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 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 elective repeat caesarean section (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.

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 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 ERCS 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 ERCS should be discussed using the RCOG information leaflet.

- Discussions should be documented using the BAC Checklist. Care planning should then follow the appropriate pathway (Appendix 3).

- 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 or VBAC clinic for the opportunity of further discussion.

- Where ERCS is planned 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. A detailed plan should be completed by 36 weeks to include a date for ERCS at 39 weeks.

- 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.

<u>Ongoing antenatal care</u>

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

- Regular (every 48 hours) membrane sweep may be offered from 40 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 ERCS 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 section.

- 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.

- Ranitidine 150mg should be offered 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 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.

- Lack of 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 emergency caesarean section or postpartum laparotomy.

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

<u>Induction of labour (IOL) and augmentation</u>

- 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 ERCS.

- 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). Low-dose prostaglandin E2 may be as safe as spontaneous labour however there is currently not reliable evidence to confirm this.

- The use of oxytocin to augment poor 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.

<u>Planned VBAC in special circumstances</u>

- 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 ERCS (19/ 10,000). Rates of blood transfusion also increase in VBAC after two LSCS (1.99%) compared to ERCS (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 sections. 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 sections, 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.

<u>Care for women requesting care outside of current recommended guidelines</u>

- 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 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 (Appendix 4), and filed in the maternal records.

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Appendices

Appendix 1 Information Leaflet

Information for you

Published in July 2016

Health & care information you can trust

The Information Standard Certified Member

Royal College of Obstetricians & Gynaecologists

Birth options after previous caesarean section

About this information

This information is for you if you have had one caesarean section and want to know more about your birth options when having another baby. It may also be helpful if you are a relative or friend of someone who is in this situation.

How common is it to have a caesarean section?

More than one in five women in the UK currently give birth by caesarean section. About half of these are as a planned operation and the other half are as an emergency. Many women have more than one caesarean section.

What are my choices for birth after one caesarean section?

If you have had a caesarean section, you may be thinking about how to give birth next time. Planning for a vaginal birth after caesarean (VBAC) or choosing an elective repeat caesarean section (ERCS) have different benefits and risks.

In considering your options, your previous pregnancies and medical history are important factors to take into account, including:

- the reason you had your caesarean section

- whether you have had a previous vaginal birth
- whether there were any complications at the time or during your recovery
- the type of cut that was made in your uterus (womb)
- how you felt about your previous birth
- whether your current pregnancy has been straightforward or whether there have been any problems or complications
- how many more babies you are hoping to have in future; the risks increase with each caesarean section, so if you plan to have more babies it may be better to try to avoid another caesarean section if possible.

To help you decide, your healthcare professionals will discuss your birth options with you at your antenatal visit, ideally before 28 weeks.

What if I have had more than one caesarean section?

If you are considering a vaginal birth but have had more than one caesarean section delivery, you should have a detailed discussion with a senior obstetrician about the potential risks, benefits and success rate in your individual situation.

What is VBAC?

VBAC stands for 'vaginal birth after caesarean'. It is the term used when a woman gives birth vaginally, having had a caesarean section in the past. Vaginal birth includes normal delivery and birth assisted by forceps or ventouse (vacuum cup).

What is an ERCS?

ERCS stands for 'elective (planned) repeat caesarean section'. You will usually have the operation after 39 weeks of pregnancy. This is because babies born by caesarean section earlier than this are more likely to need to be admitted to the special care baby unit for help with their breathing.

What are my chances of a successful VBAC?

After one caesarean section, about three out of four women with a straightforward pregnancy who go into labour naturally give birth vaginally.

A number of factors make a successful vaginal birth more likely, including:

- previous vaginal birth, particularly if you have had previous successful VBAC; if you have had a vaginal birth, either before or after your caesarean section, about 8–9 out of 10 women can have another vaginal birth
- your labour starting naturally
- your body mass index (BMI) at booking being less than 30.

What are the advantages of a successful VBAC?

Successful VBAC has fewer complications than ERCS. If you do have a successful vaginal birth:

- you will have a greater chance of a vaginal birth in future pregnancies
- your recovery is likely to be quicker, you should be able to get back to everyday activities more quickly and you should be able to drive sooner
- your stay in hospital may be shorter
- you are more likely to be able to have skin-to-skin contact with your baby immediately after birth and to be able to breastfeed successfully
- you will avoid the risks of an operation
- your baby will have less chance of initial breathing problems.

What are the disadvantages of VBAC?

- You may need to have an emergency caesarean section during labour. This happens in 25 out of 100 women. This is only slightly higher than if you were labouring for the first time, when the chance of an emergency caesarean section is 20 in 100 women. An emergency caesarean section carries more risks than a planned caesarean section. The most common reasons for an emergency caesarean section are if your labour slows or if there is a concern for the wellbeing of your baby.
- You have a slightly higher chance of needing a blood transfusion compared with women who choose a planned second caesarean section.
- The scar on your uterus may separate and/or tear (rupture). This can occur in 1 in 200 women. This risk increases by 2 to 3 times if your labour is induced. If there are warning signs of these complications, your baby will be delivered by emergency caesarean section. Serious consequences for you and your baby are rare.
- Serious risk to your baby such as brain injury or stillbirth is higher than for a planned caesarean section but is the same as if you were labouring for the first time.
- You may need an assisted vaginal birth using ventouse or forceps. See the RCOG patient information *An assisted vaginal birth (ventouse or forceps)* (www.rcog.org.uk/en/patients/patientleaflets/assisted-vaginal-birth-ventouse-or-forceps).
- You may experience a tear involving the muscle that controls the anus or rectum (third or fourth degree tear). See the RCOG patient information *A third- or fourth-degree tear during birth* (www.rcog.org.uk/en/patients/patient-leaflets/third--or-fourth-degree-tear-during-childbirth) for more information.

When is VBAC not advisable?

VBAC is normally an option for most women but it is not advisable when:

- you have had three or more previous caesarean deliveries
- your uterus has ruptured during a previous labour
- your previous caesarean section was 'classical', i.e. where the incision involved the upper part of the uterus
- you have other pregnancy complications that require a planned caesarean section.

What are the advantages of ERCS?

- There is a smaller risk of uterine scar rupture (1 in 1000).
- It avoids the risks of labour and the rare serious risks to your baby (2 in 1000).
- You will know the date of planned birth. However, 1 in 10 women go into labour before this date and sometimes this date may be changed for other reasons.

What are the disadvantages of ERCS?

- A repeat caesarean section usually takes longer than the first operation because of scar tissue. Scar tissue may also make the operation more difficult and can result in damage to your bowel or bladder.
- You can get a wound infection that can take several weeks to heal.
- You may need a blood transfusion.
- You have a higher risk of developing a blood clot (thrombosis) in the legs (deep vein thrombosis) or lungs (pulmonary embolism). See the RCOG patient information *Reducing the risk of venous thrombosis in pregnancy and after birth* (www.rcog.org.uk/en/patients/patient-leaflets/reducing-therisk-of-venous-thrombosis-in-pregnancy-and-after-birth).
- You may have a longer recovery period and may need extra help at home. You will be unable to drive for about 6 weeks after surgery (check with your insurance company).
- You are more likely to need a planned caesarean section in future pregnancies. More scar tissue occurs with each caesarean section. This increases the possibility of the placenta growing into

  the scar, making it difficult to remove during any future deliveries (placenta accreta or percreta). This can result in bleeding and may require a hysterectomy. All serious risks increase with every caesarean section you have.

- Your baby's skin may be cut at the time of caesarean section. This happens in 2 out of every 100 babies delivered by caesarean section, but usually heals without any further harm.

- Breathing problems for your baby are quite common after caesarean section but usually do not last long. Between 4 and 5 in 100 babies born by planned caesarean section at or after 39 weeks have breathing problems compared with 2 to 3 in 100 following VBAC. There is a higher risk if you have a planned caesarean section earlier than 39 weeks (6 in 100 babies at 38 weeks).

What happens when I go into labour if I'm planning a VBAC?

You will be advised to give birth in hospital so that an emergency caesarean section can be carried out if necessary. Contact the hospital as soon as you think you have gone into labour or if your waters break.

Once you start having regular contractions, you will be advised to have your baby's heartbeat monitored continuously during labour. This is to ensure your baby's wellbeing, since changes in the heartbeat pattern can be an early sign of problems with your previous caesarean scar. You can choose various options for pain relief, including an epidural.

What happens if I do not go into labour when planning a VBAC?

If labour does not start by 41 completed weeks, your obstetrician will discuss your birth options again with you. These may include:

- continue to wait for labour to start naturally
- induction of labour; this can increase the risk of scar rupture and lowers the chance of a successful VBAC
- ERCS.

What happens if I have an ERCS planned but I go into labour?

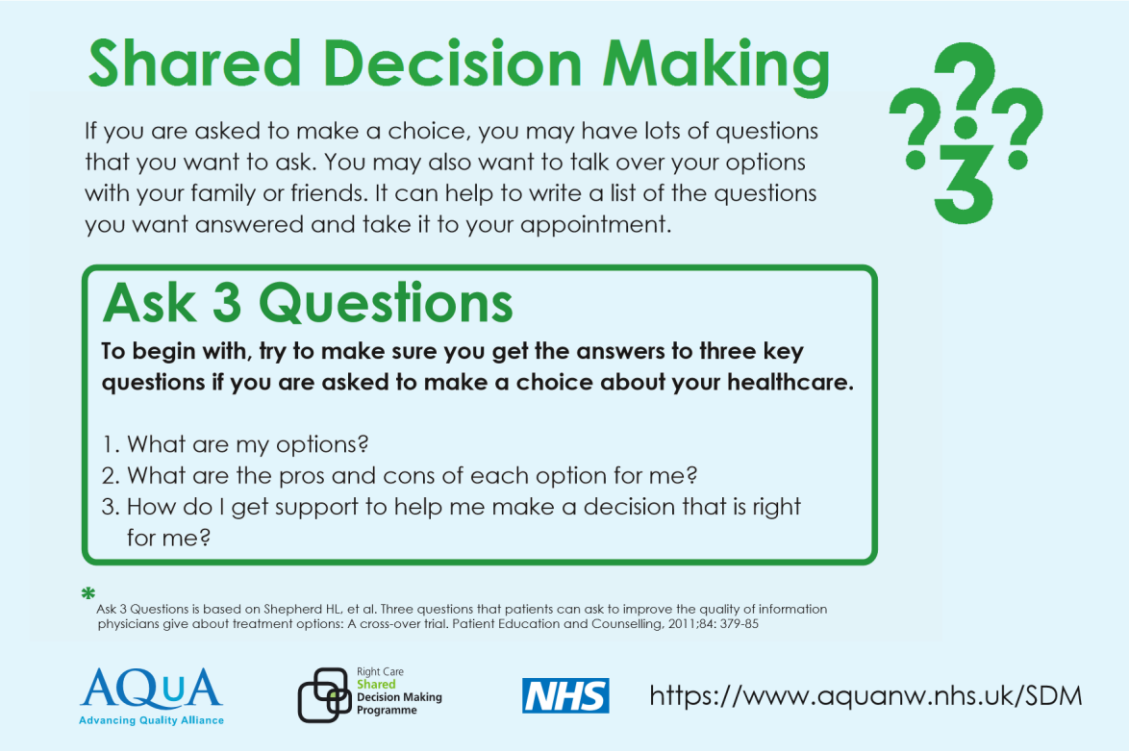
Let your maternity team know what is happening. It is likely that an emergency caesarean section will be offered once labour is confirmed. If labour is very advanced, it may be safer for you and your baby to have a vaginal birth. Your maternity team will discuss this with you.

Key points

- If you are fit and healthy, both VBAC and ERCS are safe choices with very small risks.
- 3 out of 4 women who have had one caesarean section and then have a straightforward pregnancy and go into labour naturally give birth vaginally.

- 9 out of 10 women will have a successful VBAC if they have ever given birth vaginally. Successful VBAC has the fewest complications.
- Giving birth vaginally carries small risks for you and your baby but, if you have a successful vaginal birth, future labours are less complicated with fewer risks for you and your baby.
- Having a caesarean section makes future births more complicated.
- Most women who have a planned caesarean section recover well and have healthy babies, but it takes longer to get back to normal after your baby is born.

Making a choice



Further information

- NICE guidance on caesarean section: www.nice.org.uk/guidance/cg132
- RCOG patient information *A third- or fourth-degree tear during birth*: www.rcog.org.uk/en/patients/ patient-leaflets/third--or-fourth-degree-tear-during-childbirth
- RCOG patient information *An assisted vaginal birth (ventouse or forceps)*: www.rcog.org.uk/en/patients/patient-leaflets/assisted-vaginal-birth-ventouse-or-forceps

Sources and acknowledgements

This information has been developed by the RCOG Patient Information Committee. It is based on the RCOG Green-top Clinical Guideline *Birth after Previous Caesarean Birth* which you can find online at: www.rcog.org.uk/ en/guidelines-research-services/guidelines/gtg45.

This leaflet was reviewed before publication by women attending clinics in Raigmore Hospital, King's College Hospital, Queen's Hospital, St Mary's Hospital, University Hospital Lewisham and Wrexham Maelor Hospital, by the RCOG Women's Network and by the RCOG Women's Voices Involvement Panel.

The RCOG produces guidelines as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant health professionals. This means that RCOG guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management.

A glossary of all medical terms is available on the RCOG website at: www.rcog.org.uk/en/patients/medical-terms.

Appendix 2: BAC checklist

BAC CHECKLIST

<table>
<tr><td>Booking appointment</td><td colspan="2">Date: …… Gestation: …….
Reason for previous CS: ……
Antenatal Risk factors? ……
RCOG (2016) information leaflet provided Yes No</td></tr>
<tr><td>BAC Discussion before 20 weeks</td><td>Discuss previous birth experience ☐
Previous obstetric notes reviewed ☐
Risks and benefits of VBAC discussed ☐
Risks and benefits of ERCS (elective repeat) ☐
Patient information leaflet given ☐ by CMW ☐
Recommendation for VBAC ☐ ERCS ☐</td><td>Recommended care in labour:
Recommendation for birth on Obstetric unit ☐
Recommendation for CEfM ☐
Use of telemetry ☐
Use of water for labour ☐
FBC/GS taken on admission and venous access assessment. ☐
Support in labour ☐
Mobility in labour ☐
Additional information
……..</td></tr>
<tr><td>Plan</td><td colspan="2">Woman wishes:
VBAC ☐ Appointment to be arranged for 40 weeks in ANC clinic
ERCS ☐ Refer to ANC (discontinue pathway. Detailed plan to be documented in maternal records by 36/40)
Undecided ☐ Referral to VBAC clinic or consultant midwife by 28 weeks
Other:
Signed: …… Printed: ……</td></tr>
</table>

- The risk of scar rupture overall is 5:1000 (0.5%) in planned VBAC,<2/10,000 (0.02%) in ERCS
- Likelihood of successful planned VBAC; after a single previous caesarean is 72-76%, with at least 1 previous vaginal birth 85-90%.
- Pervious LSCS for malpresentation increases likelihood of successful VBAC to 84%
- Unsuccessful VBAC more likely in IOL,BMI more than 30,no previous vaginal birth, and labour dystocia.Success rate falls to 40% where all factors are present.
- ERCS increases the risk of serious complications in future pregnancies (placenta praevia/morbidly adherent placenta).
- Risk of birth-related perinatal loss during VBAC is comparable to the risk for women having their first baby **RCOG (2015) birth after previous caesarean Birth (Green-top guideline 54)**
- Maternal Mortality 4/100,000 VBAC, 13/100,000 ERCS

BAC CHECKLIST

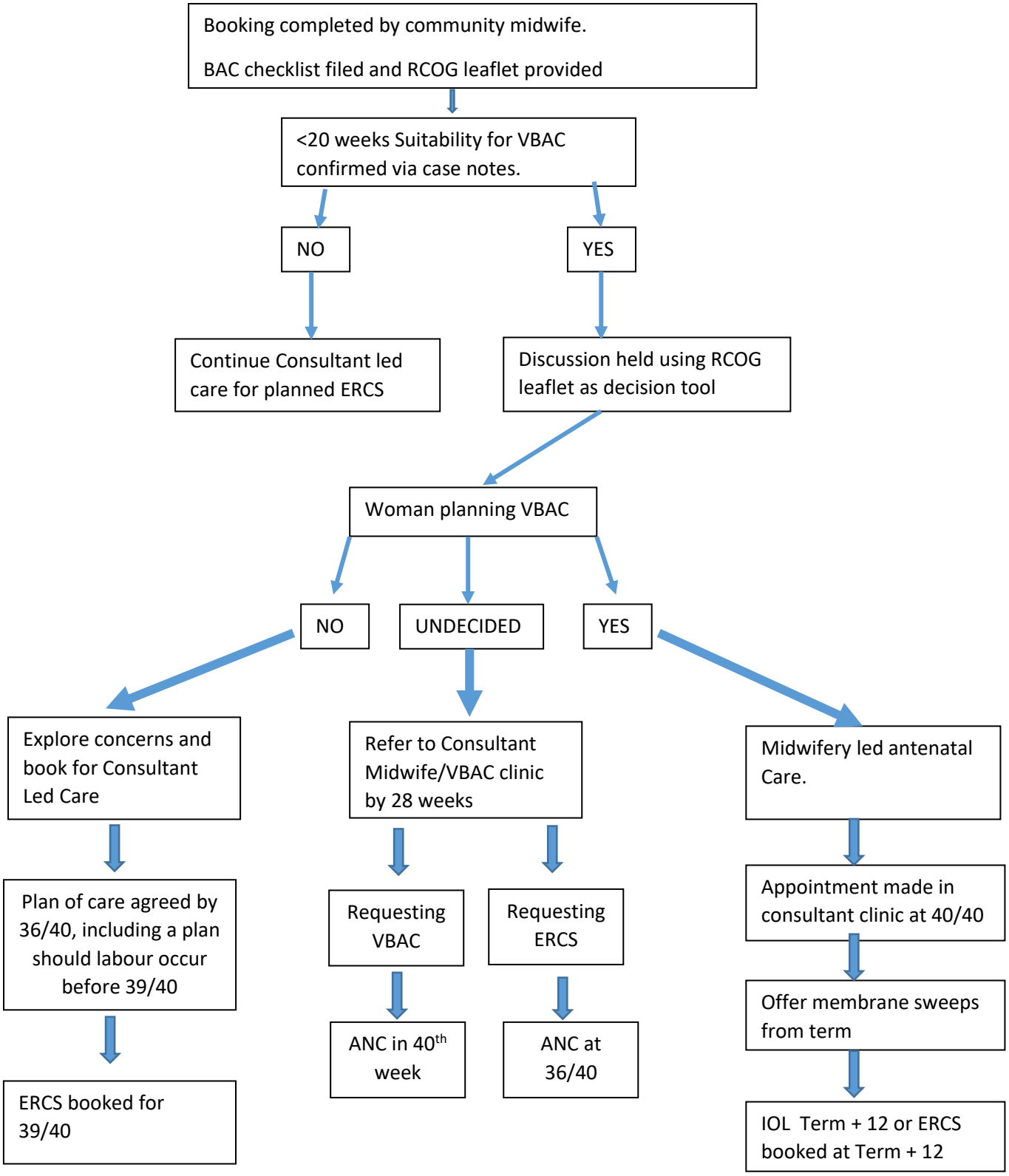
Subsequent appointment		
Plan		

Clinic appointment in the 40th week	Date: …….. Gestation: …….. Is VBAC still recommended Yes ☐ No ☐ If no, why? …… ……	**Discussion:** Methods used for induction of labour ☐ Increased risk of scar rupture and LSCS ☐ Recommendation for cervical assessment and stretch and sweep ☐ ☐ Cervical assessment carried out Yes ☐ No ☐ Bishop's score ……..
Plan	Where spontaneous labour has not occurred by Term+12 Woman wishes IOL ☐ ERCS ☐ Book ERCS for 40+12 ☐ Date…… Pre-op clerking booked ☐ Date …… *a comprehensive plan should be developed where women are planning ongoing conservative management.	Book IOL for 40+12: Propess ☐ Prostin ☐ Traction Catheter/ Arm ☐ Oxytocin ☐ Other …… Date of IOL ……..
	Signed: …….. Printed: ……	

- Rates of uterine rupture increase 2/3 fold with IOL via Prostaglandin and oxytocin.
- Emergency LCSC increases 1.5 fold compared to spontaneous labour **RCOG (2015).**

Appendix 3 Care Pathway

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



Appendix 4 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 section, 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.	☐	☐	☐
Ranitidine administered 6 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 section needs to be undertaken.	☐	☐	☐

Only water or isotonic drinks to be drunk during established labour.	In case a Caesarean section 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:	Labour ward 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:	Labour ward forum and antenatal forum.
Name of Pharmacist (mandatory if drugs involved):	N/A
Issue / Version No:	2
Please list any policies/guidelines this document will supercede:	VBAC- Vaginal birth after a Caesarean Section (ABMU,2013)
Date approved by Group:	17th July 2019
Next Review / Guideline Expiry:	July 2022
Please indicate key words you wish to be linked to document	VBAC, BAC, Vaginal birth after Caesarean Section. Birth after Caesarean Section.
File Name: Used to locate where file is stores on hard drive	