBAC in 4 in 10 women (40%)

VBAC Vs planned Caesarean at 39 weeks

Change of Complication	VBAC	Caesarean
Uterine Rupture	1 in 200	<1 in 500
Blood Transfusion	2 in 100	1 in 100
Infection in the womb (endometritis)	No significant difference	
Baby developing temporary breathing problems after the birth	2-3 in 100	4-6 in 100
Baby developing hypoxic ischaemic encephalopathy (brain injury) at birth	8 in 10,000	<1 in 10,000
Stillbirth beyond 39 weeks whilst waiting for labour	1 in 1000	N/A
Serious issues in future pregnancies eg LLP, invasive placenta, surgical complications, stillbirth	N/A	Increased risk
Maternal Mortality	4 in 100,000	13 in 100,000

Caesarean birth Vs Vaginal birth – Risks (Nice 2021)

This information comes from studies comparing outcomes in women who choose a caesarean birth vs women who choose a vaginal birth. This information is intended to help you make your decision. **Please note that the majority of these risks are rare outcomes.**

Outcomes more likely with Caesarean birth	**Outcomes more likely with vaginal birth**	**No difference between Caesarean and Vaginal birth**
Increase in length of hospital stay (1-2 days)	Urinary incontinence lasting more than a year (extra 21,180/100,000 women)	Blood clots in legs and lungs
Uterine rupture in future pregnancies (extra 980/100,00 women)	Faecal incontinence lasting more than a year (extra 7,690/100,000 women)	Major Haemorrhage
Hysterectomy (extra 60/100,000 women)	Vaginal Tears 3rd/4th degree (extra 560/100,00 women)	Postnatal Depression
Stuck placenta in future pregnancies (extra 60/100,000 women)	Pain during birth and 3 days after (increased pain scores during and 3 days after birth)	Baby admitted to neonatal unit
Maternal death (extra 20/100,000 women)		Infection in baby
Childhood obesity (extra510/100,000 women)		Delayed speech in child
Childhood asthma (extra 310/100,000 women)		Death of child up to a year
Death of baby soon after the birth (extra 20/100,000 babies)		