

Clinical Guideline

South Australian Perinatal Practice Guidelines – birth options after caesarean section

Policy developed by: SA Maternal & Neonatal Clinical Network

Approved SA Health Safety & Quality Strategic Governance Committee on:
10 June 2014

Next review due: 30 June 2017

Summary Clinical practice guideline on birth options for women who have had a caesarean section in a previous pregnancy

Keywords VBAC, TOLAC, vaginal birth after caesarean section, caesarean section, uterine rupture, oxytocin, prostaglandins, spontaneous labour, pregnancy, inverted T incision, incision scar, hysterotomy, uterine rupture, placenta praevia, accreta, increta, percreta, myomectomy, myometrial dissection, malpresentation, vaginal birth, uterine scar, unripe cervix, obstetrician, fetal bradycardia, Perinatal Practice Guidelines, birth options after caesarean section, clinical guideline

Policy history Is this a new policy? **N**
Does this policy amend or update an existing policy? **Y**
Does this policy replace an existing policy? **Y**
If so, which policies?
Birth options after caesarean section

Applies to All SA Health Portfolio
All Department for Health and Ageing Divisions
All Health Networks
CALHN, SALHN, NALHN, CHSALHN, WCHN, SAAS
Other

Staff impact N/A, All Staff, Management, Admin, Students, Volunteers
All Clinical, Medical, Nursing, Allied Health, Emergency, Dental, Mental Health, Pathology

PDS reference CG136

Version control and change history

Version	Date from	Date to	Amendment
1.0	08 Mar 2004	22 Oct 2007	Original version
2.0	22 Oct 2007	18 Jan 2011	Reviewed
3.0	18 Jan 2011	25 Mar 2014	Reviewed
4.0	25 Mar 2014	17 June 2014	Reviewed
5.0	17 June 2014	Current	

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Note

This guideline provides advice of a general nature. This statewide guideline has been prepared to promote and facilitate standardisation and consistency of practice, using a multidisciplinary approach. The guideline is based on a review of published evidence and expert opinion.

Information in this statewide guideline is current at the time of publication.

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Health practitioners in the South Australian public health sector are expected to review specific details of each patient and professionally assess the applicability of the relevant guideline to that clinical situation.

If for good clinical reasons, a decision is made to depart from the guideline, the responsible clinician must document in the patient's medical record, the decision made, by whom, and detailed reasons for the departure from the guideline.

This statewide guideline does not address all the elements of clinical practice and assumes that the individual clinicians are responsible for discussing care with consumers in an environment that is culturally appropriate and which enables respectful confidential discussion. This includes:

- The use of interpreter services where necessary,
- Advising consumers of their choice and ensuring informed consent is obtained,
- Providing care within scope of practice, meeting all legislative requirements and maintaining standards of professional conduct, and
- Documenting all care in accordance with mandatory and local requirements

Literature review

- > Women considering their options for birth after a single previous caesarean should be informed that, overall, the average success rate when vaginal birth after caesarean section (VBAC) is attempted is 72-76 %^{1,2,3}
- > Compared with repeat caesarean section, women who give birth vaginally after a previous caesarean section have a lower morbidity and fewer post-partum complications¹
- > In developed countries, the incidence of any type of uterine rupture after caesarean section is estimated to be 0.5 % to 1 %^{1,2,4,5}
- > With appropriate care, 9 out of 10 uterine ruptures will be recognised and acted upon such that long term harm to both mother and / or baby can be avoided
- > An Australian study has shown that, irrespective of whether oxytocin or prostaglandins are used, induction of labour and augmentation of labour in women with a previous caesarean section increases the risk of uterine rupture compared with spontaneous labour⁶

Definition

- > Vaginal birth in a current pregnancy after a caesarean section in a previous pregnancy (VBAC)

Incidence

- > In 2010, of those who had previously given birth in South Australia, 30 % underwent a caesarean section. Only 18 % of these women had a vaginal birth in their current pregnancy⁷

Contraindications

- > VBAC is contraindicated in the following circumstances:
 - > Previous classical, inverted T incision or unknown incision scar.
 - > Previous hysterotomy
 - > Previous uterine rupture

ISBN number: 978-1-74243-645-6
Endorsed by: South Australian Maternal & Neonatal Clinical Network
Last Revised: 17/6/14
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- > Placenta praevia, accreta, increta, percreta
- > Previous myomectomy involving entry of the uterine cavity or extensive myometrial dissection
- > Transverse lie or other malpresentation contraindicating vaginal birth

Precautions

- > Advice should be individualised according to the woman's specific circumstances
- > Prostaglandins for cervical priming are generally contraindicated for use in women with a caesarean section scar⁹
- > In women with an unripe cervix at term, induction of labour with a cervical balloon catheter is similar to induction of labour with prostaglandin E₂ gel, with fewer maternal and neonatal side effects¹⁰. However, too little information from randomised controlled trials is available to make the recommendation that all women requiring induction of labour who have had a previous caesarean section should have a cervical balloon catheter⁹
- > When induction of labour is deemed necessary in the presence of a uterine scar and an unripe cervix, careful consideration should be given to alternative options, such as postponing the induction or caesarean section

Antenatal care

- > Women who present with a history of caesarean section require obstetric referral and counselling appropriate to their individual needs
- > **NB:** In third world countries, lower uterine segment caesarean sections are often performed with a midline skin incision. If this can be identified from the history, these cases can be managed in the same manner as other lower segment caesarean sections

Obstetric review

- > Should occur at first or second antenatal visit
- > Exclude any medical / obstetric contraindication to VBAC
- > Document suitability for VBAC in case notes
- > Thorough review of previous births should take into account all contributing factors
- > The review should take the woman's autonomy (ability to make her own decisions) into account. Any discrepancy between what is advised by her caregivers and preferred by the woman should be documented
- > If VBAC is not advisable, offer appropriate counselling and advice regarding the timing of an elective caesarean section (follow link to [caesarean section: antenatal preparation and postnatal care](#))
- > If the woman chooses repeat caesarean section (where VBAC has been advised by an experienced obstetrician as a safe option) this discussion and the woman's informed consent should be documented
- > Explain surgical and anaesthetic risks of caesarean section, both short and long term if elective caesarean section is decided upon. Explain possibility (approximately 1 in 3) of emergency caesarean section if VBAC is chosen
- > Assess the woman's emotional needs around the birth
- > Recommend support groups as appropriate

36-38 week obstetric review

- > The decision for VBAC or elective caesarean section may be reviewed at the request of the woman or her primary caregiver

Management of women at 41⁺⁰ weeks or more

- > A clinical assessment and opinion from an obstetrician should be sought for women who proceed to 41⁺⁰ weeks or more and require induction of labour

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- > The decision to induce labour, in a woman, who has had a previous caesarean section, should be based on a full history as well as clinical assessment. An unripe cervix, unengaged head or large fetus reduce the likelihood of vaginal birth. The final decision for induction or elective caesarean section should be an informed choice made by the woman guided by advice from her obstetrician and midwife

Intrapartum care

- > Ensure the hospital of choice is equipped with services to manage an acute uterine rupture, e.g. appropriate obstetric, paediatric, anaesthetic, theatre and transfusion services. For further information see [Standards for Maternal and Neonatal Services in South Australia 2010](#)
- > Continuous midwifery support of the woman in labour
- > Intravenous access once established in labour
- > Group and save with access to prompt cross-match
- > Use of the partograph to monitor progress of labour
- > Any lack of progress in the first or second stage must trigger a complete clinical reassessment by an experienced obstetrician
- > Continuous electronic fetal monitoring is recommended when the woman is in established labour. 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^{11,12,13,14}
- > 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 an experienced obstetrician^{13,14}

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Useful references

- > **RANZCOG: (C-Obs 38) Planned Vaginal Birth after Caesarean Section (Trial of Labour) Available from URL:**
http://www.ranzcog.edu.au/component/docman/doc_download/971-c-obs-38-planned-vaginal-birth-after-caesarean-section-trial-of-labour-.html
- > **RANZCOG: (C-Obs 39) Caesarean delivery on maternal request (CDMR).** Available from URL: <http://www.ranzcog.edu.au/college-statements-guidelines.html>

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Abbreviations

CDMR	Caesarean delivery on maternal request
et al.	And others
RCOG	Royal College of Obstetricians and Gynaecologists
VBAC	Vaginal birth after caesarean

Version control and change history

PDS reference: OCE use only

Version	Date from	Date to	Amendment
1.0	08 Mar 04	22 Oct 07	Original version
2.0	22 Oct 07	18 Jan 11	Reviewed
3.0	18 Jan 11	25 Mar 14	Reviewed
4.0	25 Mar 14	17 June 14	Reviewed
5.0	17 June14	Current	

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