

# Vaginal Birth after Caesarean - Intrapartum Management



## Immediate Actions

Women must be assisted to make an informed choice regarding whether to attempt a vaginal birth or whether to plan another caesarean section.

Women with spontaneous rupture of membranes and regular, painful uterine contractions should be cared for on the Birth Centre as this combination indicates that labour has begun.

Vaginal assessments ideally to be conducted by a Level 4 registrar or above. The responsibility lies with the registrar to notify the consultant of findings at each assessment.

Once labour has been diagnosed and fetal monitoring is continuous, the maternal oxygen saturation probe must be used so that the fetal and maternal heart rates are easily distinguishable

## 1. Purpose

VBAC should be considered as an option for all women who present for prenatal care with a history of previous caesarean birth. Where contraindications exist a repeat caesarean section will be advised, but in the majority of cases successful vaginal birth can be achieved safely for both mother and baby<sup>1</sup>.

The success rate of VBAC at The Women's is around 60-65%.

It is essential women make an informed choice regarding whether to attempt a vaginal birth or whether to plan another caesarean section. Therefore, these guidelines recommend that obstetricians and women discuss the risks and benefits of VBAC (reinforced by the provision of appropriate literature) to plan the birth.

### Contraindications to VBAC

The following conditions are highlighted as being associated with an increased risk of uterine rupture or unsuccessful VBAC:

Previous classical or vertical lower uterine segment incision

More than one previous caesarean section

Less than 18 months since the previous caesarean section

BMI >40

Fetal weight > 4 kg.

## 2. Definitions

**VBAC-vaginal birth after caesarean:** a planned attempt to birth vaginally in a woman who has had a previous caesarean section

**Latent phase of labour:** from the start of uterine contractions until progressive cervical dilatation.

Women who are having uterine activity or have spontaneous rupture of membranes and a planned VBAC, but who have not yet had labour diagnosed may be cared for on either the Birth Centre or the ward with an agreed plan of management. This plan should contain an agreed timeframe for further assessment and decision making. For example, should labour not establish within six hours of admission, consult with the woman and medical staff regarding a management plan.

**Note:** women with spontaneous rupture of membranes and regular, painful uterine contractions should be cared for on the Birth Centre as this combination indicates that labour has begun.

## 3. Responsibilities

Midwifery and obstetric medical staff.

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## 4. Procedure

### 4.1 On admission

Inform Senior Registrar /Consultant and midwife in charge on admission to Birth Centre of all women who have a uterine scar

The senior registrar must refer to The Women's Next Birth after Caesarean Decision Aid (appendix 1) to review and revise the management plan prepared antenatally in consultation with the woman

Notify anaesthetist and theatre of any patient for planned TOL in Birth Centre in labour

IV access with 16G cannula from onset of labour.

Blood to be taken for:

- Group and save
- Haemoglobin
- Analgesia prescribed on request- epidural is not contraindicated in VBAC<sup>1</sup>.

### Electronic fetal monitoring (EFM)

[Refer to The Women's guideline CTG Interpretation and Response](#)

A uterine scar is an indication for continuous electronic fetal surveillance in labour.

Continuous fetal monitoring using telemetry is an option available to women if they wish to ambulate during labour.

It is reasonable for women to have short breaks from electronic fetal monitoring in the following circumstances:

If the electronic fetal heart rate monitoring has been and is considered normal

The interruption is for a short period only i.e. 15 minutes

If the number of interruptions is infrequent

If the interruption does not occur immediately after any intervention that might be expected to alter the fetal heart rate

This arrangement has been discussed prior to labour and documented in the antenatal notes.

Several VBAC studies have reported that in over 70 % of cases of uterine rupture, the first signs or symptoms presented as prolonged fetal bradycardia. Of these cases, only 8 % presented with pain and 3 % with bleeding.

Once labour has been diagnosed and fetal monitoring is continuous, the maternal oxygen saturation probe must be used so that the fetal and maternal heart rates are easily distinguishable. Loss or change of fetal heart rate and loss of uterine activity are symptoms of uterine rupture. The toco must be insitu and regularly 'zeroed'.

### 4.2 First Stage

Prostaglandins (Prostin E2 Gel) is contraindicated

Oxytocin administration is not contraindicated for induction of labour in women undergoing a VBAC. However, this decision must be taken in consultation with the Birth Centre Consultant<sup>3</sup>

Consideration should be given to the use of an intrauterine pressure catheter to monitor contraction strength and guide oxytocin dosage

*Augmentation* with oxytocin is not recommended.

The available evidence suggests that the use of oxytocin is associated with a 1% increased risk of rupture/dehiscence<sup>1,2,3</sup>. Oxytocin may be used with caution in women with a previous caesarean section, following discussion with the obstetric consultant on-call for Birth Centre.

Women who have had 1 previous caesarean may use water immersion for pain management in the following circumstances and providing all other criteria are met (see [Water Immersion in Labour guideline](#)):

- Spontaneous labour and CTG remains normal
- Conduct 15 minutely maternal pulse to ensure fetal heart rate is being monitored (in lieu of the pulse oximeter) whilst in the water.

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### 4.3 Progress and recognition of delay:

Trial of labour mandates vigilant assessment of progress of labour with vaginal examinations 4 hourly in the early active labour and 2 hourly after the cervix reached 7cm dilatation<sup>2</sup>.

Note: vaginal assessments ideally to be conducted by a Level 4 registrar or above. The responsibility lies with the registrar to notify the consultant of findings at each assessment.

The cervix should dilate at least 1cm per hour after labour has been diagnosed and the cervical dilatation has reached at least 5cm<sup>2</sup>.

Amniotomy should be considered when clinically indicated.

Any delay in either the latent or active phase of labour or significant fetal heart rate abnormalities should be discussed immediately with the midwife in charge, obstetric senior registrar and/or consultant on-call for Birth Centre. Recommendations on how to progress should be discussed with the woman and a plan for care and further assessment documented<sup>3</sup>.

In suspected uterine rupture activate a Code Green<sup>1</sup>.

#### Signs and symptoms of uterine rupture

Abnormalities in the fetal heart trace, such as variable or late decelerations, prolonged fetal bradycardia, warrant immediate review by senior registrar or consultant. These abnormalities may be the first signs of scar rupture.

Be vigilant for the symptoms and signs of scar rupture, which may include:

Abnormal fetal heart rate or CTG

Abnormal vaginal bleeding or frank haematuria

Suprapubic tenderness and/or severe constant abdominal pain which continues between contractions

Maternal tachycardia, hypotension or shock

Chest pain or shoulder tip pain, sudden onset shortness of breath

No progress/inadequate progress in labour

In-coordinate uterine action in active labour or cessation of contractions

Changes of the uterine shape

Loss of station of the presenting part (disengagement of presenting part)

If pain does develop an atypical pattern, particularly with unusual radiation (such as to the shoulder tips), or pain previously controlled by analgesia (epidural or otherwise) which becomes more severe, then complete clinical reassessment is required by a Senior Registrar or Consultant.

### 4.4 Second Stage

Duration should not exceed 2 hours: 1 hour to allow for passive descent, but no more than 1 hour of active pushing (or 30 minutes if the woman has had a prior vaginal birth)<sup>3</sup>

The option of any mid-cavity assisted vaginal birth **must** be discussed with the consultant

No mid-cavity assisted delivery to be performed without the consultant being present, and then to be performed in the operating theatre.

### 4.5 Third Stage

Active management. Refer to guideline: [Third Stage Management](#)

Exploration of the uterus to detect dehiscence scar after a vaginal birth is not advisable as it may increase the risk of puerperal infections and may cause iatrogenic perforation. However, excessive vaginal bleeding, abdominal pain or unexplained maternal collapse at the birth, will require prompt assessment and the need to repair the dehiscence or rupture if this occurred<sup>3</sup>.

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## 5. Evaluation, monitoring and reporting of compliance to this procedure

To be developed.

## 6. References

1. Society of Obstetricians and Gynaecologists of Canada (SOGC) Clinical Practice Guidelines No 155 (2005): Guidelines for Vaginal Birth After Previous Caesarean Birth *International Journal of Gynaecologists and Obstetricians* 89 319-331.
2. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists Statement: C-Obs 38 (2015) Birth after Caesarean Section (Trial of Labour) Avail at <http://www.ranzcog.edu.au>.
3. The Royal Australian and New Zealand College of Obstetricians and Gynaecologists Clinical Guidelines: Intrapartum Fetal Surveillance (2014).
4. Sentilhes L et al (2013) delivery for women with a previous caesarean: Guidelines for clinical practice from the French College of Gynaecologists and Obstetricians (CNGOF) *European Journal of Obstetrics, Gynaecology and Reproductive Biology* 170 25-32.

## 7. Legislation/Regulations related to this procedure

Not applicable.

## 8. Appendices

NA

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