# Birth after previous caesarean section Guideline

| Guideline Number: | 641 | Supersedes: | | Classification | Obstetrics & maternity |
|---|---|---|---|---|---|
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| Version No: | Date of EqIA: | Approved by: | Date Approved: | Date made active: | Review Date: |
|---|---|---|---|---|---|
| 2 | standard | Obstetric written documentation review group | 04/06/2019 | 04/06/2019 | 01/05/2022 |
| | | Extended whilst review is being undertaken - Obstetric Group | 30.06.2022 | 08.07.2022 | 30.12.2022 |

| Brief Summary of Document: | To ensure appropriate information and support for women who have undergone a previous caesarean section in deciding mode of birth in their current pregnancy |
|---|---|
| | |
| Scope | Medical and midwifery staff involved with the care of pregnant women who have previously had a caesarean section.<br>'The term "woman/women" in the context of this document is used as a biologically based term and is not intended to exclude trans and non-binary people who do not identify as women.' |

| To be read in conjunction with: | NICE CG132. Update: Caesarean Section<br>https://www.nice.org.uk/guidance/cg132<br>RCOG: Birth After Caesarean Section<br>https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_45.pdf<br>RCOG Birth Options After Previous Caesarean Section (Patient Information Leaflet)<br>https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pregnancy/pi-birth-options-after-previous-caesarean-section.pdf |
|---|---|

| Owning committee/group | Obstetric Guideline and Audit Group |
|---|---|

| Reviews and updates | | |
|---|---|---|
| Version no: | Summary of Amendments: | Date Approved: |
| 1 | New guideline | 2017 |
| 2 | Review and addition of RCOG guidance:<br>Birth after previous caesarean section,<br>Pathway for women choosing VBAC outside of an obstetric unit | 04/06/2019 |

Glossary of terms

| Term | Definition |
|---|---|
| ARM | Artificial Rupture of Membranes |
| ERCS | Elective repeat caesarean section |
| VBAC | Vaginal birth after caesarean section |
| | |

| Keywords | Caesarean section<br>Vaginal birth after caesarean section |
|---|---|

# Contents

## 1. Aim of Guideline

- The aim of this guideline is to support midwives and obstetricians to provide information and plan care for women who have undergone a previous caesarean section.

## 2. Objectives

- To assess the benefits and harm of planned elective repeat caesarean section and planned vaginal birth after caesarean section for women with a previous caesarean birth.
- To ensure maternity clinicians offer advice to women that is evidenced based and consistent.
- That a consultation occurs in a timely manner early in the pregnancy so that women are able to consider the information and make a decision prior to labour starting.

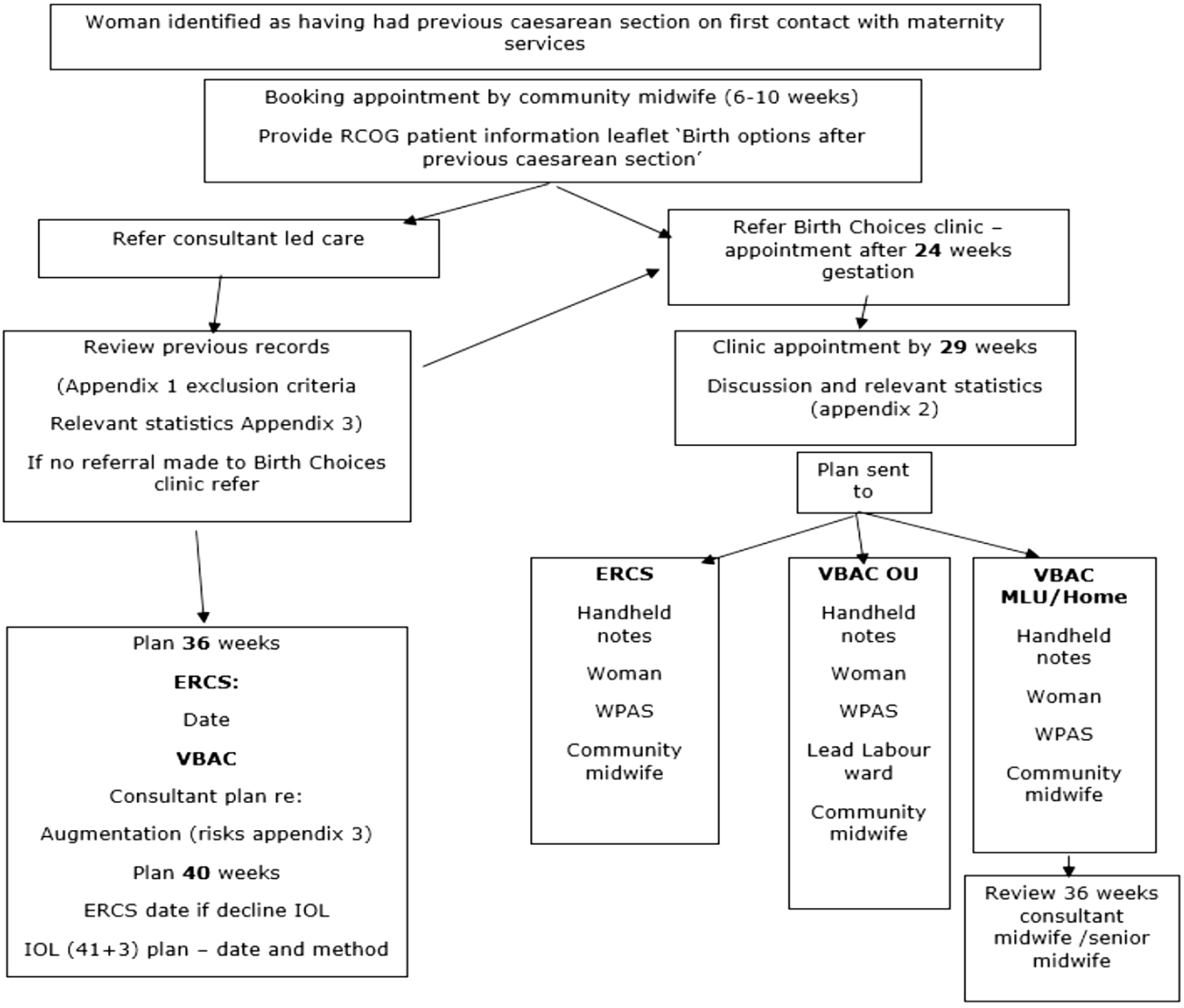
## 3. Scope

- Applicable to medical and midwifery staff involved with the care of pregnant women who have previously had a caesarean section.

## 4. Introduction

- There has been continued debate about defining an acceptable caesarean delivery rate and what rate achieves optimal maternal and infant outcomes.
- Counselling women for and managing birth after caesarean delivery are considered important issues to limit any escalation of the caesarean delivery rate and maternal morbidity associated with multiple caesarean deliveries.

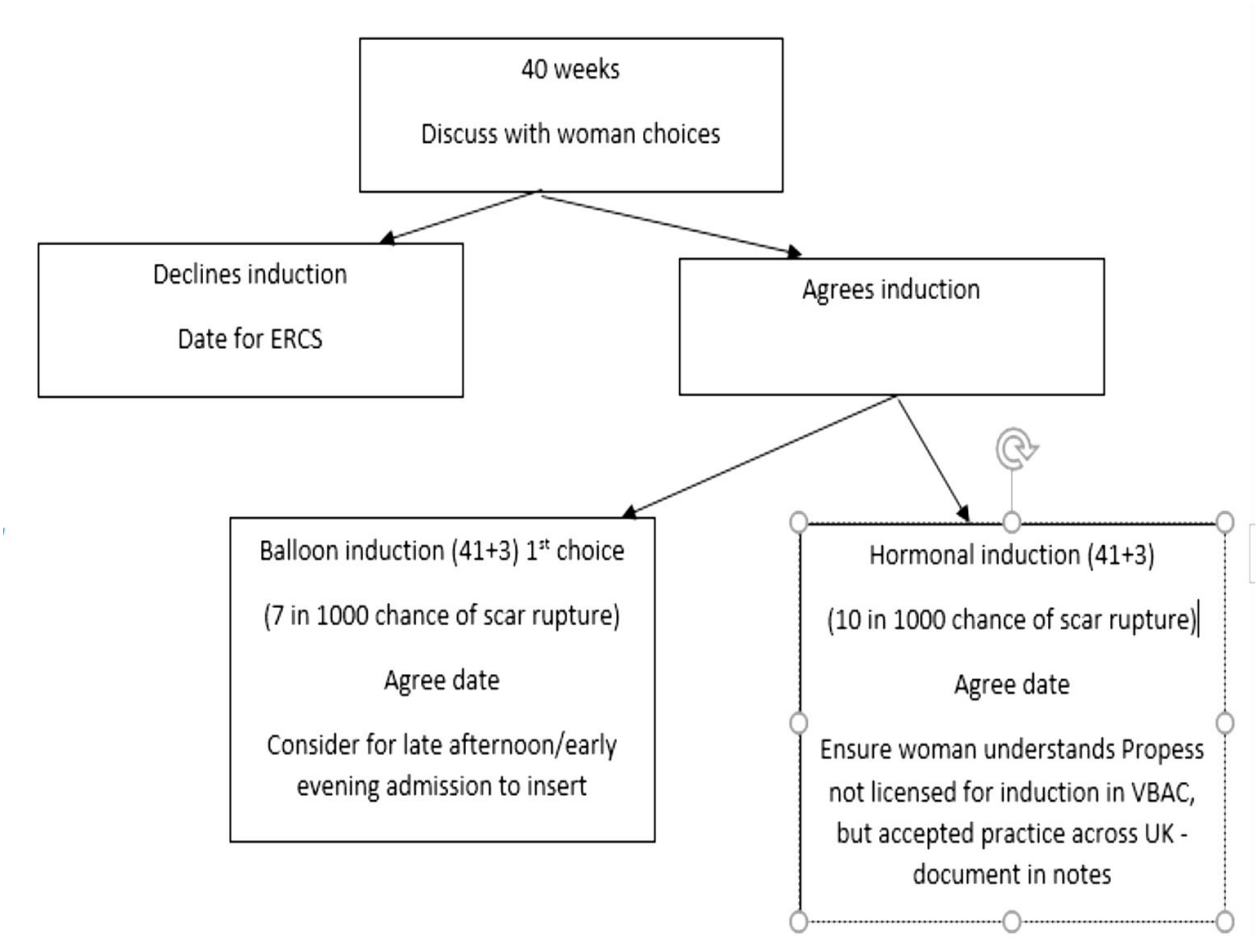
## 5. Management – Antenatal Pathway:




### 5.1 Care in labour

- Women should be advised to contact their midwife or the hospital when membranes rupture or if they think they are in labour.
- If women planning to birth labour ward or midwife led unit they should be advised to come in, peak incidence of uterine scar rupture is 4-5 cm cervical dilatation.
- If women planning to birth at home midwife should attend as soon as possible.
- Regardless of planned place of birth, women should be encouraged to be as upright and mobile as possible.
- Do not routinely insert an intravenous cannula in labour (NICE 2019)
- Continuous electronic fetal monitoring
- Women who choose to labour/birth in midwife led unit or at home –Follow pathway for VBAC women outside of OU.

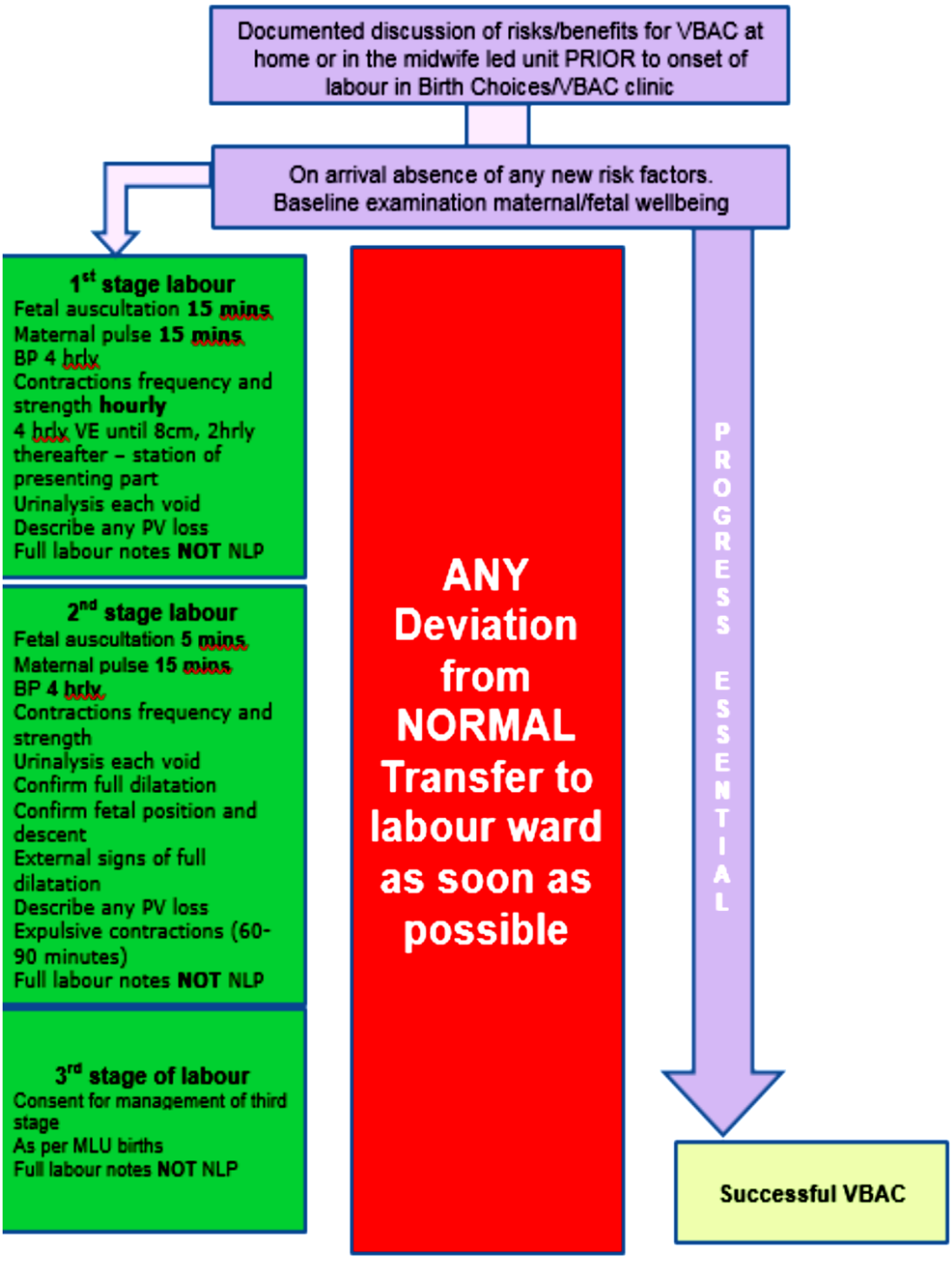
## 5.2. Post Dates Pregnancy




## 5.3.Pathway for VBAC women outside of OU

- It must be documented that women have been informed that homebirth and birth in a midwife led unit is not recommended for VBAC.
- It must be recorded that women have been informed that labour/birth must be progressing physiologically if they intend to give birth at home or in a midwife led unit.
- If the midwife considers performing artificial rupture of membranes (ARM), for slow progress, continuous monitoring should be considered and discussed with the woman (NICE 2019).
- The Health Board Labour and Delivery Record must be used to record all intrapartum care.

**Pathway for VBAC women outside of OU**




## 6. Auditable Standards

- Data to be collected monthly for all elective repeat caesarean sections undertaken.
- Data to be collected monthly for all attempted and successful VBACs.
- Maternal and neonatal outcomes to be reviewed.
- Completion of the Labour and Delivery Record to be audited for all VBACs who start their labours outside an obstetric unit

- Datix Incident Reporting for all adverse Maternal and Perinatal outcomes for women who have had a previous caesarean section.

## 7. References


- RCOG (2015) Birth after previous caesarean birth. Greentop No 45 RCOG:London
- NICE (2019) Intrapartum care for women with existing medical conditions or obstetric complications and their babies NG121

## 8. Appendix 1 – exclusion criteria

| Exclusion Criteria | |
|---|---|
| **Criteria** | **Comment** |
| • Recurrent obstetric factors requiring repeat caesarean section | |
| • Previous classical or “T” uterine scar (20–90/1000 risk of uterine rupture) | |
| • No access to details of previous surgery – Write to previous service requesting details of previous caesarean section | |
| • Previous hysterotomy or extensive surgery at myomectomy | |
| • Previous uterine rupture, risk of rupture in subsequent pregnancy is unknown | |
| • Previous three or more caesarean sections | Women should be made aware that there is a lack of safety data on VBAC following ≥2 previous caesarean sections.<br>Arrange a review with Consultant Obstetrician<br>IOL/ Augmentation of labour is contraindicated |
| • Other obstetric/non obstetric contraindication of vaginal birth | |

## 9. Appendix 2 – Birth Choices consultation

Discussion in the antenatal period should cover the following points

- Risks and benefits of VBAC
- Risks and benefits of planned ERCS
- Chances of achieving vaginal delivery
- Risk of uterine rupture and its effects on mother and baby, VBAC and ERCS.
- Mechanisms used to identify uterine rupture – continuous fetal monitoring, maternal observations.
- Place of delivery and differences in services provided in each location including
    - Fetal monitoring
    - Transfer times
- A discussion about if the woman is admitted in labour (especially in the active stages of labour) where an ERCS has been planned prior to the date of her ERCS provided there is no contraindication to VBAC.
- A reduced risk of uterine rupture in case of preterm labour
- Induction (hormonal and mechanical) and augmentation of labour. Implications for chances of successful VBAC.
- Women who are considering a planned VBAC at home or in the midwife led unit should be advised that all the evidence available refers to in-hospital outcomes and should not be applied to home or midwife led unit VBAC.

## 10. Appendix 3 – Statistics

**Benefits and risks of VBAC**

| **BENEFITS** | **RISKS** |
|---|---|
| Reduces the incidence of TTN **2-3** in **100** (Transient Tachypnoea of the Newborn) | Uterine rupture<br>**5** in **1000 spontaneous**<br>**7** in **1000 induced** (balloon)<br>**10** in **1000 induced** (hormone)<br>**8.7** in **1000 augmented** |
| After a single previous caesarean should be informed that, overall, the chances of successful planned VBAC are **72-76** in **100** | Risk of perinatal death<br>Antenatal **10** in **10 000** – after 39 weeks<br>**4** in **10 000** risk of birth-related perinatal death when compared with ERCS.<br>**Equal** to the risk of perinatal death for **nulliparous woman**. |
| Reduces the incidence of RDS **2-3** in **100** (Respiratory Distress Syndrome of the newborn). | HIE (Hypoxic Ischaemic Encephalopathy) of newborn (**8** in **10 000**) |
| Avoids risks associated with surgery | Risk of blood transfusion and endometritis (**1** in **100** additional risk) |
| Provides more rapid and less painful recovery | Chance of emergency c/section<br>Spontaneous onset **20-25** in **100**<br>Augmented **26** in **100**<br>Induced **33** in **100** |
| Requires a shorter hospital stay | This risk compares with women having their first birth. |

**Benefits and risks of Elective Repeat Caesarean Section (ERCS)**

| BENEFITS | RISKS |
|---|---|
| Planned delivery | TTN and RDS of newborn (**6 in 100)** at >39/40) |
| The risk of intrauterine death beyond 39 weeks is eliminated (**<1** in **1000**) | Longer hospital stay |
| Avoids the risks of trial of labour | Increased risk of thrombosis/need for LMWH medication |
| Hypoxic Ischaemic Encephalopathy **<1** in **1000** | Increased risk of blood transfusion >4 units |
| | Risk of injury to bladder, bowel or ureter (bladder most common),<br>First c/section **3** per **1000**<br>Second c/section **8** per **1000**<br>Third c/section **24** per **1000** |
| | Increased risk of hysterectomy (rare) |
| | Increased risk of abnormal placentation such as placenta accrete, placenta praevia<br>After<br>First **1** in **100**<br>Second **4.1** in **100**<br>Third **+ 33** in **100** |

**Factors influencing success of VBAC**

| **Increased** (**87-92** in **100)** | **Reduced (40** in **100 when all factors present)** | **Other factors decreasing success of VBAC** |
|---|---|---|
| Previous vaginal delivery | Induced labour | VBAC at or after 41 weeks of gestation |
| Spontaneous labour | No previous vaginal birth | birth weight greater than 4000G |
| | BMI>30 | no epidural anaesthesia |
| | Previous section for dystocia if no malposition involved | previous preterm caesarean birth |
| | | cervical dilatation at admission less than 4 cm |
| | | less than 2 years from previous caesarean birth |
| | | advanced maternal age |
| | | non-white ethnicity |
| | | short stature |
| | | male infant. |