Ref: Birth After Caesarean Section

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Guidelines Definition

Clinical guidelines are systemically developed statements that assist clinicians and patients in making decisions about appropriate treatments for specific conditions.

They allow deviation from a prescribed pathway according to the individual circumstances and where reasons can be clearly demonstrated and documented.

Equality Impact Assessment Statement

This Procedure has been subject to a full equality assessment and no impact has been identified.

Related Guidelines

☐ Fetal Heart Monitoring and Interpretation

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Background

- Previous Caesarean section is the commonest primary indication for elective repeat caesarean section (ERCS) in the United Kingdom (UK), contributing to 28% of all caesarean section births (Dodd, Crowther, Huertas, Guise & Horey 2013).
- There is consensus that, for the majority of women with a single previous lower segment caesarean section (LSCS), planning a vaginal birth in the next pregnancy is considered a clinically safe choice. A successful vaginal birth after caesarean section (VBAC) is known to reduce the overall chance of adverse outcome when compared to an ERCS. Of the women who attempt VBAC, 72-75% will succeed in achieving a vaginal birth (RCOG ,2015).
- This guideline will support midwives and obstetricians when discussing and planning births with women who have had a previous caesarean, with a focus on reducing maternal morbidity linked with multiple caesarean birth.

Scope of guideline

This guideline applies to all clinicians working within maternity services.

Monitoring and effectiveness

Local service improvement planning will guide monitoring and effectiveness.

Care management following caesarean section

- Women who have undergone a caesarean section should be debriefed by a senior obstetrician, preferably the attending obstetrician, and a recommendation for future births should be made prior to hospital discharge. Suitability for VBAC should be clearly documented on surgical documentation, in the maternal records and on the electronic discharge summary. Women should also be given the CTM 'Letter for women following their first CS' (Appendix 4)

- Women identified as suitable for VBAC should receive the RCOG information leaflet 'Birth options after previous caesarean section' RCOG (2016) (RCOG Woman Information leaflet) prior to community midwifery discharge.

- Referral to Perinatal Mental Health Team should be made if PTSD is suspected especially after traumatic birth experience like emergency CS

- A referral to the consultant midwife should also be considered to discuss the birth experience if the woman feels this would be helpful.

Booking

- At the initial booking appointment the community midwife should discuss the pathway of care for women who have had a previous caesarean section, and provide the woman with the RCOG, 2016 information leaflet 'Birth options after Caesarean section' (Appendix 1).

- All discussions and information provided should be recorded on the Birth after Caesarean Section (BAC) Checklist (Appendix 2) which will then be filed in the hand held maternity records.

- It is appropriate to advise women that, where a woman has undergone a previous caesarean section, planning a VBAC is a safe and professionally recommended option.

- Women should be informed that it is recommended that birth should be planned on an obstetric unit with access to immediate obstetric and neonatal services.

Antenatal care (see Appendix 1 – 'Birth after Previous Caesarean Antenatal Pathway')

- Antenatal counselling should consider all known risks and benefits of planned VBAC versus ERCS and the woman's wishes should be explored and respected.

    - Women should be made aware that successful VBAC has the fewest complications and therefore the chance of VBAC success or failure is an important consideration when choosing the mode of delivery.

    - Women should be made aware that the greatest risk of adverse outcome occurs in a trial of VBAC resulting in emergency caesarean delivery.

    - Women should be informed that planned VBAC after one CS is associated with an approximately 1 in 200 (0.5%) risk of uterine rupture.

    - Women should be informed that the absolute risk of birth-related perinatal death associated with VBAC is

extremely low and comparable to the risk for nulliparous women in labour.

- Women should be informed that ERCS is associated with a small increased risk of placenta praevia and/or accreta in future pregnancies and of pelvic adhesions complicating any future abdominopelvic surgery.
- The risk of perinatal death with ERCS is extremely low, but there is a small increase in neonatal respiratory morbidity when ERCS is performed before 39**+0** weeks of gestation. The risk of respiratory morbidity can be reduced with a preoperative course of antenatal corticosteroids

- An appointment will be arranged between 21 and 28 weeks in antenatal clinic for an obstetrician to review the previous intrapartum operative records to confirm appropriate planning and discussions.

- VBAC should be considered for women with one previous uncomplicated lower segment caesarean section in a singleton pregnancy with a cephalic presentation over 37 weeks gestation.

- All discussions and information provided should be documented in the notes.

- Use the 'Birth after previous caesarean (BAC) counselling proforma' (Appendix 2) to facilitate counselling regarding the risks and benefits of VBAC versus ERCS – this should then be filed in the hand held maternity records

- Document the woman's preference for delivery and discuss with consultant if she is requesting a caesarean section

- The 'Birth after Previous Caesarean Intrapartum Management Proforma' (Appendix 3) can be used to document discussions around intrapartum care, scenarios such as spontaneous labour before ERCS date and considerations regarding induction of labour.

- A final decision for mode of birth should be agreed upon by the woman and member(s) of the maternity team before the expected/planned date of delivery.

- Care planning should then follow the appropriate pathway (Appendix 4).

- Where VBAC is planned and there is no other indication for consultant led care then the woman should return to midwifery led care for the antenatal period. An appointment should be arranged in a consultant clinic for 40+ weeks to discuss ongoing care.

- Where a woman is undecided around choosing mode of birth then a referral should be made to the consultant midwife for the opportunity of further discussion. This appointment should be offered by 28 weeks of pregnancy. The consultant midwife will plan the care dependent on the outcome of consultations and will arrange further obstetric appointments where necessary.

- If VBAC is declined or where there are comorbidities the woman should be offered consultant led antenatal care and an appointment arranged as appropriate. Where ERCS is planned, indications for this should be documented in the hand held records. By 36 weeks there should be a detailed plan to include a date for ERCS at 39+ weeks. 10 % of women will labour prior to 39 weeks; these circumstances should be discussed with the woman and any plan should include actions in this instance. These discussions should be documented on the 'Birth after Previous Caesarean Intrapartum Management Proforma' (Appendix 3)

Factors that decrease the success rate of VBAC

- Raised BMI
- Previous history of labour dystocia (particularly where the cervix was less than 8cm dilated)
- Postdates birth
- Induction of labour
- Suspected macrosomia
- Maternal age over 40 years

It should be noted that third trimester ultrasound scanning is not a reliable predictor of macrosomia and should not solely inform decisions around planning birth

Factors that increase success rates

- Previous LSCS occurred due to a malpresentation, success rate can be up to 84%.
- A previous vaginal birth is the best predictor of VBAC success, increasing success rates to 85-90%. Previous vaginal birth is also associated with a reduced chance of scar rupture

<u>Contraindications to planning a VBAC</u> (pertain to increased risk of uterine rupture)

- Previous uterine rupture
- High vertical classical uterine scar
- Extended uterine incision at index LSCS (e.g. T or J shaped incisions)

- Previous myomectomy (especially when the endometrial cavity is breached)or prior complex uterine surgery
- Other definitive contraindications to a vaginal birth irrespective of uterine scar
- Women who have complicated uterine scars should be reviewed by a consultant obstetrician

Circumstances where the increased risk of uterine rupture should be considered include:

- Short interval between LSCS and VBAC (risk of rupture unknown)
- Multiple pregnancy (unknown)
- Suspected fetal macrosomia (unknown)
- Induction/augmentation of labour (2-3 fold increase)
- Three previous LSCS (unknown)

Ongoing care

- The women should be advised to report any scar tenderness or vaginal bleeding.

'Post-dates' care will need to be tailored to the individual clinical circumstances and woman's preferences. As a guide:

- A membrane sweep may be offered from 38-39 weeks of pregnancy for those planning VBAC.

- Where the pregnancy is progressing normally induction of labour may be offered from term + 7 days to maximise the opportunity for a spontaneous labour. The time for induction of labour depends on the clinical circumstances and will be after discussion of the risks and benefits with the woman

- Where spontaneous labour has not occurred and the woman declines induction of labour then ERCS can be scheduled for term + 7-10 after discussion of the risks and benefits with the woman

- Where spontaneous rupture of membranes has occurred (after 37/40) in the absence of contractions or any concerns, then intermittent auscultation can be used to assess fetal wellbeing. Women presenting with pre labour rupture of membranes should be offered the same primary management as a woman with no history of prior caesarean section. Antenatal assessment should include a CTG where contractions are present.

Planned VBAC in special circumstances

- VBAC can be offered as an option to women undergoing preterm birth with a history of prior caesarean birth following appropriate counselling. Women planning a pre term VBAC should be informed that rates of success are similar to VBAC at term, and the chance of uterine rupture is substantially less (34/10,000 versus 74/ 10,000),perinatal outcome appears to be the same

- Women who have had two or more prior lower segment caesarean deliveries may be offered VBAC after counselling by a senior obstetrician. This should include the risk of uterine rupture and maternal morbidity, and the individual likelihood of successful VBAC (e.g. given a history of prior vaginal delivery). Labour should be conducted in a centre with suitable expertise and recourse to immediate surgical delivery

- For women requesting planned VBAC with 3 or more Caesarean sections, antenatal counselling should occur with a consultant obstetrician. Consultations must include documented discussion around the limitations of the evidence base, a professional opinion around risk of scar rupture considering current and previous obstetric history, and a comprehensive plan for the intrapartum period, to include expected progress of cervical dilatation and plan in case of primary or secondary labour dystocia.

Intrapartum care during planned VBAC

- Women should be advised that planned VBAC should be conducted in an obstetric unit, with continuous intrapartum monitoring and available resources for immediate caesarean section and advanced neonatal resuscitation.

- Initial assessment of labour should be offered with continuous fetal monitoring as part of the assessment. In the latent phase where contractions are irregular, both fetal and maternal wellbeing have been confirmed and the woman is coping, then she may be encouraged to return home to await events with relevant advice.

- A senior obstetric review should be advised on a second or subsequent admission where the woman remains in the latent phase of labour.

- When in established labour women should be admitted to the obstetric unit with one to one midwifery care.

- An FBC and Group and save should be offered on admission for all women planning VBAC.

- Intravenous access should be assessed by a midwife on admission in labour and documented in the maternal records.

- Intravenous access should be secured if; cannulation is predicted to be difficult or where there is any additional fetal or maternal concern.

- Omeprazole 40 mg should be administered orally every 6 hours.

- The normal physiology of labour and birth should be supported in all environments to optimise outcome, this includes mobilisation, bladder care and hydration with water or still isotonic drinks.

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

- Regular (no less than 4 hourly) assessment of progress in the 1st stage of labour should be advised, with hourly assessment in the 2nd stage.

- Expected progress is 0.5cm every hour depending on previous history of vaginal birth. Obstetric review should occur after 1 hour of active pushing in the 2nd stage if delivery is not imminent

- Lack of progress should be discussed with the registrar and consultant obstetrician on call.

- Women should be advised to have continuous electronic fetal monitoring following the onset of regular contractions for the duration of planned VBAC

- Telemetry is available in POWH and PCH and should be utilised where possible.
- Women using telemetry can be encouraged to use the birthing pool on the obstetric units, provided that; there is no contraindication to using the birthing pool, labour is progressing normally, there is no hyperstimulation and fetal and maternal wellbeing have been confirmed. There is no evidence to suggest that the use of water in labour and birth should be contraindicated in planned VBAC as long as women have no problems with mobility and continuous fetal monitoring can be performed.

- All methods of routine pharmacological analgesia are suitable during a planned VBAC, including epidural analgesia.

- Early diagnosis of uterine scar rupture followed by expeditious laparotomy and resuscitation is essential to reduce associated morbidity and mortality in mother and infant. Health professionals should be knowledgeable about indicators of uterine rupture. There is no single pathognomonic clinical feature that is indicative of uterine rupture but the presence of any of the following should raise the concern of the possibility of this event:
    - Abnormal CTG (present in 55-87% of uterine rupture)
    - Severe abdominal pain, especially if persisting between contractions
    - Chest pain or shoulder tip pain, sudden onset of shortness of breath
    - Acute onset scar tenderness
    - Haematuria
    - Abnormal vaginal bleeding or haematuria
    - Cessation of previously efficient uterine activity
    - Maternal tachycardia, hypotension, fainting or shock
    - Loss of station of the presenting part.

- The diagnosis is ultimately confirmed at emergency caesarean section or postpartum laparotomy.

- Where uterine scar rupture is suspected follow the labour ward guideline for ruptured uterus.

Induction and augmentation

- The decision to induce or augment labour should be made by a consultant obstetrician together with the woman and any plan should include proposed methods, the time intervals for vaginal examination and any parameters of cervical progress that would indicate discontinuing VBAC.

- The woman should be informed of the increased chance of uterine scar rupture with the use of prostaglandins/ oxytocin; this should be discussed alongside the risks and benefits of ERCS.

- There is a 2-3 fold increased chance of scar rupture and a 1.5 fold increase in emergency LSCS with induction/augmentation of labour.

- Clinicians should be aware that IOL using mechanical methods is associated with a lower incidence of uterine scar rupture compared to prostaglandin/oxytocin.

- Where prostaglandins are used it is important not to exceed the safe recommended limit, see induction of labour guideline.

- The use of oxytocin to augment poor progress or secondary arrest must be done with caution and must be a senior obstetrician's decision.

- If oxytocin is used contractions must not exceed the maximum rate of 4 contractions in ten minutes.

- Consider reducing or stopping any oxytocin infusion once optimum contractions are reached.

Care for women requesting care outside of current recommended guidelines

- Where women decline to birth in an obstetric unit or choose a package of care outside of the recommendations her choices for labour and birth must be discussed and documented in detail. Where possible the woman should be seen by the consultant midwife/ lead midwife to discuss her choices for birth and develop a plan which supports the woman in informed decision making. Where midwives are providing care for women making birth choices outside of recommendations without antenatal counselling the manager on call should be informed and utilised for support.

- It may be appropriate for consultant obstetricians to hand the care to consultant midwives in circumstances where women are choosing to labour and birth in midwifery led areas.

- Any antenatal counselling around birth choices outside of recommendations should be documented on the relevant discussion form (Appendix 4) and filed in the maternal records. Information of these choices should be forwarded via email to the community midwife, labour ward/community coordinator, relevant matron and named consultant obstetrician (where appropriate).

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Auditable topics

- Documented discussion of risks and benefits of VBAC versus ERCS/use of VBAC checklists (100%).
- Proportions of women experiencing successful versus unsuccessful spontaneous and induced planned VBAC (particularly with reference to the induction method).
- 100% reporting of serious maternal (e.g. uterine rupture, peripartum hysterectomy, mortality) and neonatal (e.g. antepartum stillbirth, HIE, intrapartum and neonatal mortality) morbidity/mortality consequent to VBAC versus ERCS via a local incident reporting system.
- Effectiveness of antenatal screening for placenta praevia and accreta, including frequency of 'missed' antenatal diagnoses against locally agreed standards.
- Use of continuous electronic fetal monitoring during VBAC labour (100%).
- Documentation of senior obstetrician involvement in induction and augmentation of VBAC labour (100%).

Appendix 1 CTMUHB Birth after Previous Caesarean Antenatal Pathway

Booking / 12 weeks	Community midwife to discuss delivery options (VBAC and ERCS) and give patient information leaflet – 'Birth options after previous caesarean section'. Document the discussion in the maternity records
21-28 weeks	Antenatal counselling appointment with obstetrician for women with uncomplicated singleton pregnancies and single previous lower segment caesarean delivery Review the previous caesarean delivery, with her old notes Establish & document any contraindications to VBAC Documented counselling of risks and benefits of VBAC versus ERCS (facilitated by use of 'Birth after previous caesarean counselling proforma') Document woman's preference for delivery – discuss with consultant if requesting CS Complete intrapartum management proforma
32-34 weeks	Obstetric review of women with previous caesarean delivery who are identified to have a low-lying placenta at 32–34-week obstetric ultrasound Subsequent imaging and management plan for possible placenta accreta Ensure FBC result from 28 weeks has been documented in notes and acted on appropriately (see 'Anaemia in Pregnancy' guideline)
36 weeks	Obstetric review of women who choose ERCS / undecided on MOD / ERCS is indicated ERCS to be booked for 39+ weeks
40+ weeks	Senior obstetric review of women awaiting VBAC Discuss stretch and sweep / IOL / ERCS / expectant management

Appendix 2 Birth after previous caesarean counselling proforma

(To be completed at 21 – 28 weeks)

Likelihood of:	Overall	Tick when discussed
Successful VBAC (one previous caesarean delivery, no previous vaginal birth)	3 out of 4 or 72–75%	
Successful VBAC (one previous caesarean delivery, at least one previous vaginal birth	Almost 9 out of 10 or up to 85–90%	
Successful VBAC more likely in: spontaneous labour, previous vaginal delivery (particularly previous VBAC), greater maternal height, maternal age less than 40 years, BMI less than 30, previous caesarean for fetal malpresentation, gestation of less than 40 weeks and infant birthweight less than 4 kg (or similar/lower birthweight to/than index caesarean delivery) Unsuccessful VBAC more likely in: induced labour, no previous vaginal delivery, BMI greater than 30 and previous caesarean for labour dystocia. If all of these factors are present, successful VBAC is achieved in 40% of cases.		

Risk of:	VBAC	ERCS	Tick when discussed
Uterine rupture	Overall 5 per 1000/0.5% (Spontaneous labour (0.15–0.4%), induced (0.54–1.4%) or augmented (0.9–1.91%)	< 2 per 10000/< 0.02%	
Blood transfusion	2 per 100/2%	1 per 100/1%	
Endometritis	No significant difference in risk		
Serious complications in future pregnancies	Not applicable if successful VBAC	Increased likelihood of placenta praevia/ morbidly adherent placenta	
Maternal mortality	4 per 100000/0.004%	13 per 100000/0.013%	
Transient respiratory morbidity	2–3 per 100/2–3%	4–6 per 100/4–6% (risk reduced with corticosteroids, but there are concerns about potential long-term adverse effects)	
Antepartum stillbirth beyond 39+0 weeks while awaiting spontaneous labour	10 per 10000/0.1%	Not applicable	
Hypoxic ischaemic encephalopathy (HIE)	8 per 10000/0.08%	< 1 per 10000/< 0.01%	
Consideration of woman's future reproductive plans			
Woman's preference for delivery	VBAC		
	ERCS		
	Undecided		
Info leaflet provided	Birth options after previous caesarean section (RCOG)		

Appendix 3 Caesarean Intrapartum Management Proforma

To be completed at 21 -28 weeks gestation

Intrapartum care for VBAC		Tick when discussed
Birth on the consultant delivery suite		
Continuous electronic fetal monitoring at the onset of regular uterine contractions		
Need for intravenous (IV) access in labour		
Management plan in the event of:		
Preterm labour <37 weeks	VBAC	
	Em CS	
Spontaneous labour before ERCS date	VBAC	
	Em CS	
	Dependent on stage of labour – see comments	
No spontaneous labour after 41 weeks – review by senior obstetrician	Sweep	
	IOL	
	ERCS	
	Expectant Mx	
Senior obstetrician plan re use of oxytocin in labour	As per CTMUHB protocol	
	Other	
Senior obstetrician plan for IOL	As per CTMUHB IOL guideline	
	Other	
ERCS booking details	ERCS date (39+weeks)	
	Preadmission date	
	Steroids if indication for ERCS < 39 weeks	
Additional comments		

Appendix 4 Letter for Women following their First Cesarean Section

Date

Dear _____

Congratulations on the birth of your baby _____.

Childbirth may be a completely new experience for you and it is difficult to be fully prepared even when you have read a great deal and talked to many friends, family and health professionals. While most women wish childbirth to be as natural as possible, for a variety of reasons, a Caesarean Section (CS) becomes necessary. A CS, whether planned or emergency, would have been recommended and performed in the joint interest of mother and baby.

Because you have just had a CS, you may have questions now or in the future. For example, you may wonder:

1. Why did I need a CS?
2. How might this affect my future pregnancies and childbirth?

The best way to get answers is to ask the midwives and doctors who looked after you. They can check your records for specific details. We would like to encourage you to discuss anything that is not clear about your CS while the experience is still fresh in your mind. Your midwives and doctors would be glad to discuss things while you are in hospital. If you would rather wait, an appointment can be arranged later for you to see your midwife, GP or hospital consultant obstetrician.

It is important that you know that one CS on its own is not often a deciding factor in how your next baby might be born and that most women who have had one CS have a 75% chance (or more) of normal birth in a future pregnancy.

Remember:

1. Most women who have had one CS have good prospects of normal childbirth in future so, having a CS this time does not mean you need one in the future. When you get pregnant again, during the antenatal period, your obstetrician will discuss plans and precautions specific to you.
2. Although most women can plan to have a normal birth, some may be advised to have a planned CS for future babies. If you fall into this group, your obstetrician will discuss it with you.
3. It is best to discuss any worries as soon as possible, rather than wait until your next pregnancy.

Once again, congratulations

Cwm Taf Morgannwg Obstetric and Gynaecology consultants.

Directorate of Women & Child Health Checklist for Clinical Guidelines being submitted for Approval by Quality & Safety Group

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Brief outline giving reasons for document being submitted for ratification	New CTM Guideline
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Please list any policies/guidelines this document will supercede:	New for CTMUHB
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