National Women & Infants Health Programme

QUICK SUMMARY DOCUMENT

Vaginal Birth After Caesarean Section

This Quick Summary Document (QSD) is a resource for all clinicians working in healthcare in Ireland who are involved in provision of Vaginal Birth After Caesarean (VBAC).

Following a comprehensive literature review a number of evidence-based recommendations for Vaginal Birth After Caeserean (VBAC) were agreed upon.

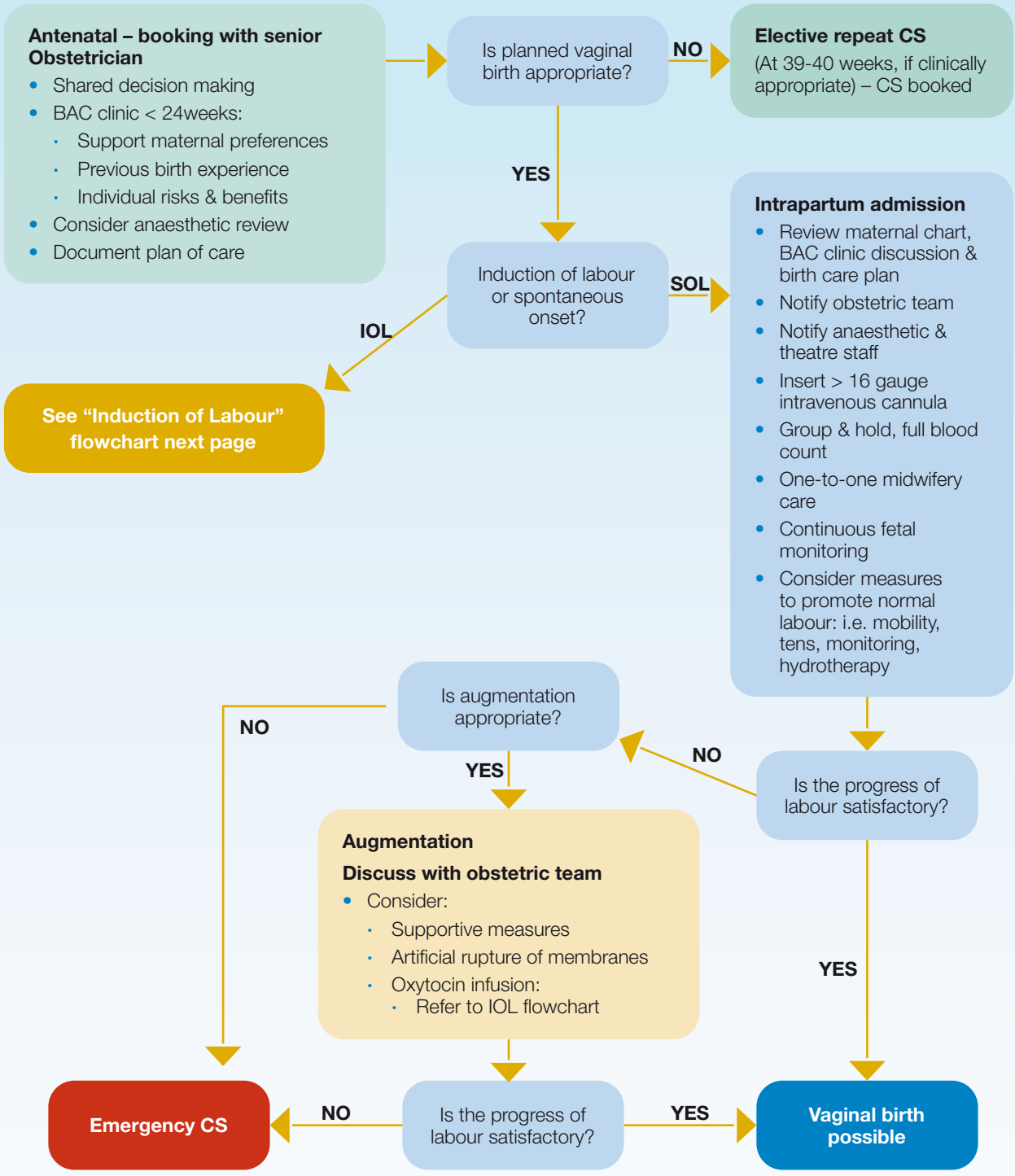
Key Recommendations

1. A woman with previous caesarean section(s) should be assessed by a senior Obstetrician at the booking antenatal visit.
2. Previous maternity records should be available for review at the booking visit or sought for further review at the next visit.
3. Women with a previous caesarean birth should be cared for through the Assisted Care Pathway.
4. The decision for intended mode of birth should be agreed and documented in the maternity records in the second trimester.
5. Placental location should be confirmed as per local/national guidelines.
6. Planned Vaginal Birth After Caesarean (VBAC) is a safe and appropriate option for the majority of women with one previous transverse lower segment caesarean section, with a singleton term pregnancy and cephalic presentation.
7. Absolute contraindications include previous classical caesarean birth, uterine rupture, placenta praevia and where a woman declines a planned VBAC.
8. Women should be advised of the risks of VBAC versus Elective Repeat Caesarean Section (ERCS).
9. The preferred mode of birth should be determined by the woman and her care provider after appropriate counselling.
10. Women should be informed that a successful VBAC carries the lowest morbidity rates.
11. Women should be informed that the most serious risk associated with a VBAC attempt is the risk of uterine rupture, in the region of 0.2-0.7%.
12. Women should be informed that ERCS confers risk to both the current pregnancy and subsequent pregnancies, including the risk of placenta accreta and hysterectomy and these risks increase with each subsequent caesarean birth.
13. Women should be informed of the increased risk of transient tachypnoea of the newborn (TTN) with ERCS.
14. Women should be advised that the overall reported VBAC success rates are in the region of 72-75%.
15. Women should be informed that a history of one or more previous vaginal births is the best predictor for successful VBAC with success rates as high as 85-91%.
16. If there is no contraindication to VBAC, maternal request for reversal of a prior plan for ERCS is acceptable after discussion with the Obstetrician and Midwife providing care.
17. If the plan is for ERCS, and labour ensues before the assigned date, it is important to document the agreed plan of action, either a planned VBAC or caesarean birth, as per the woman's wishes and dependent on the clinical situation at the time.

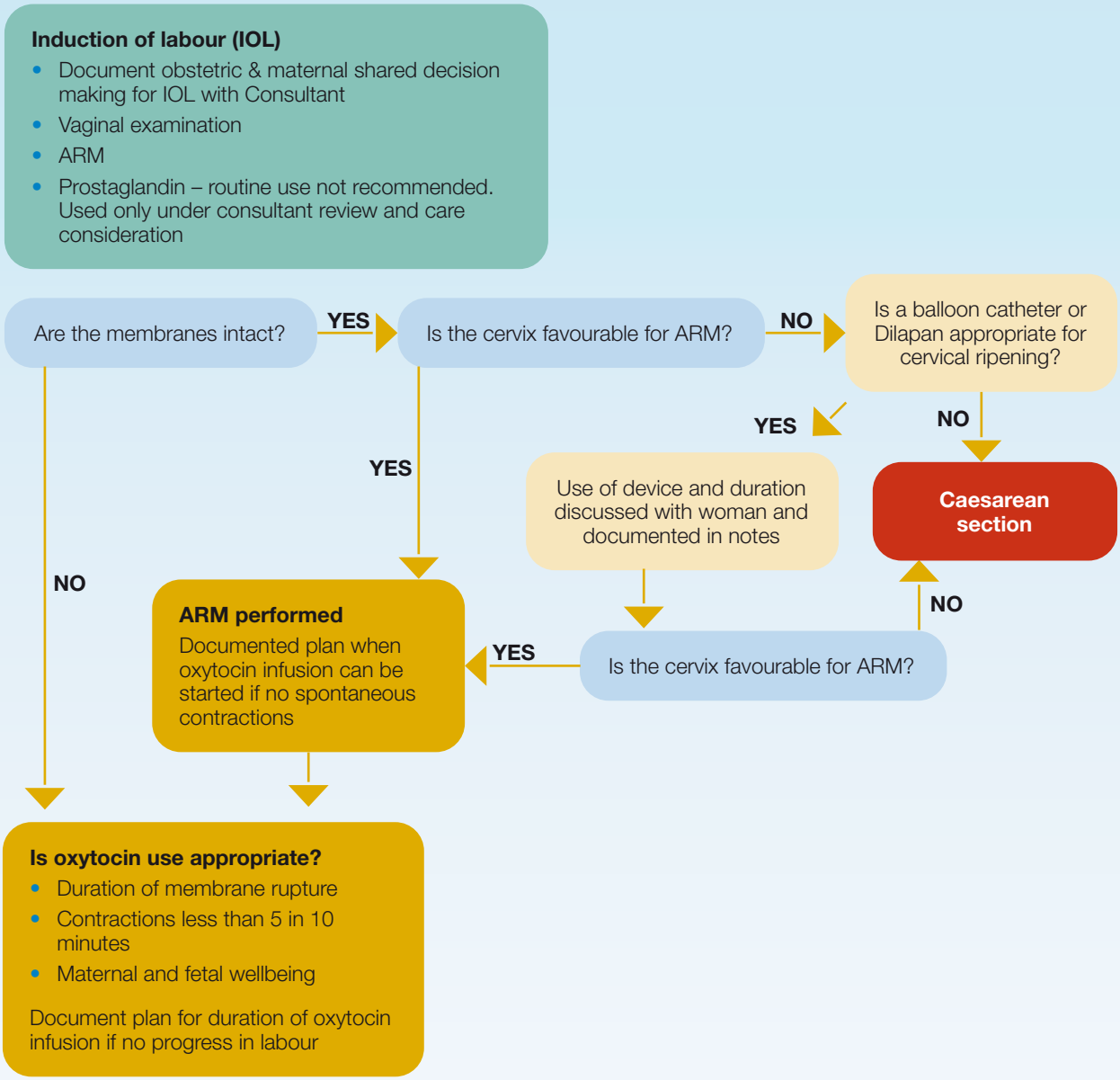
18. VBAC should be facilitated in a hospital with the capacity to provide a timely caesarean section if required and should have the necessary Obstetric, Anaesthetic, operating theatre staff and Neonatal expertise, as well as access to laboratory services and blood products.
19. Women planning a VBAC should have one-to-one care in labour.
20. The Obstetric Consultant on call should be made aware of the woman's admission to delivery suite.
21. Continuous electronic fetal monitoring (CEFM) should be commenced from the diagnosis of labour.
22. Recognition of the clinical features of uterine rupture and prompt escalation to senior Obstetric review and laparotomy is vital to ensure the best outcome for the woman and infant.
23. Otherwise unexplained post-partum haemorrhage should be considered uterine rupture until out ruled.
24. Women should be informed that the risk of uterine rupture is higher for a VBAC labour that is either induced or augmented versus a spontaneous VBAC labour.
25. Women should be informed that there is an increased risk of unplanned caesarean birth if a VBAC labour is induced or augmented.
26. The decision to induce or augment VBAC labour should be determined following careful Obstetric assessment and be made by senior Obstetricians in consultation with the woman.
27. The option of VBAC for the woman with two previous caesarean births may be considered. This decision requires senior Obstetric input.
28. Routine debriefing should occur with the woman after caesarean birth, this should outline both the reasons for the caesarean section and the implications for future pregnancies and births.
29. There are several clinical situations for which careful individual consideration of the benefits and risks of VBAC versus ERCS should be considered by the woman and her Obstetrician and these include macrosomia, twin pregnancy, postdates pregnancy, as well as preterm gestation and other possible clinical scenarios.

Algorithm

Algorithm 1: Birth After Caesarean Section (BAC)



Algorithm 2: Induction of labour (IOL) after Caesarean Section



Uterine rupture – signs & symptoms

- Prolonged, persistent & profound bradycardia
- Abnormal FHR pattern suggesting fetal compromise
- Abdominal pain, acute onset of scar tenderness
- Abnormal progress in labour, prolonged first or second stage of labour
- Vaginal bleeding
- Cessation of previously efficient uterine activity
- Loss of station of the presenting part
- Chest pain or shoulder tip pain
- Maternal tachycardia, hypotension or shock

Auditable standards

Audit using the key recommendations as indicators should be undertaken to identify where improvements are required and to enable changes as necessary, and to provide evidence of quality improvement initiatives.

Auditable standards for this Guideline include:

1. Number of women that have a documented booking visit with a senior Obstetrician
2. Number of women that have previous maternity records available for review at/after the booking visit
3. Number of women where the risks of VBAC vs ERCS are discussed as documented in maternity notes
4. Number of cases where a management plan is clearly documented if spontaneous labour should occur before a planned ERCS
5. Number of women where a debrief is documented in her notes following a caesarean birth and the inclusion of
    A. Reasons for the caesarean section
    B. Implications for future pregnancies and births.
    C. Possible suitability for VBAC as an option for future births

Recommended reading:

1. HSE Nomenclature for Clinical Audit- https://www.hse.ie/eng/about/who/nqpsd/ncca/nomenclature-a-glossary-of-terms-for-clinical-audit.pdf
2. HSE National Framework for developing Policies, Procedures, Protocols and Guidelines at https://www.hse.ie/eng/about/who/qid/nationalframeworkdevelopingpolicies/
3. RCOG. Greentop Guideline No 45 Birth After Caesarean section 2015. https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_45.pdf
4. Dodd JM, Crowther CA, Huertas E, Guise JM, Horey D. Planned elective repeat caesarean section versus planned vaginal birth for women with a previous caesarean birth. Cochrane Database Syst Rev. 2013(12):CD004224 https://pubmed.ncbi.nlm.nih.gov/24323886/
5. RANZCOG. Best Practice Statement. Birth after previous caesarean section. First endorsed by RANZCOG: July 2010 Current: March 2019 https://ranzcog.edu.au/wp-content/uploads/2022/05/Birth-after-previous-caesarean-section.pdf
6. Martel MJ, MacKinnon CJ. No. 155-Guidelines for Vaginal Birth After Previous Caesarean Birth. J Obstet Gynaecol Can. 2018;40(3):e195-e207 https://pubmed.ncbi.nlm.nih.gov/29525045/
7. ACOG. ACOG practise bulletin number 115: vaginal birth after previous caesarean delivery. Obstet Gynecol. 2010. p. 450-63 https://pubmed.ncbi.nlm.nih.gov/20664418/

Authors

Ryan G, Duggan J, Finnegan C, Morrison JJ. National Clinical Practice Guideline: Vaginal Birth After Caesarean Section. National Women and Infants Health Programme and The Institute of Obstetricians and Gynaecologists. January 2023

https://www.hse.ie/eng/about/who/acute-hospitals-division/woman-infants/clinical-guidelines/

https://www.rcpi.ie/faculties/obstetricians-and-gynaecologists/national-clinical-guidelines-in-obstetrics-and-gynaecology/