Vaginal Birth after Caesarean Section (VBAC)

Site Applicability: SPH

Skill Level:

RN, RM, MD

- RN with Advanced Skill – specialized education in Perinatal Nursing
- RM as outlined by College of Midwives BC (CMBC)
- MD with maternity privileges (includes OB/GYN and GPs)

Quick links

a) Policy
b) Guideline
c) Appendix A – Definitions
d) Appendix B – Contraindications
e) Appendix C – Induction Methods and Medication

Related Documents and Resources:

1. B-00-07-10012 – Indications for Obstetrical Consultation
2. B-00-07-10048 – Fetal Health Surveillance (FHS) – Intrapartum
3. B-00-07-10021 – Nourishment/Hydration in Labour
4. B-00-12-10037 – Delivery Set Up
5. B-00-07-10062 – Stabilette
6. B-00-07-10030 – Oxytocin Induction/Augmentation
7. B-00-07-10035 – Caesarean Section Classification/Times
8. B-00-07-10036 – Code Pink
9. BD-00-02-40056 - Postpartum Nursing Care Pathway

Clinical Indication:

Pregnant women who have experienced a Caesarean delivery in a previous pregnancy with no other indications for Caesarean Section in the present pregnancy.

Policy

- Vaginal Birth After previous Caesarean (VBAC) is a safe alternative to a repeat

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Caesarean Section for women with no other indications for Caesarean Section in the present pregnancy.

- SPH ensures that emergency Caesarean Section is available within 30 minutes for women undertaking a VBAC who have indications for immediate operative delivery.
- Consultation with an Obstetrician is necessary when the woman is admitted in labour. A prenatal consultation with an Obstetrician is at the discretion of the primary health care provider (see IDG1055 – Indications for Obstetrical Consultation)
- Providers will practice according to the SOGC Guidelines for Vaginal Birth after Previous Caesarean Birth

Need to Know:

- Planning a VBAC is a safe option for women with no other indications for Caesarean Section in the present pregnancy.
- 60 to 80% of women who attempt a VBAC are successful in having a vaginal birth.
- The recommended inter-delivery interval after a Caesarean section is 18-24 months at a minimum.

PRACTICE GUIDELINE

Equipment & Supplies:

- Labour and Delivery Supplies (including Newborn Resuscitation, Stabilette and delivery cart)
- External Fetal Monitor
- IV supplies (tubing, etc.)

Guideline:

Informed Consent

- Informed Consent is the Responsibility of the Primary Care Provider
- Provided there are no contraindications, a woman with one previous transverse low-segment Caesarean section should be offered a trial of labour (TOL).
- Patient receives information and resources from primary care provider (Obstetrician, Family Practice Physician, Registered Midwife)
    - Prior to labour starting, the physician and/or midwife (primary obstetrical caregiver) discusses with the woman and her family the maternal and perinatal risks and benefits, document discussion.
    - Labour management including need for continuous fetal monitoring and IV access during labour is described, discussed and documented.

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- If Electronic fetal monitoring is normal patient can have periods of up to 20-30 minutes off the Electronic fetal monitoring (with the exception of when oxytocin is continuing to be increased). Continue fetal monitoring by intermittent auscultation every 15 minutes.

- The physician and/or midwife (primary obstetrical caregiver) documents the delivery plan and informed consent for VBAC and includes it in the health record (Antenatal Record and related patient documents) of all women with a previous Cesarean section.
- Obstetrical consultation in the prenatal period is obtained at the discretion of the primary care provider to determine eligibility for VBAC (See B-00-07-10012 – Indications for Obstetrical Consultation)

Admission for women planning a trial of labour (VBAC)

- A woman in early (prodromal) labour may remain at home.
- Admit a woman who is planning a VBAC to hospital when she is in active labour.
- Obtain a CBC and a Group and Screen on admission (Group and Screen must be run).
- Place IV saline lock access on admission.
  - NOTE: A routine intravenous infusion is not mandatory
- Consultation with an Obstetrician is necessary when the woman is admitted in labour. (B-00-07-10012 – Indications for Obstetrical Consultation)

Fetal Health Assessment

- Assess fetal health by continuous electronic fetal monitoring when in active labour.
  - If Electronic fetal monitoring is normal patient can have periods of up to 20 to 30 minutes off the Electronic fetal monitoring (with the exception of when oxytocin is continuing to be increased). Continue fetal monitoring by intermittent auscultation every 15 minutes.
- The EFM tracing is an important marker of uterine rupture.

Labour Support

- One to one care by a registered nurse is provided at all times in active labour.
- There is no need to restrict activity (telemetry can facilitate mobility while allowing continuous monitoring).
- Clear fluids are acceptable in active labour (B-00-07-10021)

Labour Assessment

Assess the progress of labour frequently as per B-00-07-10048- Fetal Health Surveillance - Intrapartum.

- Note: SOCG states ". . . there is some evidence that prolonged or desultory labour is associated with an increased risk [likelihood] of failure and uterine rupture," pg. 167.
- Note: SOCG states "The most reliable first sign of uterine rupture is a non-reassuring (abnormal) fetal heart tracing." Pg. 167.

Signs and Symptoms of Uterine Rupture

Early recognition of uterine rupture by the healthcare team is essential.

- An abnormal fetal heart rate tracing
- Vaginal bleeding
- Hematuria
- Maternal tachycardia, hypotension or hypovolemic shock
- Easier abdominal palpation of fetal parts
- Unexpected elevation of the presenting part
- Acute onset of scar pain or tenderness
- Chest pain, shoulder tip pain and/or sudden shortness of breath
- A change in uterine activity, such as an in-coordinate uterine pattern, an increase, decrease, or cessation of contractions.
- loss of station of the fetal presenting part

Management of Uterine Rupture

This is a perinatal emergency. **Call a Code Pink – OB**. Survival of the mother and fetus depends on:

- Prompt identification
- Rapid volume expansion and the use of blood products
- Timely access to a surgical team for surgical intervention
- Uterine repair or hysterectomy
- Prophylactic antibiotics
- The attendance of a neonatal resuscitation team

Induction Medications and Method (See Appendix C)

- Oxytocin - Medical induction of labour with oxytocin occurs only after full informed consent of the woman and consultation with an obstetrician.

- Prostaglandin E1 (misoprostol) is associated with a high risk of uterine rupture and is not used for a VBAC.
- Medical induction of labour with prostaglandin E2 (dinoprostone) is associated with an increased risk of uterine rupture and should not be used in a term VBAC. In rare circumstances (i.e. a preterm VBAC), after an obstetrical consultation and appropriate counselling of the woman a medical induction may be appropriate.
- An intracervical Foley catheter may be used for ripening the cervix as indicated. Mechanical methods of cervical ripening do not increase the risk of uterine rupture.

Pain Management

- Epidural or other analgesia may be used. Epidural is a reasonable choice for analgesia and may not mask the pain of uterine rupture

Postpartum Assessment

- Postpartum assessment, interventions and documentation as per Postpartum Nursing Care Pathway

Patient/Resident Education:

Review with patient and support person:

- The roles of the interdisciplinary team members and need for Obstetrical consultation.
- The need for fetal monitoring in labour.
- Normal plan of care.
- Provide ongoing information about progress of labour and fetal well-being.
- Provide explanations for emergency interventions as needed.
- Review with patients the signs and symptoms of uterine rupture

Optimal Birth BC http://optimalbirthbc.ca/wp-content/uploads/resources/for-bc-health-practitioners/brochures-vbac/OptimalBirth_Brochure.pdf .

Documentation:

1. British Columbia Perinatal Triage and Assessment Record (PSBC form 1590)
2. Consultation form (Obstetrician) – detail the nature of the consultation and plan assessments
3. Interdisciplinary Progress Notes
4. BC Labour Partogram (PSBC form 1583)
5. Postpartum Care Pathways – variances, notifications, interventions and responses

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References:

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2. MoreOB Vaginal Birth after Caesarean Section 15th Edition (published Sept 26, 2016)
3. BC Women's Hospital (2013) Vaginal Birth after Cesarean Section Policy and Procedure retrieved from http://policyandorders.cw.bc.ca
4. SOCG. (2007). Fetal Health Surveillance: Antepartum and Intrapartum Consensus Guideline
5. SOGC. (2015). Vaginal Birth After Caesarean Section (VBAC). 22nd Edition ALARM Course Manual. Author.
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8. Grobman, W. (Mar 2018). Cervical ripening and induction of labor in women with a prior cesarean delivery. Berghella, V. (Ed), UpToDate, Accessed March 15, 2018.
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Persons/Groups Consulted:

Maternity Safety and Quality Committee

Regional (VCH-PHC) Perinatal Educator Group

RN, SPH Maternity Centre

ObGyn, SPH

Anesthiologist, SPH

Revised By:

Clinical Nurse Educator, Maternity Services

Approved By (2018):

Maternity Safety and Quality Committee

PHC Professional Practice

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Appendix A: Definitions

Vaginal birth after Caesarean (VBAC): Vaginal delivery after having a previous Caesarean birth.

Trial of labor after caesarean (TOLAC): The plan to attempt labor when a woman has had a previous Caesarean birth, with the goal of achieving a successful vaginal birth.

Elective repeat Caesarean section (ERCS): a Caesarean delivery performed before the onset of labor.

Uterine scar rupture: The "complete separation of the Myometrium with or without extrusion of the fetal parts into the maternal peritoneal cavity".

Uterine scar dehiscence: The fetal membranes are not ruptured and the fetus is not outside of the uterus. Usually the peritoneum over the defect is intact. Morbidity and mortality are NOT increased as they are with uterine rupture

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Appendix B: Contraindications

The following situations are contraindications to a TOLAC:

1. Previous classical or inverted “T” uterine scar
2. Previous hysterotomy or myomectomy entering the uterine cavity
3. Previous uterine rupture
4. Presence of a contraindication to labour, such as placenta previa or malpresentation
5. The woman declines a TOLAC and requests a repeat Caesarean section following an informed discussion with Primary Care Provider and/or Obstetrician.

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Appendix C: Induction Methods and Medication

Intracervical Foley Catheter	• For ripening the cervix as indicated.
Oxytocin	• Medical induction of labour with oxytocin occurs ***cautiously*** after full informed consent with the patient • Requires obstetric consultations for all VBAC inductions and/or augmentations

CONTRAINDICATIONS

Prostaglandin E_1 (misoprostol)/ Prostaglandin E_2 (dinoprostone)	• Is ***CONTRADINDICATED*** as it is associated with a high risk of uterine rupture for women planning a VBAC • In rare circumstance of fetal demise, an obstetrical consultation with appropriate counseling for the woman, this method of induction for a VBAC may be appropriate.

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