Aneurin Bevan University Health Board

Management of women with previous Caesarean Section

N.B. Staff should be discouraged from printing this document. This is to avoid the risk of out of date printed versions of the document. The Intranet should be referred to for the current version of the document.

Status: Issue 3
Approved by: Clinical Effectiveness Forum
Owner: Maternity Services
Issue date: 5 December 2019
Review by date: 5 December 2022
Policy Number: ABUHB/F&T/0569

Contents:

1 Executive Summary

Caesarean section rates in Wales, Scotland and Northern Ireland are higher than in England. In 2012-13 the caesarean section rate in Wales was 27.5% (RCOG 2015). There is a consensus (NICE 2011, RCOG 2015) that planned vaginal birth after caesarean section (VBAC) is a clinically safe choice for the majority of women with a single previous lower segment caesarean delivery. Health Boards in Wales are exploring ways to decrease the caesarean section rate and it is suggested that 72-75% of women agreeing to vaginal birth after caesarean section will succeed in achieving a normal birth. This guideline aims to support midwives and obstetricians when counselling and planning births for women who have had previous caesarean sections and to limit any escalation of the caesarean delivery rate and maternal morbidity associated with multiple caesarean deliveries.

1.1 Scope of guideline

This guideline applies to all clinicians working within maternity services

1.2 Essential Implementation Criteria

Auditable standards are stated where appropriate

2 Aims

To provide support for clinical decision making

3 Responsibilities

The Maternity Management team

4 Training

Staff are expected to access appropriate training where provided. Training needs will be identified through appraisal and clinical supervision.

5 Monitoring and Effectiveness

Local service Improvement Plan will guide monitoring and effectiveness.

This policy has undergone an equality impact assessment screening process using the toolkit designed by the NHS Centre Equality & Human Rights. Details of the screening process for this policy are available from the policy owner.

6.1 Management of Care following Caesarean Section

- Women who have a caesarean section should be debriefed, preferably by the attending obstetrician, re suitability for VBAC next pregnancy. The *Having a Baby after Caesarean Section – Planning for the Future* leaflet (Appendix2) should be given and discussed prior to discharge home.

- This suitability should be documented in the women's medical records, on the e-discharge, the maternity information system and in the caesarean section notes on ORMIS

- Surgical Site Infection information is now a mandatory field on CSC (new maternity database) and actions should be achieved prior to discharge home

- Community midwives should discuss suitability for VBAC on discharge to primary health care team and the Natural Childbirth after caesarean section leaflet (Appendix 3) should be given to women

- The GP should be informed of suitability for VBAC via e discharge, CSC discharge documentation and CWS.

6.2 Booking

- Prior to the initial booking meeting, the midwife should access the Maternity information system to determine the woman's suitability for VBAC.

- At the initial booking appointment the midwife should discuss the pathway of care for previous caesarean section and provide the *Vaginal Birth after Caesarean Section* leaflet (Appendix 4). Discussions about birth choices should always be recorded in the records along with a copy of the VBAC form (Appendix 3).

- If VBAC is declined, the reasons, concerns and fears underlying the woman's request are explored, discussed and recorded and an appointment to see an obstetrician should be offered.

- The woman will be booked for an appointment at 34-36 weeks, with her consultant obstetrician to discuss further management of care.

- If a VBAC is planned the woman will be reviewed again in a consultant led clinic at term

- Irrespective of mode of delivery, women should be advised to book for obstetric led care in an obstetric unit

Information for Staff

- VBAC should be considered for women with one previous caesarean section, a single pregnancy with cephalic presentation at 37+ weeks gestation. Contraindications include previous uterine rupture or classical incision scar or those where vaginal birth is contraindicated irrespective of the presence or absence of a uterine scar. Complex cases require Consultant Obstetrician input in decision making. This includes women with more than one previous caesarean section. A cautious approach is required for women who are post dates, multiparous, with evidence of macrosomia, antepartum stillbirth or maternal age over 40 years (RCOG, 2015).

- The overall success rate for VBAC is 72 to 75%

- Approximately 25% of women attempting a VBAC will need an emergency caesarean delivery in labour

- A previous vaginal birth prior to caesarean section is a good indicator of a successful VBAC and increases the success rate up to 85-90%

- There is a 1 in 200 (0.5%) risk of scar rupture (RCOG 2015)

- Risk of scar rupture with induction
    - Non prostaglandin agents – 8 per 1000
    - With use of prostaglandins – 24 per 1000

6.3 Antenatal care

- If the decision is made for a caesarean section the reasons should be clearly stated on the consent form, with any underlying reason for maternal request. A clearly documented plan should be in place for if labour occurs prior to the planned date for elective caesarean section

- Women should be advised to report any scar pain, tenderness or vaginal bleeding during pregnancy

- If VBAC is agreed there should be no further medical intervention unless otherwise indicated

- If the pregnancy is progressing normally, induction of labour is offered at term +12 days to maximise the opportunity for the spontaneous onset of labour. The Induction of labour protocol should be followed (see Labour ward guidelines)

- Women and healthcare professionals should be aware that with induction of labour the likelihood of uterine rupture/scar dehiscence is increased to 8 per 1000 when labour is induced with non prostaglandin agent and 24 per 1000 when labour is induced with prostaglandins

- A membrane sweep may be offered from 40+7 weeks of pregnancy in line with routine antenatal care guidance

6.4 Labour & Birth

- Labour should be managed with minimal intervention to optimise a normal outcome

- Birth should be planned at an obstetric unit with the availability of an obstetric theatre and onsite access to blood for transfusion. If birth in an obstetric unit is declined by the woman, her choices for birth should be discussed in detail to ensure that risks and limitations of the service are fully explored, thus enabling her to make an informed choice. A Supervisor of Midwives, Lead Midwife for Birth Centre/community or Consultant Midwife should be involved in the discussion

- IV Access should be obtained and blood samples for FBC and Group and Save sent

- One to one care with a midwife should be facilitated at all times in labour

- Continuous electronic fetal monitoring (STAN where appropriate) should be performed once labour is established (Fetal distress has been reported to precede uterine rupture)

- Meticulous monitoring of progress of labour. Concerns with progress of labour should be reported to the obstetric registrar/consultant on call for labour ward

- The use of Syntocinon to augment poor progress or secondary arrest must be discussed with the Consultant Obstetrician. The guidance for the use of Syntocinon in VBAC is identical to the guidelines for its use with any other labour

- Epidural analgesia is available on request; however, increased pain may indicate uterine rupture

- Regular maternal observations including blood pressure, pulse, respiratory rate and temperature should be recorded at the standard frequency for normal labour, unless otherwise indicated

- All staff should be aware of the classical symptoms of scar rupture – pain, scar tenderness, bleeding PV, maternal tachycardia, hypotension, altered contraction pattern and fetal distress. Post partum scar palpation is not required

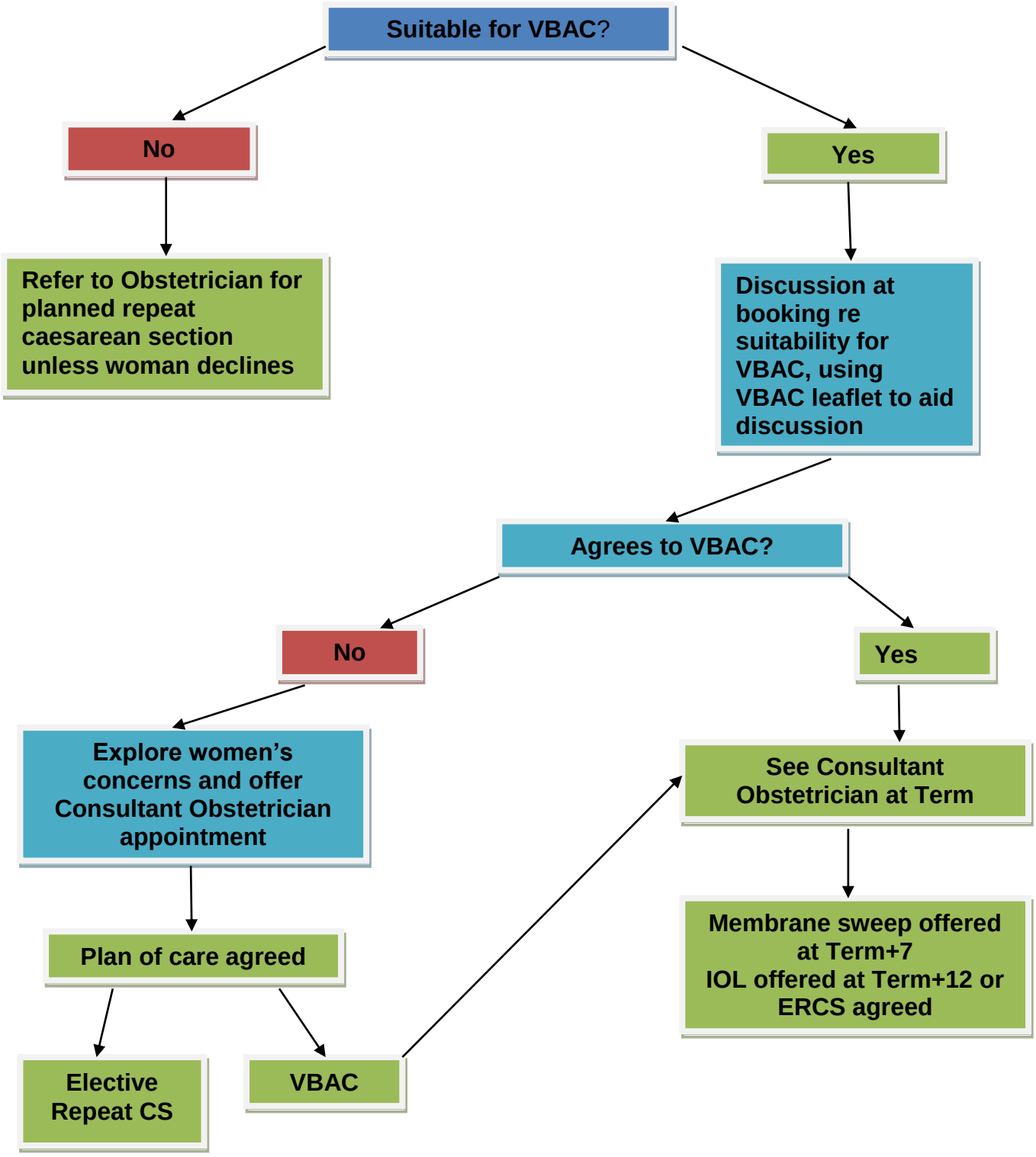
References

National Institute for Health and Clinical Excellence (2011) *Caesarean section - NICE clinical guideline 132.* Manchester: NICE

Royal College of Obstetricians and Gynaecologists (2015) *Birth after Previous Caesarean Section – Green Top Guideline number 45* London: RCOG

7 Appendices

Appendix 1 - Algorithm for Management of women with previous Caesarean Section



Appendix 2

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Aneurin Bevan University Health Board

Having a Baby after a Caesarean Section Planning for the Future

Your next baby can usually be born normally after you have had a caesarean section.

75% of women can have a normal birth following one caesarean section and if you have already had a baby normally this increases to 90% of women.

Your doctor will discuss your caesarean section with you before you go home from hospital and together we can plan the most appropriate care for your next pregnancy. We can aim for a normal birth unless there is a strong reason for you to have another caesarean section.

Doctors advise you to have a normal birth after a caesarean section because you will have less pain afterwards and will recover quicker from the birth. You can also go home from hospital with your baby sooner. Other advantages include smaller blood loss, less risk of developing a blood clot, and you will be less likely to have a problem getting pregnant in the future.