VAGINAL BIRTH AFTER CESAREAN SECTION

POLICY

Vaginal Birth After previous Cesarean (VBAC) is a safe alternative to a repeat Cesarean Section for women with a previous lower segment transverse scar who have no other indications for Cesarean Section in the present pregnancy.

At BC Women’s Hospital an emergency Cesarean Section is available imminently for women undertaking a VBAC who have indications for immediate operative delivery.

Notification with an Obstetrician is necessary when the woman is admitted in labour. A consultation is at the discretion of the primary health card provider.

Applicability: Women undertake a VBAC in the Delivery Suite, not in Single Room Maternity Care (SRMC).

PROCEDURE

1.1 Informed Consent

Provided there are no contraindications, a woman with one previous transverse low-segment Cesarean section should be offered a trial of labour (TOL).

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.

The physician and/or midwife (primary obstetrical caregiver) documents the process of informed consent and includes it in the health record of all women with a previous Cesarean section.

1.2 Admission for women undertaking a VBAC

- A woman in prodromal labour may remain at home.
- Admit a woman who is planning a VBAC to hospital when she is in active labour.

1.3 Induction Medications and Method

- Oxytocin - Medical induction of labour with oxytocin occurs only after full informed consent of the woman. See Labour Induction: Oxytocin.
- Prostaglandin E₁ (misoprostol) is associated with a high risk of uterine rupture and should not be 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.
- Use an intracervical foley catheter for ripening the cervix, as indicated.

1.4 Fetal Health Assessment

- Assess fetal health by continuous electronic fetal monitoring.
- The EFM tracing is an important marker of uterine rupture
- There is no need to restrict activity (telemetry can facilitate mobility while allowing continuous monitoring

1.5 Labour Support

- Isotonic calorie-containing clear fluid or water intake in active labour.
IV access - On admission, start a saline lock if IV access is predicted to be difficult. Start an IV infusion when indicated. NOTE: A routine intravenous is not mandatory.

1.6 Pain Management
Epidurals or other analgesia may be used. Epidurals are a reasonable choice for analgesia.
- **Note:** At BC Women’s the dosage in the epidural solutions are diluted and will not mask the pain of uterine rupture.

1.7 Labour Assessment
Assess the progress of labour frequently as per Intrapartum Electronic Fetal Monitoring.
- **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.

1.8 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 (seldom masked by an epidural; this sign is neither sensitive nor specific)
- Chest pain, shoulder tip pain and/or sudden shortness of breath
- A change in uterine activity (decrease or increase) is an uncommon and unreliable sign.

1.9 Management of Uterine Rupture

This is a perinatal emergency. 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

**DOCUMENTATION**
- Consent for Procedure or Treatment
- Labour Partogram
- Triage and Assessment Record
REFERENCES


Intrapartum Electronic Fetal Monitoring, Intrapartum Electronic Fetal Monitoring Flow Diagram, Algorithm-Clinical Management of Normal, Abnormal, Atypical EFM.

Labour Induction: Oxytocin Administration, Prostaglandin E₂ Administration, Cervical Ripening by Cervidil Administration, or Cervical Ripening by Foley (2011).

MOREob Module 1 (2013) Vaginal Birth after Cesarean Section.

