Birth after Caesarean Section (BAC) Guideline

Summary statement: How does the document support patient care?	The purpose of this guideline is to provide good practice evidence for staff caring for women who have previously had a caesarean section
Staff/stakeholders involved in development:	Obstetric Anaesthetists, Obstetric Consultants and Senior Midwifery Staff
Division:	Women and Children's
Department:	Maternity
Responsible Person:	Chief of Service
Author:	Obstetric Consultant/trainee/midwife
For use by:	All staff involved in the management of Birth after Caesarean Section (BAC)
Purpose:	To provide evidence-based guidance the management of women choosing Birth after caesarean
This document supports:	NICE guideline Caesarean Section CG132 (2011) (Last updated September 2019). RCOG Birth After Previous Caesarean Birth (Green Top 45) (2015). Health and Social Care Act Regulations
Key related documents:	**Maternity Guidelines**: Care of Women in Labour, Fetal Surveillance, Caesarean Section, Induction of Labour and Use of Oxytocin, Antenatal Risk Assessment, Labour Risk Assessment
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Version	Date	Author	Status	Comment
1.0	July 2010	Consultant Obstetricians & BAC Midwife	Archived	New Trustwide guideline
2.0	February 2011	CNST Midwife	Archived	Minor Administrative amendment
3.0	March 2012	Consultant Obstetrician, BAC Midwife & CNST Midwife	Archived	Amendments to guideline and VBAC Care pathway as a result of RCA recommendations
4.0	August 2013	Consultant Obstetrician & CNST Midwife	Archived	Version 3 expired-minor updates only required
5.0	September 2016	Consultant obstetrician, BAC midwife, Clinical Effectiveness midwife, Patient Safety midwife and Practice Development input.	Archived	Update as required as version 4 expired. Another review will be required in November 2017 when next documents from NICE are released.
6.0	May 2019 initial review. Jan 2020 consultant review	Obstetric trainee, Consultant obstetrician	Archived	Reviewed in line with NICE (2011) and RCOG (2015)
6.1	January 2021	Midwife (J. Collard), Consultant (Matthew Jolly), G. Addison, A. Hamilton	Live	Additions from NICE CG132 Caesarean Section and NICE NG121 Intrapartum Care of Women with Existing Medical Conditions or Obstetric Complications and their Babies Additions regarding homebirths and water births after CS.

The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert

Index

1.0 Aim 4
2.0 Scope 4
3.0 Responsibilities 4
4.0. Introduction 4
5.0. Antenatal Management 5
5.1 Referral pathway (See Appendix 1) 5
5.2 Antenatal Counselling 5
5.3 Special circumstances: 6
6.0. Intrapartum Management: 7
6.1 Diagnosis of labour 7
6.2 Admission and ongoing management in labour 8
6.3 Diet and prophylactic antacids 8
6.4 Electronic fetal monitoring in labour (EFM) 8
6.5 Mobility in labour 9
6.6 Analgesia in labour 9
6.7 First stage 9
6.8 Induction or Augmentation in labour 10
6.9. Second stage of labour 10
6.10 Third stage of labour 11
7.0. Induction and augmentation of labour with VBAC 11
7.1 Key points 11
8.0. Uterine Rupture 11
9.0. Women requesting care outside of Guidelines 12
9.0 Audit 13
10.0. References 14
Appendix 1 Flow chart for women with one previous caesarean section 15
Appendix 2 BAC Pathway form 16

Birth after caesarean Section (BAC) Guideline

1.0 Aim

To provide guidance on the management of women during pregnancy and in childbirth who have had a previous caesarean section.

2.0 Scope

The objectives of this guideline are:

- To support staff in the management of pregnant women who have had a previous caesarean section.
- To ensure the safety of patients throughout the process.
- To ensure woman are supported throughout their pregnancy and labour and at the time of birth.
- To ensure that women receive appropriate and consistent information to support them in making an informed decision about mode of birth.

3.0 Responsibilities

Midwives & obstetricians are expected:

- To access, read, understand and follow this guidance.
- To use their professional judgement in the application of this guideline.

Management are expected:

- To ensure the protocol is reviewed as required in line with Trust and National recommendations.
- To ensure the protocol is accessible to all relevant staff.

4.0. Introduction

Vaginal birth after caesarean (VBAC) versus elective repeat caesarean section (ERCS) clinical care pathway is recommended for best practice in antenatal counselling, shared decision making and documentation. Planned VBAC is appropriate for and may be offered to the majority of women with a singleton pregnancy of cephalic presentation at 37 weeks or beyond who have had a single previous lower segment caesarean delivery, with or without a history of previous vaginal birth. Birth after caesarean (BAC) is the term used to refer to the discussion required when women have had a previous caesarean and can include a vaginal birth or repeat caesarean.

5.0. Antenatal Management

5.1 Referral pathway (See Appendix 1)

Women who have had one uncomplicated lower segment caesarean section (LSCS) for a non-recurring factor (e.g. breech; placenta praevia; suspected fetal compromise) and who in this pregnancy have no other risk factors, can receive the majority of their antenatal care from the named midwife. If the woman requests a VBAC at booking or is unsure about her preferred mode of birth, she should directed to Family Assist: Birth after caesarean section this contains a link to patient information leaflet RCOG Birth options after previous caesarean section, or given a copy of the RCOG leaflet. The BAC Care Pathway (Appendix 2) should be commenced for all women regardless of their preferred mode of birth since it allows consistent documentation of plans for vaginal birth in case this occurs before an elective repeat section date.

Referral to the BAC counselling midwife should be made as early as possible. A consultant appointment should be arranged shortly after the counselling session (by 32 weeks gestation).

5.2 Antenatal Counselling

Antenatal counselling must be documented in the notes using the BAC Care Pathway since this facilitates and captures shared decision making (RCOG 2015).

Successful VBAC has the fewest complications, and the success rate of planned VBAC is approximately 72- 75%.

Planned VBAC is contraindicated in women with previous uterine rupture or classical caesarean scar (NB this is a vertical scar on the uterus, not the anterior abdominal wall), and in women who have other absolute contraindications to a vaginal birth that apply irrespective of the presence or absence of a scar (e.g. Major Placenta Previa).

All women following previous CS should be reviewed by BAC counselling midwife as early as possible in the pregnancy. The BAC pathway should be commenced.

Obstetric notes from the previous LSCS should be reviewed wherever possible to help in the decision making process and to rule out any potential risks / contra-indications. If the woman has had a CS in another hospital we need to request notes to see if she is suitable for a VBAC. In women with complicated uterine scars, caution should be exercised and decisions should be made on a case-by-case basis by an Obstetric Consultant with access to the details of the previous surgery.

Women with one or more previous vaginal births should be informed that the previous vaginal birth, particularly previous VBAC, is the single best predictor of successful VBAC and is associated with a planned VBAC success rate of 85-90%. Previous vaginal delivery is also independently associated with a reduced risk of uterine rupture.

Women should be made aware that the greatest risk of adverse outcome occurs in a trial of VBAC resulting in emergency caesarean delivery. They should be informed that planned VBAC is associated with an approximate 1:200 risk of uterine rupture (although this risk assessment will vary depending on prior medical and obstetric history).

This small risk of uterine rupture with vaginal birth should be discussed again with women when in labour. It should also be discussed that an emergency caesarean section may mean a higher chance of:

- Heavy bleeding needing a blood transfusion.
- Infection, for example, intrauterine infection.
- A longer hospital stay.

(NICE NG121 Intrapartum Care of Women with Existing Medical Conditions or Obstetric Complications and their Babies)

Women should be advised that preterm VBAC is as successful as term VBAC and the risk of uterine rupture is lower.

5.3 Special circumstances:

Clinicians should be aware that there is uncertainty about the safety and efficacy of planned VBAC in pregnancies complicated by postdates, twin gestation, fetal macrosomia, antepartum stillbirth or maternal age of 40 years or more. Hence, a cautious approach is advised if VBAC is being considered in such circumstances. Care should be individualised as per discussion with women and her obstetrician and documented in the woman's records (including the maternity information system).

Women who are preterm should be informed that planned preterm VBAC has similar success rates to planned term VBAC but with a lower risk of uterine rupture.

Women who have had two or more LSCS, requesting a VBAC may be supported after detailed counselling by a senior obstetrician. This should include the risk of uterine rupture and maternal morbidity, and the individual likelihood of a successful VBAC. These women should be recommended to labour on the labour ward because there is recourse to immediate surgical delivery (RCOG 2015).

Clinically there is little or no difference in the risk associated with a planned caesarean section and a planned vaginal birth in women who have had up to 4 previous caesarean sections. The risk of fever, bladder injuries and surgical injuries does not vary with planned mode of birth. The risk of uterine rupture, although higher for planned vaginal birth, is rare. If a woman chooses to plan a vaginal birth after she has previously given birth by caesarean section, she should be fully supported in her choice. (NICE CG132 Caesarean Section)

The absolute risk for birth-related perinatal death associated with VBAC is extremely low and comparable to the risk for nulliparous women in labour (0.1%). There is a small increase in

neonatal respiratory morbidity when ERCS is performed before 39^{+0} gestation (3-4% at 39/40, 6% at 38/40), which can be reduced with a preoperative course of antenatal corticosteroids. It is advisable to book ERCS ≥39 weeks unless clinically indicated.

Women should be informed that ERCS is associated with a small increased risk of placenta previa and/or accreta in future pregnancies and of pelvic adhesions complicating any future abdominopelvic surgery.

If VBAC is appropriate the management of prolonged gestation should be discussed; including membrane sweeps, delaying elective LSCS to 41+ weeks or induction of labour (see Induction of labour guideline). Induction for prolonged gestation should be between 41 and 42 weeks gestation and the woman should either have been reviewed by a consultant in clinic or reviewed by a consultant on admission for induction. In the case of a woman booked for elective caesarean section, there should be a clear plan documented in the notes should she labour prior to birth.

A discussion between the woman and consultant obstetrician should take place regarding an agreed plan for mode, timing and place of birth. This should be documented in the handheld and hospital notes by 32 weeks. This discussion should include an individualised plan for birth.

If the discussion reveals that the woman would like to labour in water or avoid continuous monitoring, this plan should be documented in the BAC Care Pathway along with clear documentation of the risks and benefits of choosing these options. However water birth is not contraindicated if using continuous waterproof telemetry.

A homebirth is not recommended but if requested (against medical advice) the guidance to support the individualised plan of care can be found in the Homebirth Guideline. There should be an individualised plan for those women who request a homebirth with previous uterine scar. It is recommended that this involves a discussion between the woman, a consultant obstetrician and a senior community midwife regarding risks and benefits of this option for birth. All discussions should be documented fully and clearly.

6.0. Intrapartum Management:

6.1 Diagnosis of labour

The diagnosis of labour should be made in the same way as for women without a uterine scar (see Care of Women in Labour guideline).

Women can be triaged on the phone in the usual way with the same advice given for mobilising, eating and drinking and pain management at home however there should be a lower threshold for admission and assessment given the difficulties of diagnosing labour over the phone. All telephone conversations should be documented on the electronic maternity information system to enable those triaging repeated calls to access previous history and advice and act on a suspected long latent phase.

If, on admission, the woman is diagnosed as being in the latent phase of labour, a senior obstetrician should be informed and consulted. The woman may either be admitted to the antenatal ward or sent home, to return when labour has established if deemed suitable to do so.

6.2 Admission and ongoing management in labour

It is recommended that women who wish to have a VBAC should be admitted and cared for on labour ward to ensure the best availability of resources for immediate caesarean delivery and advanced neonatal resuscitation if required.

Women with an unplanned labour onset and a history of previous caesarean delivery should have a discussion with an experienced obstetrician to determine feasibility of VBAC, if not already done so antenatally (RCOG 2015).

Following an initial assessment by the midwife, the obstetric team on duty must be informed of the admission and review the antenatal plan. This can be found on the BAC Care Pathway.

Epidural analgesia is not contraindicated in a planned VBAC, although an increasing requirement for pain relief in labour should raise awareness of the possibility of potential scar dehiscence.

Women should be advised to have continuous electronic fetal monitoring (CEFM) for the duration of planned VBAC including the risks and benefits, commencing at the onset of regular uterine contractions (active labour). If this is declined, document this discussion and decision in the records.

If there are any concerns or deviations from normal progress throughout the labour the obstetric team should be notified immediately and a management plan must be documented.

As a minimum, labouring women who have had a previous caesarean section should have a documented review by the obstetric team every 4 hours.

6.3 Diet and prophylactic antacids

Women may drink during labour and should be informed that non fizzy isotonic drinks may be beneficial. Food and non-clear drinks should be avoided once labour has established.

Prophylactic antacids should be commenced once labour has established.

6.4 Electronic fetal monitoring in labour (EFM)

Continuous Electronic Fetal Monitoring (cEFM) is recommended for women having a VBAC, commencing at the onset of regular uterine contractions.

If the woman has requested intermittent auscultation, this should have been discussed antenatally with the obstetric consultant and be documented on the BAC Care Pathway.

6.5 Mobility in labour

Women should be encouraged to remain mobile and adopt upright positions during labour. Where women have continuous EFM the use of telemetry (where available) is encouraged to aid mobility.

6.6 Analgesia in labour

The indications for analgesia in women having a VBAC are the same as for any woman in labour.

The use of the birthing pool for analgesia requires prior antenatal discussion with VBAC counselling midwife and consultant obstetrician and should be documented in the VBAC Care Pathway. Water birth is not contraindicated if using continuous waterproof telemetry.

Epidural analgesia is not contraindicated in women having a VBAC, as it does not hinder the diagnosis of uterine rupture; pain alone is not a reliable indicator. However, an increasing requirement for pain relief in labour with previously good working epidural analgesia should raise the alarm of the possibility of an impending scar dehiscence. Women should be aware that epidural analgesia might not rule out the need for a general anaesthetic in the unlikely event of sudden fetal or maternal compromise.

It should also be discussed with women in labour who have had a previous caesarean section that regional analgesia is associated with:

- A reduced chance of another caesarean section
- An increased chance of an instrumental birth.
  (NICE NG121 Intrapartum Care of Women with Existing Medical Conditions or Obstetric Complications and their Babies.)

6.7 First stage

Once a diagnosis of labour has been made the partogram must be commenced.

Vaginal examinations should be undertaken in accordance with the Care of Women in Labour guideline.

Do not routinely offer amniotomy to women in labour who have had a previous caesarean section only if there is clinical need such as induction of labour or 'slow progress' (NICE NG121 Intrapartum Care of Women with Existing Medical Conditions or Obstetric Complications and their Babies).

If a diagnosis of 'slow progress' is made (i.e. less than 0.5 cm per hour) a review should be undertaken by an obstetrician and a management plan must be discussed with the woman and documented accordingly. If 'slow progress' is diagnosed and IV access has not already been established, this is an appropriate time for cannulation.

6.8 Induction or Augmentation in labour (see induction of labour guideline)

Women should be informed that there is a 2-3 fold increased risk of uterine rupture and around a 1.5 fold increased risk of caesarean delivery in induced and/or augmented labour compared with spontaneous VBAC labour. The absolute increase in risk remains small.

A senior obstetrician should discuss the following with the woman: the decision to induce labour, the proposed method of induction, the decision to augment labour with oxytocin, the time intervals for serial vaginal examination and the selected parameters of progress that would necessitate discontinuing VBAC.

The decision to undertake augmentation must only be made by a consultant obstetrician who has either reviewed the woman in person, or discussed the plan fully with the registrar. It should be clearly documented that the use of oxytocin is recommended for induction / augmentation but not for secondary arrest.

There must be clear documentation in the notes to support the diagnosis of dysfunctional uterine activity and the absence of mechanical obstruction.

The oxytocin infusion should be titrated so that contractions do not exceed the maximum rate of 3-4 in 10 minutes. If contractions exceed 4 in 10 minutes, stop the syntocinon infusion and consider tocolysis in the form of subcutaneous injection of Terbutaline 0.25 mgs.

6.9. Second stage of labour

Although there is no high-quality data on the optimum length of the second stage of labour in the presence of a uterine scar, it is accepted practice that the length of the second stage should be limited to one hour of active pushing before being reviewed by an obstetrician, unless there are additional concerns.

In women with an epidural there is evidence that delayed active pushing may help reduce the risk of instrumental delivery. Therefore, pushing can be delayed for one hour, assuming there are no concerns regarding maternal and/or fetal wellbeing.

An obstetrician should review the active phase of the second stage of labour in all VBAC women who have not achieved spontaneous delivery within one hour and an individualised plan made.

Women birthing at home or on the birth centre:

Women must be advised in the antenatal period that when birthing at home any obstetric review and / or intervention will be delayed. If the woman is birthing in the home then guidance on the second stage must follow the guidance within the hospital setting. Should birth not be achieved within the one hour time frame, then the community midwife must call the delivery suite and discuss the case with the co-ordinator. As if in a hospital setting, a plan should be made with the community midwife, the co-ordinator and the obstetrician.

6.10 Third stage of labour

Active management of the third stage is recommended for women who have had a successful VBAC.

7.0. Induction and augmentation of labour with VBAC (see Induction of labour guideline)

7.1 Key points

There is only a small amount of randomised data relating to induction of labour after caesarean section. It is therefore difficult to evaluate risks associated with induction on the basis of the data available. The rate of vaginal birth following induction is the same as for spontaneous labour and the rate of scar dehiscence or rupture in the largest observational studies ranges from 0.1-2.1% (mean 1.1%). There are a number of case reports of uterine rupture following prostaglandin administration and data from the American and Canadian observational studies suggested a higher rate of uterine rupture following induction of labour after caesarean section with the highest rate associated with the use of prostaglandins. The RCOG guideline states that clinicians should be aware that induction of labour using mechanical methods (amniotomy or Foley catheter) is associated with a lower risk of scar rupture compared with induction using prostaglandins.

The decision to induce labour should only be made by a consultant obstetrician in collaboration with the woman. The method of induction needs to be made by the consultant obstetrician on an individual basis depending on the woman's past obstetric history, current situation and wishes. Review of the past obstetric history should be documented in the maternity notes.

All VBAC inductions are high risk and it remains the consultant's decision where the induction is carried out. A clear handover must take place with the on-call consultant at each multi-disciplinary handover. This should include any decision to delay the induction due to capacity or staffing issues and should initiate appropriate escalation

7.2 Methods of induction/augmentation

The Trust protocol for 'Induction of Labour' should be adhered to (see Induction of labour guideline).

8.0. Uterine Rupture

If uterine rupture is suspected, the consultant obstetrician on call should be informed immediately and the obstetric emergency protocol followed (calling 2222).

All women with a previous scar should be carefully monitored for symptoms and signs of uterine rupture.

Warning signs include:-

- Poor progress in labour (i.e. less than 0.5 cm per hour)
- Suspicious or pathological CTG

- Severe abdominal pain, especially persisting between contractions or breakthrough pain with a previously good working epidural
- Chest or shoulder-tip pain
- Sudden onset of shortness of breath
- Acute onset scar tenderness
- PV bleed or haematuria
- Cessation of previously effective uterine contractions
- Maternal tachycardia, hypotension or shock
- Loss of station of the presenting part.

However, these are poor indicators and scar ruptures can occur suddenly and without warning and all staff should remain vigilant. In the event of a suspected **uterine rupture** Immediate (category 1) LSCS should be performed.

9.0. Women requesting care outside of guidelines

How women determine risk during pregnancy is a complex process influenced by social and cultural factors. Women deemed medically 'high risk' will also make an assessment of how 'at risk' they feel. Previous birth experience or trauma can play a role in the decisions women make.

It is often those who have had previous negative experiences with maternity or healthcare that can decline nationally recommended care. Typical requests include refusal for induction of labour, VBAC against advice, home birth or birth in birth centre, intermittent monitoring when CTG recommended or water birth.

Ideally we should be able to plan individualised care in the antenatal period. Professionals must provide sufficient, objective and unbiased information for the woman to make an informed choice. Referral must be made to the counselling midwife at earliest opportunity if women report previous negative birth experiences and/or decline care.

For women who request homebirth after caesarean (HBAC) the counselling midwife will inform both the named midwife and the team midwife so that the named midwife can arrange to accompany the woman at her consultation.

Women should be able to make decisions about their care during pregnancy, birth and postnatal through an ongoing dialogue with professionals that empowers them. They should be supported to make well informed decisions through a relationship of mutual trust and respect with health professionals and their informed choices should be respected.

Women should be fully informed of the benefits and risks of an intended procedure, alternative options, and implications of not undergoing the proposed treatment. They should get enough time to reflect and ask questions.

Antenatal care planning is paramount. Women should have an appointment with a consultant (and the counselling midwife as required). There should be a personalised care plan in her notes (electronic maternity information system). A multidisciplinary team discussion is recommended if women opt for out of guidance management.

If women arrive on the delivery suite unknown to the service with a high risk pregnancy, then an immediate review should be undertaken. Midwives and doctors should work together to support

women's choices. There should be honest and open conversations when risks change and clear documentation.

9.0 Audit

Suggested auditable standards for compliance with this guideline:

- Rate of successful VBAC in women opting for vaginal birth.
- Women who have had 1 or more previous caesarean sections should have a documented discussion of the option to plan a vaginal birth.
- Women opting for vaginal birth should have a documented individual management plan for labour by obstetrician. This should include:
    - Monitoring the fetal heart in labour.
    - Induction or augmentation of labour:
    - Analgesia in labour.

10.0. References

Guise JM, McDonagh MS, Osterweil P, Nygren P, Chan BK, Helfand M. 2004. Systematic review of the incidence and consequences of uterine rupture in women with previous caesarean section. British Medical Journal. Volume 329. Pages 19-25.

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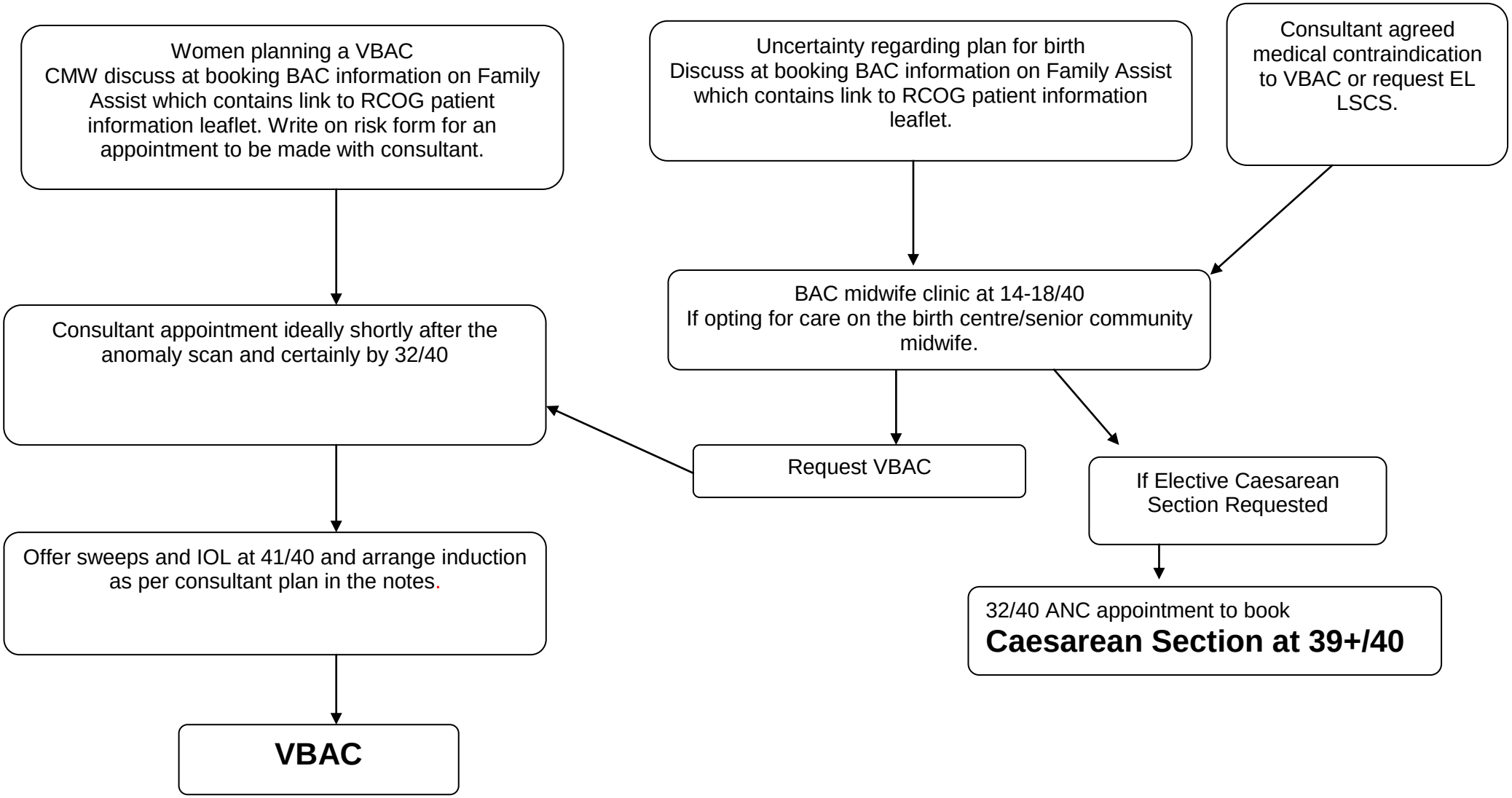
NICE (2011) Caesarean Section CG132. RCOG Press. Updated September 2019. NICE CG132

NICE (2019) Intrapartum Care of Women with Existing Medical Conditions or Obstetric Complications and their Babies NICE NG121

RCOG (2015) Birth after Previous Caesarean Birth, Green Top Guideline No 45. https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_45.pdf

Appendix 1 Flow chart for women with one previous caesarean section



Appendix 2 BAC Pathway form

Unit No: …… NHS No: …….. Surname …….. Forenames …….. Please complete or Affix Patient Label	Western Sussex Hospitals NHS Foundation Trust **Birth After Caesarean Section Pathway** **BAC = Birth after caesarean Section** **ERCS = Elective Repeat Caesarean Section**

G: **P:** **EDD:** N° of previous C/S: N° of previous vaginal births:
WSHT BAC Leaflet given ☐ Referred to VBAC clinic ☐
Previous obstetric notes reviewed ☐

Presence of any of the following contra-indications for BAC:

☐ Three / more previous CS
☐ Any uterine CS incision other than low transverse
☐ Recurring cause for CS
☐ Previous uterine dehiscence / rupture
☐ Previous non-birth related uterine surgery / damage

Woman's preferences regarding mode of birth

At booking:	☐Keen for VBAC ☐Unsure ☐Wishing ERCS	At VBAC clinic:	☐Keen for VBAC ☐Unsure ☐Wishing ERCS	At 36/40:	☐Keen for VBAC ☐Wishing ERCS

Management Plan for labour (Doctor to discuss with woman and sign below) * offer referral to senior CMW

Place of Birth: Labour Ward ☐ Birth Centre * ☐ Home * ☐

Fetal Monitoring: Continuous monitoring ☐ Intermittent Auscultation ☐
Telemetry favourable ☐

Management Plan in the event of (Doctor to discuss with woman and sign below)			
Preterm labour (<37/40)	☐ VBAC	☐ ERCS	
Spontaneous labour before ERCS date	☐ VBAC	☐ CS	☐ N/A
No spontaneous labour by 41 weeks	☐ Sweep	☐ IOL with ARM or balloon catheter ± synto	☐ ERCS
	☐ IOL with prostaglandin (consultant decision only)		☐ Balloon induction
Cannulation	☐ on admission	☐ as required	
Additional Information:			

Date:	**Name, GMC no. & signature of doctor:**

Labour management must be discussed between woman and Consultant Obstetrician.

The decision for all types of IOL and augmentation must be made by the Consultant and documented above.

Information to be discussed: VBAC versus ERCS (Information Source - RCOG)

Chance of	Overall		Incidence VBAC	Incidence ERCS
Successful VBAC (single previous CS) dependent on indication for previous CS	3 out of 4	72-76%		
Successful VBAC (at least 1 previous vaginal birth + previous CS)	Almost 9 out of 10	Up to 87-90%		
Uterine rupture			5 per 1 in 200 0.5%	1 per 1,000 / 0.1%
Baby developing breathing problems after birth			25 per 1,000 / 2-3%	35 per 1,000 / 3-4%
Infant developing hypoxic ischaemic encephalopathy			8 per 10,000 / 0.08% *	
Birth-related perinatal death			10 per 10,000 / 0.1% **	1 per 10,000 / 0.01%
Blood transfusion / endometritis	1% additional risk			
Induction of labour using pge2 uterine Rupture risk	87 per 10 000 [0.87%]versus 29 per 10 000 [0.29%]			
* National rate 1.9 per 1000 births (0.19%)				
** Equivalent to the risk for a woman having a normal birth of her first child				

Other information

- Risks of anaesthetic complications low with both VBAC and ERCS.
- ERCS may increase the risk of serious complications in future pregnancies.
- Emergency CS may mean a higher chance of heavy bleeding needing a blood transfusion, infection e.g. intrauterine infection, a longer hospital stay.

Risk factors for unsuccessful VBAC are:

- Induced labour
- No previous vaginal birth
- BMI >30
- Previous CS for dystocia

When **all** these factors are present, successful VBAC is achieved in only 40% of cases

Date of discussion:	**Name of clinician:**	**Signature:**

Please add any further information or changes to the plan here:

Name, GMC no. & signature of doctor:

Date: