Frimley Health
NHS Foundation Trust

Birth choices after Caesarean birth

Key Points

- All professionals providing antenatal care have a duty to support women in their choices.
- Senior doctors and consultant midwives are responsible for discussing VBAC with individual women and documenting this discussion in the birth after Caesarean pathway.
- Planned VBAC is appropriate for and may be offered to the majority of women with a singleton pregnancy of cephalic presentation at 37+0 weeks or beyond.
- An individualised assessment of the suitability for VBAC should be made in women with factors that increase the risk of uterine rupture.

Version: 5
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Key words: VBAC, vaginal birth after Caesarean, elective repeat Caesarean section, ERCS, uterine rupture, birth choices, intrapartum management, contraindications to VBAC

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Abbreviations

CS	Caesarean Section
EFM	Electronic Fetal Monitoring
ERCS	Elective Repeat Caesarean Section
VBAC	Vaginal Birth after Caesarean

Contents

1. Purpose and scope

The purpose of this guideline is to outline the antenatal and intrapartum care pathway for women who have had a previous Caesarean section.

2. Definitions

Vaginal Birth After Caesarean (VBAC)

VBAC stands for 'vaginal birth after Caesarean.' It is the term used when a woman gives birth vaginally after having a Caesarean birth in the past.

Elective Repeat Caesarean Section (ERCS)

An elective repeat Caesarean birth means a planned Caesarean birth. The Caesarean birth usually happens from 39 weeks gestation.

3. Antenatal care schedule

The antenatal care schedule should comply with that recommended by the NICE antenatal care guideline and local antenatal care guidelines

Women booking a subsequent pregnancy following a previous caesarean birth should be referred to ANC for an appointment to see a consultant/obstetrician ST3 or more senior.

4. Antenatal counselling

All professionals providing antenatal care have a duty to support women in their choices. Senior doctors and consultant midwives are responsible for discussing VBAC with individual women and documenting this discussion in the birth after Caesarean pathway on Epic, which incorporates checklists that are recommended by the RCOG and facilitates best practice in antenatal counselling, shared decision making and documentation (appendix 1). Women who would like additional discussion should be referred to the Birth Choices clinics.

A final decision for mode of birth should be agreed upon by the woman and member(s) of the maternity team before the expected/planned date of birth. Women can change their minds at any point and their request should be discussed and their choice supported.

When a date for ERCS is being arranged, a plan for the event of labour starting before the schedule date should be documented in the birth after Caesarean pathway (appendix 1).

All women should be referred to the birth after caesarean information at the booking appointment. The links to this information is also included in the VBAC pathway.

5. Women who have had 2 or more previous CS

Women who have had two or more prior lower segment Caesarean deliveries may be offered VBAC after counselling by a Consultant Obstetrician and being fully informed on the increased risks. This should include:

- Risk of uterine rupture (1.36%)
- Risk of hysterectomy (56/10,000 compared with 19/10,000)
- Blood transfusion (1.99% compared with 1.21%)

VBAC success rates have shown similar rates 62-75%; however, it should be noted that half of the women with 2 previous CS had also had a previous vaginal birth.

6. Suitability for planned VBAC

Planned VBAC is appropriate for and may be offered to the majority of women with a singleton pregnancy of cephalic presentation at 37+0 weeks or beyond. Evidence suggests that planned VBAC is a safe and appropriate mode of birth for the majority of pregnant women who have had a single previous lower segment Caesarean birth, with or without a history of previous vaginal birth.

7. Contraindications to VBAC

- Previous classical Caesarean birth due to the high risk of uterine rupture.
- Women with previous inverted T or J incision, low vertical uterine incisions or significant inadvertent uterine extension at the time of primary Caesarean.
- Previous uterine rupture – reported risk 5% or higher of recurrent uterine rupture with labour.
- The presence of contraindications to labour such a placenta praevia.

8. Factors influencing the increased risk of uterine rupture

An individualised assessment of the suitability for VBAC should be made in women with factors that increase the risk of uterine rupture. Due to limited data, there is uncertainty of how to incorporate this information in antenatal counselling and therefore the presence of these risk factors does not always contraindicate VBAC. However, such factors may be considered during the decision making process, particularly if considering induction or augmentation of VBAC labour.

- Post-dates pregnancy
- Maternal age of 40 years or more
- Obesity
- Lower pre-labour Bishop score
- Macrosomia

Short inter-birth interval (less than 12 months since last birth). A recent study involving 3176 women evaluated the safety of women undergoing a VBAC with a short inter-birth interval and concluded it is not a risk factor for major complications such as uterine rupture and maternal death but that it is for preterm birth.

9. Risks and benefits of opting for VBAC versus ERCS from 39 weeks of gestation

Please see appendix 1 for more detailed information

Women should be made aware that successful VBAC has the fewest complications.

The greatest risk of adverse outcomes occurs in a trial of labour resulting in an emergency CS.

VBAC is associated with an approximately 1 in 200 (0.5%) risk of uterine rupture. It is also associated with an increased risk of Obstetric Anal Sphincter Injury (OASI)
ERCS is associated with an increased risk of placenta praevia and/or accrete which can result in massive obstetric haemorrhage. It is also associated with caesarean section scar ectopic and of pelvic adhesions complicating any future abdominopelvic surgery

There is an increase in neonatal respiratory morbidity when ERCS is performed before 39 weeks.

What is the likelihood of VBAC success?

The overall success rate of planned VBAC is 72-75%.

Factors improving success of VBAC

- Previous vaginal birth is the single best predictor associated with a success rate of 85-90%. This is also associated with a reduced risk of uterine rupture.
- Cervical dilatation of 8cm or more in a previous labour
- Spontaneous onset of labour
- Favourable cervix for induction (higher Bishop score)
- One to one care in labour
- Greater maternal height
- Maternal age less than 40 years
- BMI less than 30
- Gestation of less than 40 weeks
- Infant birth weight less than 4kg

The indication for the previous Caesarean affects the likelihood of successful VBAC:

- Fetal malpresentation 84%
- Labour dystocia 64%
- Fetal distress 73%
- Previous unsuccessful instrumental birth 61%

10. Intrapartum management of planned VBAC

Ideally discussion around birth after previous Caesarean should take place in the antenatal period.

Women should be advised that planned VBAC should be conducted on the labour ward; where continuous intrapartum care and monitoring with the resources available for immediate Caesarean birth if needed. Women who choose to birth anywhere other than labour ward can be referred to a Birth Choices appointment.

Women who present with an unplanned labour and a history of previous Caesarean birth should have a discussion with an experienced obstetrician to determine feasibility of VBAC.

Women can change their mind about their preferred mode of birth and her request should be discussed and her choice supported.

Epidural is not contraindicated in a planned VBAC and equally is not a requirement due to the fact the woman has had a previous CS.

All women in established VBAC labour should be advised and recommended:

- Continuous electronic fetal monitoring (telemetry may be offered especially if the woman is labouring in water)
- Supportive one-to-one care
- Intravenous access (this may be omitted if the woman choses to labour in water)
- Full blood count and group and save
- Monitoring of maternal symptoms and signs in line with the care of women in labour guideline
- Regular (no less than 4-hourly) assessment of their progress in labour
- Omeprazole 40mg to be administered 12hourly from confirmation of labour

There should be a lower threshold for admission in the latent phase of labour.

Second stage of labour

- Inform the Labour Ward co-ordinator and/or registrar when the woman commences pushing
- Regardless of the mode of analgesia allow a maximum of one hour for descent of the head. If, after 1 hour of passive second stage, the head is above +1 to the ischial spines the obstetric registrar should be informed and review the woman for a further plan of action.
- Regardless of the mode of analgesia allow a maximum of one hour for active pushing before referring to the obstetric registrar.
- Progress should be in line with the ‘Care in Labour’ guideline and the registrar should be informed and review the woman for further plan of action if progress deviates from the expected.

The clinical features associated with uterine scar rupture include:

- Abnormal CTG
- Severe abdominal pain, especially if persisting between contractions
- Acute onset scar tenderness
- Abnormal vaginal bleeding
- Haematuria
- Cessation of previous efficient uterine activity
- Maternal tachycardia, hypotension, fainting or shock
- Loss of station of the presenting part
- Change in abdominal contour and inability to pick up fetal heart rate at the old transducer site
- Vomiting – although it is common in labour please be cautious as women who have had scar ruptures previously have presented with a history of copious vomiting due to peritoneal irritation by the amniotic fluid

How should women with a previous Caesarean birth be advised in relation to induction or augmentation of labour?

Women should be informed of the two-to-three fold increased risk of uterine rupture and around 1.5 fold increased risk of Caesarean birth in induced and/or augmented labour compared with spontaneous VBAC labour.

An obstetrician ST3 or more senior should discuss the following with the woman:

- The decision to induce labour
- Proposed method of induction
- Decision to augment labour with oxytocin
- Time intervals for serial VE's and the selected parameters of progress that would necessitate discontinuing VBAC. These should be determined by the woman's history, for example a woman who has laboured to fully dilated before can be expected to progress more rapidly in labour than a woman who has never laboured. All women whose uterus is contracting regularly with oxytocin augmentation should be reviewed by an obstetrician ST3 or more senior at least every 4 hours. Consideration should be given to vaginal examinations more frequently than every 4 hours to ensure continual and ongoing progress of labour'

The final decision should always be confirmed with a consultant obstetrician.

Induction of labour using mechanical methods such as amniotomy or balloon catheter is associated with lower risk of scar rupture compared with induction using prostaglandins.

Prelabour rupture of membranes (PROM)

- Initial management should be according to the guideline for 'prelabour rupture of membranes at term'.
- Fetal wellbeing should be assessed by EFM (Electronic Fetal Monitoring) using computerised CTG.

- The woman should be reviewed by the obstetric registrar and a plan of care documented. If she meets the criteria for conservative management, management should follow guideline for ‘prelabour rupture of membranes at term’.
- If she does not meet the criteria for conservative management, requests earlier augmentation or has not laboured spontaneously after 24 hours, her care must be discussed with a consultant obstetrician to decide whether or not the labour should be induced with oxytocin.

Previous uterine surgery

Although previous uterine surgery is not within the scope of this guideline, there is uncertainty whether women, who have undergone laparoscopic or abdominal myomectomy, particularly where the uterine cavity has been breached, are at increased risk of uterine rupture. Uterine rupture after hysteroscopic resection of uterine septum is considered a rare complication. Given this uncertainty, women who have had such uterine surgery should be considered to have birth risks at least equivalent to those of VBAC and managed similarly in labour.

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Appendix 1 – Previous or Planned Caesarean Section Pathway

Previous or Planned Caesarean section pathway – Initial visit

Patient details:
Name:
DOB:
NHS Number:
Hospital Number:

Date:

Initial preference for delivery:
Reasons:

Obstetric History
OB History
No obstetric history on file.

Current gestation: Unknown
No data recorded
Desired family size (if known):

Obstetric History (First Appointment)
Previous CS details: Cervical dilation in cm (if applicable): Reason(s) for previous CS: Complications (eg PPH, wound infection): Other previous abdominal surgery: Medical conditions relevant to surgery/ anaesthetic: Any contraindications to labour and vaginal birth: (If yes to the following, please refer to PMH ANC) Any Tokophobia: Any trauma / lasting shock or fear about labour/ delivery:

Women Choosing or Considering VBAC (First Appointment)

Information section below reviewed with woman:

Approximate likelihood of successful VBAC discussed:

VBAC management plan for labour discussed
- Hospital birth on labour ward:
- IV cannulation:
- Continuous electronic fetal monitoring:

Initial discussion re woman's preferences for induction of labour, if required:

Notes:

Plan in case of preterm labour:

Women Choosing or Considering Caesarean Birth (First Appointment)

Please refer to appropriate ANC (see pathway below)

Reason for requesting CS:

Alternatives discussed (if applicable):
Plan for labour before CS discussed:

Plan delivery by:
Decision discussed with consultant:

Notes:

Plan in case of preterm labour:

Coil Insertion at Planned or Emergency CS (For All)

An IUS (hormone-containing coil) can be inserted into your womb at the time of Caesarean section. It does not affect your recovery and is is safe for breastfeeding. It provides effective contraception for up to 5 years with a low unplanned pregnancy rate of 2:1000 women. Many women have lighter or no periods. A copper coil (non hormonal) can also be inserted if you prefer. After Caesarean section, the risk of coil expulsion (falling out) is <10% and you would require a check for this 6 weeks after giving birth.

Woman wishing for IUS in the event of Caesarean delivery:

Notes:

Further information

VBAC - Advantages

- Quicker recovery
- Less risk for future pregnancies
- Shorter hospital stay
- Fewer breathing problems in babies

Chances of Successful VBAC:

- Single previous CS, no vaginal birth - 3 out of 4 women (72-75%)
- Single previous CS, at least 1 previous vaginal birth - 9 out of 10 women (85-90%)

Unsuccessful VBAC more likely if:

- Induced labour
- No previous vaginal delivery
- BMI>30
- Previous CS for slow progress in labour

If all of these factors are present, change of successful VBAC is 4 in 10 women (40%)

VBAC vs planned Caesarean at 39 weeks

Chance of Complication	VBAC	Caesarean
Uterine rupture	1 in 200	<1 in 500
Blood transfusion	2 in 100	1 in 100
Infection in the womb (endometritis)	No significant difference	
Baby developing temporary breathing problems after birth	2-3 in 100	4-6 in 100
Baby developing hypoxic ischaemic encephalopathy (brain injury) at birth	8 in 10,000	<1 in 10,000
Stillbirth beyond 39 weeks whilst waiting for labour	1 in 1000	N/A
Serious issues in future pregnancies eg low lying or invasive placenta, surgical complications, stillbirth	N/A	Increased risk

Induction of Labour in Women with Previous Caesarean Section

- The risk of scar rupture is 1 in 200 in VBAC labour which starts spontaneously. If a woman has her labour induced, this risk is increased 2-3 fold, i.e 2-3 in 200.
- There is a 1.5 fold increased risk of Caesarean delivery in induced labour compared with spontaneous labour.

Caesarean Birth vs Vaginal Birth – Risks (NICE 2021)

This information comes from studies comparing the outcomes in women who choose a caesarean birth vs women who choose a vaginal birth. This information is included to help you make your decision. ***Please note that the majority of these risks are rare outcomes.***

Outcomes more likely with caesarean birth	Outcomes more likely with vaginal birth	No Difference between Caesarean and vaginal birth
Increased length of hospital stay *(1-2 days longer on average)*	Urinary incontinence lasting more than a year *(extra 21,180/100,000 women)*	Blood clots in legs/lungs
Uterine rupture in future pregnancies *(extra 980/100,000 women)*	Faecal incontinence lasting more than a year *(extra 7,690/100,000 women)*	Major haemorrhage
Hysterectomy *(extra 70/100,000 women)*	Vaginal tears 3rd/4th *(extra 560/100,000)*	Postnatal depression
Stuck placenta in future pregnancies *(extra 60/100,000 women)*	Pain during birth and 3 days after *(increased pain scores during and 3 days after birth)*	Baby admitted to neonatal unit
Maternal death *(extra 20/100,000 women)*		Infection in baby
Childhood obesity *Extra 510/100,000 children)*		Delayed speech in child
Childhood asthma *(extra 310/100,000 children)*		Death of child up to a year
Death of baby soon after birth *(extra 20/100,000 babies)*		

Further Information

https://www.frimleyhealthandcare.org.uk/maternity/resources/videos/

https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pregnancy/pi-birth-options-after-previous-caesarean-section.pdf

36/40 Mode of Birth Discussion (For All)

Patient details:
Name:
DOB:
NHS Number:
Hospital Number:

Date:

Current gestation: Unknown

Current preference for delivery: {36/40 preference for delivery:26750}

If Planning a Caesarean Birth

Gestation/date of planned Caesarean: ***

Management plan for spontaneous labour before CS date e.g trial of VBAC or EMCS: ***

If Planning a VBAC

Management of post-dates pregnancy (if applicable): {IOL/ ERCS:26751}

Risk of IOL in VBAC discussed (see informations section below): {Yes/ No:28063::"No"}

Suitable methods for IOL (if required): {IOL methods:26752}

Notes:

Coil Insertion at Planned or Emergency CS (For All)

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This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt contact a senior colleague or expert. Caution is advised when using guidelines after the review date. This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version Control Sheet

Version	Date	Guideline Lead(s)	Status	Comment
2.0	October 2012	Consultant Midwife, Obstetrician, Practice Development Midwife Wexham Park Hospital Guideline for Vaginal Birth after Caesarean Section (VBAC)	Final	Updated – cross site guideline for Frimley Health NHS Foundation Trust
3.0	September 2012	Karen Plews Frimley Park Hospital Vaginal birth after uterine scar (Vaginal Birth after Caesarean)	Final	Updated – cross site guideline for Frimley Health NHS Foundation Trust
3.1	September 2017	Dr M Agha	Interim	Addition to appendix 2b Amended WPH only

3.2	March 2018	Zoe Jones Frimley Park Hospital	Interim	Updated VBAC care pathway p 14. Risk ratio corrected as initial ratios incorrect and link to VBAC information online as classes no longer provided by either site. Appendix 2b has been removed
4	September 2019	Sarah Coxon and Priscilla Dike Consultant Midwives, Alison Kirkpatrick Consultant Obstetrician	Final	
4.1	January 2021	Alison Kirkpatrick Consultant Obstetrician and Gynaecologist	Interim	Amendments following SI
5.0	January 2023	Nicola Rose-Stone, Consultant Midwife, WPH Rebecca Edwards, Consultant Midwife, FPH Alison Kirkpatrick Consultant Obstetrician, FPH	Final	Review

Related Documents

Document Type	Document Name
Guideline	Trust Intranet – Obstetrics and Gynaecology clinical guidelines
Guideline	Fetal Monitoring in Labour
Guideline	Induction and Augmentation of Labour
Guideline	Booking an Elective Caesarean Section
Guideline	Care of Women in Labour
Guideline	Pre-labour rupture of membranes