Birth After Caesarean Section (BAC)

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Contents

Introduction

There is consensus that, for the majority of women with a single previous lower segment caesarean birth (LSCS), planning a vaginal birth in the next pregnancy is considered a clinically safe choice. A successful vaginal birth after caesarean birth (VBAC) is known to reduce the overall chance of adverse outcome when compared to an elective repeat caesarean birth. 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.

Booking

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

- It is appropriate to advise women that planning a VBAC is usually the safest option and would generally be the professional recommendation.

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

Antenatal care

Antenatal counselling should consider all known risks and benefits of planned VBAC versus elective repeat caesarean birth and the woman's wishes should be explored and respected. The decisions women make in planning subsequent births are multifactorial and individual, some women are particularly influenced by professional guidance (Black, Entwhistle, Bhattacharya & Gillies 2016).

Women should be informed that during spontaneous labour; the rate of uterine rupture is 1:200 and that success rates where VBAC is planned are 72-75%.

There is some evidence of a lower success rate for women with a raised BMI, previous history of labour dystocia (particularly where the cervix was less than 8cm dilated), postdates birth, induction of labour, suspected macrosomia and/or maternal age over 40 years.

It should be noted that third trimester ultra sound scanning is not a reliable predictor of macrosomia (RCOG 2015).

- At the first antenatal clinic appointment the surgical records should be reviewed to ensure suitability for VBAC. Contraindications to planning a VBAC pertain to increased risk of uterine rupture. Women with any contraindication or circumstance that would increase the chance of uterine rupture should be referred to a consultant obstetrician for antenatal care.

Contraindications include:

- Previous uterine rupture
- High vertical classical uterine scar
- Extended uterine incision at index LSCS (e.g. T or J shaped incisions)
- Previous myomectomy or prior complex uterine surgery
- Other definitive contraindications to a vaginal birth irrespective of uterine scar.

Circumstances where the possible increase in uterine rupture should be considered include:

- Short- interval between LSCS and VBAC (<12 months,risk of rupture unknown)
- Multiple pregnancy (unknown)
- Suspected fetal macrosomia (Unknown)
- Induction/augmentation of labour (2/3 fold increase)
- Three previous LSCS (unknown)
- Where there are no contraindications and previous LSCS is the only risk factor midwifery led antenatal may be offered
- The advantages and disadvantages of planned VBAC versus planned elective repeat caesarean birth should be discussed using the RCOG information leaflet.
- Discussions should be documented using the 'VBAC risks and benefits' Checklist on BadgerNet. Care planning should then follow the appropriate pathway.
- Where VBAC is planned and there is no other comorbidity then the woman should be under midwifery led care for the antenatal period. An appointment should be arranged in a consultant clinic for the 40th week of pregnancy to discuss ongoing care where required.
- Where a woman is undecided around choosing mode of birth then a referral should be made to the consultant midwife.
- Where elective repeat caesarean birth is planned or where there are comorbidities the woman should be offered consultant led antenatal care and an appointment arranged as appropriate.
- Where elective repeat caesarean birth is planned, indications for this should be documented and an intrapartum plan should be completed on BadgerNet by 36 weeks, including a date for elective caesarean birth after 39 weeks gestation.
- 10 % of women will labour prior to 39 weeks, these circumstances should be discussed and a plan documented for this event.
- Where a consultant obstetrician has made a plan for birth this should be followed unless contraindicated.
- Patient information leaflet available via RCOG pi-birth-options-after-previous-caesarean-section.pdf

Ongoing antenatal care

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

- Regular (every 48 hours) membrane sweep may be offered from 39 weeks of pregnancy for those planning VBAC.

- Where the pregnancy is progressing normally induction of labour is offered at term + 12 days to maximise the opportunity for a spontaneous labour

Where spontaneous labour has not occurred and the woman declines induction of labour then elective repeat caesarean birth should be scheduled for term + 12.

- 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 birth.

- Antenatal assessment should include a CTG where contractions are present.

Intrapartum care during VBAC

- 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.

- Once in established labour, women should be admitted to the obstetric unit for one-to-one midwifery care.

- Bloods for FBC and Group and Save should be offered on admission for all women planning VBAC.

- Intravenous access should be secured if; cannulation is predicted to be difficult, or where there is any additional fetal or maternal concern. Cannulation should not be part of routine care (NICE, 2019).

- Women should be advised to have continuous electronic fetal monitoring following the onset of regular contractions for the duration of planned VBAC (NICE 2019; RCOG 2015).

- Telemetry is available in Singleton hospital 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 hyper stimulation and fetal and maternal wellbeing have been confirmed.

- Omeprazole 20mg should be administered every 12 hours whilst in labour.

- 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 on a MEWS chart at the standard interval for normal labour, unless otherwise indicated.

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

- Expected progress is 0.5-1cm every hour depending on previous history of vaginal birth. For women who have had a previous vaginal birth progress should be expected to be 1cm per hour. Birth should be expected within 1 hour of active pushing in the 2nd stage.

- Delayed labour progress should be discussed with the registrar and consultant obstetrician on call.

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

- Early diagnosis of uterine scar rupture is essential to reduce associated morbidity and mortality in mother and infant. There is no single 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.

- Diagnosis is ultimately confirmed at unplanned caesarean birth or postpartum laparotomy.

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

Induction of labour (IOL) and augmentation

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

- There is an increased chance of uterine scar rupture with the use of prostaglandins/ oxytocin (2/3 fold increased rate of uterine rupture, 1.5 fold increased chance of LSCS, perinatal death due to rupture increases from 4.2/10000 to 11.2/10000), this

should be discussed alongside the risks and benefits of elective repeat caesarean birth.

- Clinicians should be aware that IOL using mechanical methods (amniotomy/traction catheter) is associated with a lower incidence of uterine scar rupture compared to prostaglandin (29/10000 versus 87/10000).

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

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

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

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

- There is some low grade evidence to suggest that the risk of uterine rupture increases 4 fold or more where the dose of oxytocin administered exceeds 20 milliunit/minute.

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),perinatal outcome appears to be the same (RCOG,2015).

- A cautious approach is advised when considering planned VBAC in women with multiple pregnancy, fetal macrosomia and short inter- delivery interval (<12 months).

- Women who have under two previous LSCS can be offered VBAC after discussion with a senior obstetrician. There is an increase in hysterectomy associated with VBAC (56/10,000) after two caesarean births compared with elective repeat caesarean birth (19/ 10,000). Rates of blood transfusion also increase in VBAC after two LSCS (1.99%) compared to elective repeat caesarean birth (1.21%). Counselling in this group should include chance of scar rupture (1/200), maternal morbidity and individual likelihood of success based on previous obstetric history. Where VBAC is planned in these instances then a comprehensive plan should be made for the intrapartum period. This should include a plan for cervical progress parameters and instances whereby VBAC should be discontinued.

- There is no reliable evidence around planned VBAC in women with 3 or more caesarean births. The relative and/or absolute risk of maternal or neonatal adverse outcome in this group is unknown. For women requesting planned VBAC with 3 or more Caesarean births, antenatal counselling should occur with a consultant obstetrician. Consultations must include documented discussion around the limitations

of the evidence base, and a professional opinion around risk of scar rupture considering current and previous obstetric history. A comprehensive plan for the intrapartum period, to include expected cervical progress and plan in case of primary or secondary labour dystocia.

Care for women requesting care outside of current recommended guidelines

- A person who is giving birth has a right to decide where they birth and cannot be compelled to accept a recommended mode or place of birth (Birthrights, n.d)

  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 discussedand documented in detail. Where possible the woman should be seen by the consultant midwife/ lead midwife to 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 woman 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 in BadgerNet. The discussion aid (Appendix 3) can also be used to share information with the relevant team members and then scanned into the maternal BadgerNet record.

References

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UKOSS- Fitzpatrick K, Kurinczuk J, Alfirevic Z, Spark P, Brocklehurst P, et al. (2012) Uterine Rupture by Intended Mode of Delivery in the UK: A National Case-Control Study. *PLoS Med* 9(3): e1001184. Doi:10.1371/journal.pmed.1001184

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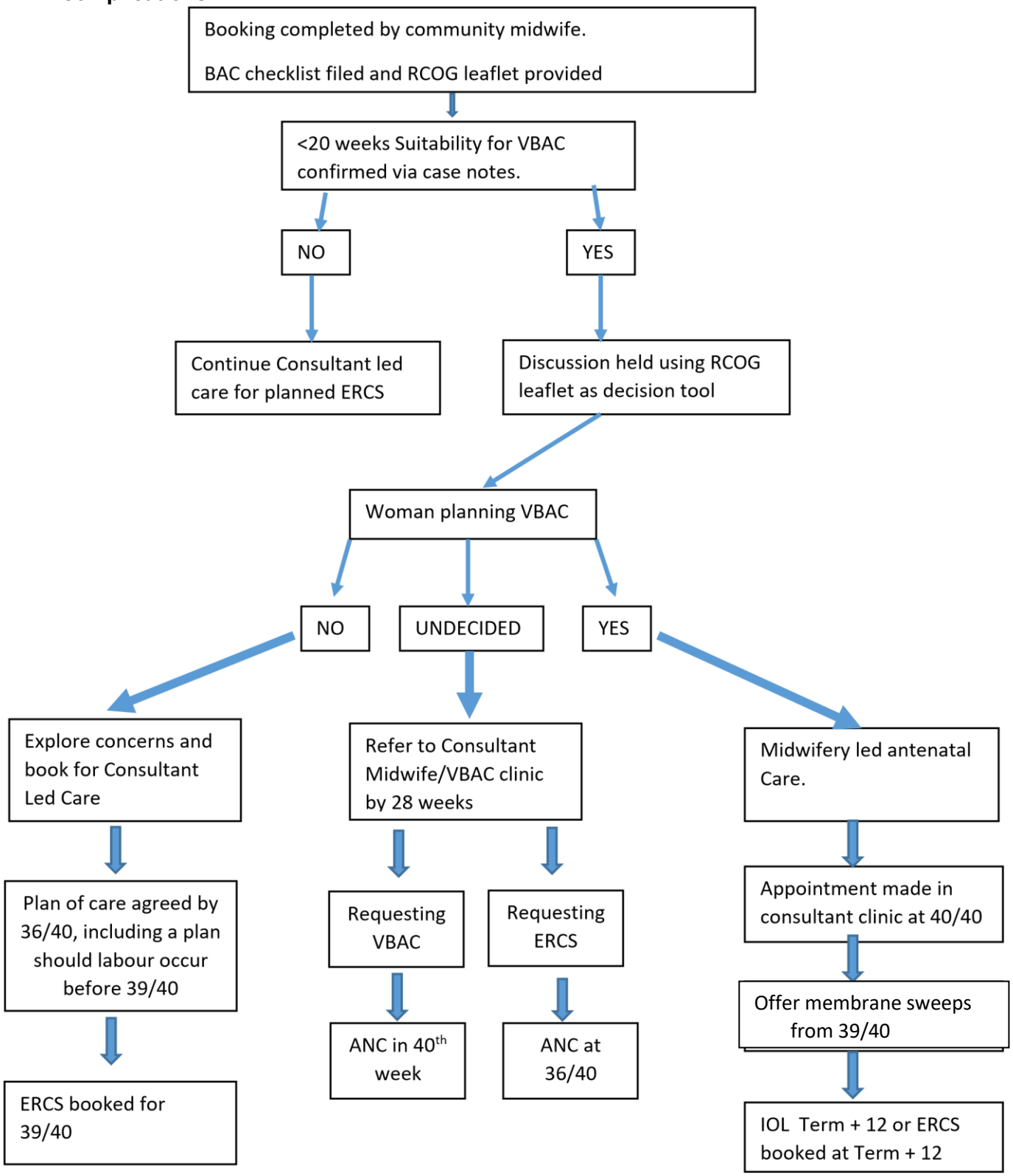
Appendix 1 Care Pathway

Algorithm for planning care of women with one caesarean birth and no other antenatal complications.



Appendix 2 Discussion Aid

Discussion outline for women planning VBAC outside of recommended care.

Addressograph

Date: **EDD:** **Previous Births:**

Success rate for vaginal birth is estimated to around 72-75%. The success rate is higher amongst women with a previous vaginal birth. Advice to women having a VBAC is that they should labour on the Central Delivery suite in Singleton Hospital.

Rarely (around 1 in every 200 births) the uterine scar opens during labour. Scar rupture is an obstetric emergency, immediate delivery of the baby is required to minimise the risk of severe morbidity (Including haemorrhage or hypoxia) or even death to mother and baby. Because of this risk women are recommended to be cared for where there is immediate access to caesarean birth, on site blood transfusion and advanced neonatal services.

Recommended care (Based upon NICE (2014)	**Rationale**	**Understood**	**Accepted**	**Declined**
Labour care provided on obstetric unit.	Caesarean section can be performed quickly if necessary. Time is a critical element when scar rupture occurs. It is reasonable to expect a baby should be delivered within 30 minutes for a category 1 caesarean section (category 1 section = Immediate threat to life of woman or fetus) If transfer from home, AMU or FMU is required this time interval may be increased substantially. This additional time may have severe consequences for either mother or baby.	☐	☐	☐
Consider Intravenous access (A drip attachment in the back of your hand)	When labour is progressing normally IV access is not required, however if any concerns arise during your care, IV access is recommended in case IV fluids, blood products or quick delivery of the baby is required. If labouring in a midwifery led setting IV access will not be secured.	☐	☐	☐

Blood sample taken on admission	It is important to have up to date blood results for both haemoglobin and platelet count should urgent delivery of	☐	☐	☐
	the baby be required. A recent sample for blood group should also be available should an urgent blood transfusion be required. If labouring in a midwifery led setting this sample will not be taken.			
Continuous electronic monitoring of baby during labour.	Rarely (around 1/200) the uterine scar opens during labour. The first sign of this can be the occurrence of changes in the fetal heart rate (present in 66-76% of uterine rupture, RCOG,2015). Scar rupture is an obstetric emergency. Intermittent Auscultation (IA) of the fetal heart may not detect fetal heart changes that would alert staff to possible scar rupture There is no reliable evidence around the use of intermittent or no auscultation were VBAC is planned, therefore the risks or advantages are unknown. Women labouring in a midwifery led setting will only receive intermittent auscultation. Where intermittent auscultation is use it will be offered in line with NICE (2014) guideline.	☐ ☐	☐ ☐	☐ ☐
Vaginal examinations performed 4 hourly in the first stage and hourly in the 2nd stage	In line with NICE, 2014 intrapartum care guideline	☐	☐	☐
Advice to transfer to consultant unit will be made where cervical dilatation is < 6cm over six hours in first stage. Where ARM is indicated transfer to the OU will be advised	The risk of scar rupture is increased in prolonged labour.	☐	☐	☐
Transfer to consultant unit and or advice to leave the birthing pool will be recommended after 60 minutes of active pushing in the second stage (30 minutes for women with a previous vaginal birth).	The risk of scar rupture is increased in prolonged labour.	☐	☐	☐

Omeprazole 20mg administered 8 hourly in labour to minimise acidity of stomach contents. This will not be available in a midwifery led setting.	This may reduce the risk of general anaesthetic, in case a Caesarean birth needs to be undertaken.	☐	☐	☐
Only water or isotonic drinks to be drunk during established labour.	In case a Caesarean birth needs to be undertaken	☐	☐	☐

Any woman choosing to labour outside of the consultant unit can change her mind about her chosen care package at any time. The midwife providing intrapartum care should inform the appropriate delivery suite that the woman is in labour, a senior obstetrician and anaesthetists should also be informed. Intrapartum care should be documented fully on a continuation sheet in addition to a partogram (the All Wales clinical pathway for normal labour pathway is not a suitable documentation tool in this instance). All clinical findings, recommended care and their relevance should be discussed and documented with the woman in order that she can make informed decisions on her care.

Additional Information is available at: http://www.healthtalkonline.org/Pregnancy_children
www.**nice**.org.uk/

Signed: …….. (Pregnant woman)

Signed: …….. (Consultant Midwife)

Maternity Services

Checklist for Clinical Guidelines being Submitted for Approval

Title of Guideline:	Birth After Caesarean Section
Name(s) of Author:	Intrapartum Forum
Chair of Group or Committee approving submission:	Madhu Dey Consultant lead Obstetrician for labour ward
Brief outline giving reasons for document being submitted for ratification	Document update
Details of persons included in consultation process:	Intrapartum forum
Name of Pharmacist (mandatory if drugs involved):	N/A
Issue / Version No:	3
Please list any policies/guidelines this document will supercede:	Birth after a Caesarean (2019)
Date approved by Group:	July 2026
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Please indicate key words you wish to be linked to document	VBAC, BAC, Vaginal birth after Caesarean. Birth after Caesarean.