Bedfordshire Hospitals NHS Foundation Trust

CLINICAL PROCEDURAL DOCUMENTS

Document Title: **Management of Pregnant Women with Previous Lower Segment Caesarean Section or Other Uterine Scar**

This document is relevant for staff at: *(please indicate)*	**Luton Hospital site** **X**	**Bedford Hospital site**	**Both Hospital sites**

Document Type: *(please indicate)*	**Clinical Guideline** **X**	**Standard Operating Procedure** **X**	**PGD**	**Integrated Care Pathway**

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Is this document new or revised / or has minor amendments?
Minor amendment Oct 22 - on Page 22 to include previous caesarean section at full dilatation

Reason for minor amendments?
Due update

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Target Audience/Scope:	Obstetricians, Midwives
Associated Trust Documents:	CG310 Maternity Care Pathways and Risk Assessments CG124 Pre-Labour Rupture of Membranes at Term Guideline for Diagnosis and Management CG151 Mother and Baby Transfer of Care Guidelines for Health Professionals CG263 Electronic Fetal Monitoring in Labour CG393 Midwifery Led Rapid Assessment Guideline CG309 Bladder Care in Labour and Following Delivery CG200 Guideline for Management of Perineal Tears including Third and Fourth Degree Tears CG262 The Use of Oxytocin in Labour CG259 Guideline for the use of the Obstetric Early Warning (OEWS) Chart CG210 Operative Vaginal Delivery CG140 Obstetric Anaesthetic Guidelines Including Epidural and

	Dural Tap CG283 Induction of Labour CG128 The Management of Breech Presentation CG264 Non-elective Caesarean Section **SOP: Pre-term Birth Screening Clinic**	
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Management of Pregnant Women with Previous Lower Segment Caesarean Section or Other Uterine Scar Including management of Uterine Rupture and Scar Dehiscence

Introduction

The overall caesarean delivery rate in England for 2012–2013 was 25.5%. Although the majority of these caesarean deliveries were emergency (14.8%) rather than elective (10.7%) caesarean births (RCOG, 2015), the rising and high levels of caesarean rates are nevertheless a concern, and has led to an increasing number of women booking with maternity services with a history of a previous CS. Therefore, counselling women for and managing birth after caesarean delivery are important issues.

This guideline is largely concerned with the care of women who have had previous lower segment caesarean section (LSCS), and is also aimed to support staff in providing care for women who could be considered for a vaginal birth after a previous uncomplicated CS. Such women booking at the Luton and Dunstable University Hospital should have an opportunity to attend the Joint Birth after Caesarean (BAC) clinic.

Those who have had other types of caesarean, or uterine incision for other procedures, should be considered on an individual case-by-case basis, by a consultant. Similarly preterm delivery in women with uterine scar will need individual consideration, as will breech presentation (see CG128 Breech guidelines).

There is a consensus that planned VBAC is a clinically safe choice for the majority of women with a single previous lower segment caesarean delivery (National Institute for Health and Care Excellence (NICE); Royal College of Obstetricians and Gynaecologists (RCOG); American College of Obstetricians and Gynecologists (ACOG); National Institutes of Health (NIH).

Definitions:

In this guideline the terms frequently used of “planned vaginal birth after Caesarean” and “elective repeat caesarean section” are abbreviated to VBAC and ERCS respectively.

Departmental policy is based on Royal College of Obstetricians & Gynaecologists (RCOG) evidence-based guideline (Birth after previous Caesarean Birth – RCOG – Green top guideline 45 – October, 2015).

Antenatal care

Women with a prior history of up to four uncomplicated lower-segment caesarean sections (uncomplicated transverse incision), in an otherwise uncomplicated pregnancy at term, with no

contraindication to vaginal birth, should be able to discuss the option of planned VBAC and the alternative of an elective repeat caesarean section (ERCS).

The antenatal discussion with the woman should be documented in the maternity notes. The woman should be offered a “Vaginal Birth after Previous Caesarean” information leaflet at her first appointment, with either the midwife or an obstetrician.

Women should be referred for consultant led care at booking, including the option of joint clinic where the lead carer is the named obstetric consultant. **This clinic is run jointly with a consultant obstetrician/experienced midwife. The role of this clinic to provide more detailed counselling and support concerning options for women who have had a previous CS. It is not necessary for all women with a previous CS to be referred to this clinic. For most women who either accept the offer of VBAC or who are strongly of the view that they do not wish VBAC management can be dealt with through any routine consultant antenatal clinic.**

Referrals to the Joint VBAC, Midwife Birth After Caesarean (MBAC) or Consultant (CBAC) clinics should be around 16 weeks (or later if not seen previously) for discussion of mode of birth. Women who have other risk factors will be referred to the named obstetric consultant at the Joint VBAC or MBAC clinic or to their named obstetric consultant as appropriate for antenatal care in line with the antenatal risk assessment. **Women must be informed why they are being referred and preferably given a link to the Patient Decision- Aid (see below).**

At this appointment an opportunity is given to the patient to discuss:

- Her previous caesarean birth experience
- The options and suitability for either a planned vaginal birth or an elective caesarean section
- Benefits and risks associated with both an elective repeat caesarean section (ERCS) as well as planned vaginal birth after caesarean section (VBAC)
- Further information about the risks and benefits to support her decision, including leaflets (RCOG leaflet Appendix 1).
- Overall plan for labour and birth for the current pregnancy

The clinical management pathway for women booking with a single previous caesarean section includes an initial review ideally at 14-18 weeks but by 34wks. The schedule of care for these women enables them the opportunity of considering the options and ensuring that a robust plan is in place. A final decision for planned mode and place of birth should be agreed between the

woman and the practitioner seeing her - either consultant/experienced midwife or consultant obstetrician before the expected/planned delivery date (ideally by 36 weeks of gestation).

A full assessment of past medical history must be made, including information about the previous birth, accessed either from the hard copy of previous hospital records or from the electronic records. Where additional information is needed from another maternity unit for the previous caesarean delivery, the clerks must be asked to request these using the standardised request form, or a dictated letter sent from the Secretary. A copy of this request form or letter must also be filed in the Hospital notes and electronic records. If the woman has had a previous caesarean section at full dilatation she will require cervical length screening (see SOP Pre-Term Screening Clinic).

A plan for the event of labour starting prior to the scheduled date of an ERCS should be documented in the woman's records.

It is essential that a documented antenatal discussion of the mode of delivery occurs. Following the discussion at the Joint BAC clinic, the consultant midwife, BAC midwife and/or her team will complete the BAC Counselling Proforma (Appendix 2). This must be attached to the hand held antenatal notes and a copy filed in the hospital records.

The booking process for referral to the Joint VBAC clinic is:

- For women being cared for by the caseloading BAC Team, the appointment can be booked through antenatal clinic reception. The clinic codes are MBAC for low risk and CBAC for women with a complexity that need to see an obstetrician.
- Women who have not been seen at 16 weeks should be referred as soon as possible.

The consultant midwife or named consultant obstetrician can be contacted in person if there are any queries regarding the referral process.

Women considering their options for birth after a single previous caesarean should be informed that, overall, the chances of successful planned VBAC are about 3 in 4. The risk of uterine rupture in labour is variously quoted from different studies but a risk of 0.2% overall risk is reasonable. This figure though would not include induced and augmented labours. Induction of labour by any method increases (by two to three fold) the risk of scar rupture; multiple methods increase the risk still further.

All women who have experienced a prior caesarean birth should be informed of the maternal and perinatal risks and benefits of planned VBAC and ERCS when deciding the mode of birth.

The risks and benefits should be discussed in the context of the woman's individual circumstances, including her personal motivation and preferences to achieve vaginal birth or ERCS, her attitudes towards the risk of rare but serious adverse outcomes, her plans for future pregnancies and her chance of a successful VBAC. In addition, where possible, there should be review of the operative notes of the previous caesarean to identify the indication, type of uterine incision and any perioperative complications.

In cases where a caesarean section has been performed in this Unit, the operation records must be reviewed and discussed with the patient at their first BAC appointment, or at the first obstetric consultant appointment (whichever arises first). If the records or not available on the Trust's electronic record system the Maternity Records Manager should be asked to locate the paper records.

Depending on the history and the location, it may be appropriate to seek information from the Unit in which the previous CS took place.

For continuity of care, the named consultant chosen for the woman should be the same consultant involved in the previous birth episode (where possible and if the mother agrees), to allow continuity of carer and consistency of advice given, unless women are in the geographically based BAC continuity of care team.

As up to 10% of women scheduled for ERCS go into labour before the 39th week, a plan must be put in place in the antenatal period, stating what actions should be taken if this occurs, and this decision making must include the woman, and be documented in the handheld notes, highlighting a clear plan for the event of labour starting prior to the scheduled date. A personalised management plan must be made by on admission by the obstetric consultant.

If a woman has decided in the antenatal period that she is opting for an elective repeat caesarean then this decision should be respected even in she goes into spontaneous labour and should only be changed if the woman herself requests the change or we are unable to facilitate due to imminent delivery or theatre availability.

A conversation including the details and risks and benefits of induction of labour must be discussed in the antenatal period, informing her that:

- It is not contra-indicated
- It is associated with 2 – 3 fold increased risk of uterine rupture especially if unfavourable cervix and with use of PGE_2 gel
- It is associated with 1.5 fold increased risk of CS
- Offer alternate option of CS
- PGE_2 gel can be offered but at a low dose; 1mg dose only and then re-evaluate

In the event that a woman planning VBAC reaches 41 weeks, she should be reviewed in the same consultant's clinic to consider the options of continuing to await spontaneous onset of labour, induction of labour or ERCS.

Contraindications to VBAC

Women with a prior history of one classical caesarean section are recommended to give birth by ERCS.

Women with a previous uterine incision other than an uncomplicated low transverse caesarean section incision who wish to consider vaginal birth should be assessed by a consultant with full access to the details of the previous surgery.

Women with a prior history of up to four uncomplicated low transverse caesarean sections, in an otherwise uncomplicated pregnancy at term, with no other contraindication for vaginal birth, who have been fully informed by a consultant obstetrician, may be considered suitable for planned VBAC.

If necessary women requesting VBAC after two or more previous caesareans (= $VBAC^2$) may be referred to the specialist consultant BAC antenatal clinic, where they can see the named consultant with a particular interest in this field, for advice. If VBAC is planned a clear plan of management should be documented antenatally in the maternity records.

There is insufficient and conflicting information on the risk of uterine rupture in women with previous myomectomy or prior complex uterine surgery. Each case should therefore be considered on an individual basis. Individualised plans must be made by the obstetric consultant, setting out details for Induction of Labour (IOL), augmentation, duration of labour, etc. These women do not need to be seen in the joint BAC clinic unless the woman requests it.

There is limited evidence on whether maternal or neonatal outcomes are significantly influenced by the number of prior caesarean births or type of prior uterine scar (See NICE CG132). NICE

also recommend informing women who have had up to and including four caesarean sections that the risk of fever, bladder injuries and surgical injuries does not vary with planned mode of birth and that the risk of uterine rupture, although higher for planned vaginal birth, is rare.

Due to higher absolute risks of uterine rupture or unknown risks, planned VBAC is contraindicated (or relatively contraindicated) in women with:

- Previous classical (2-9 per 100 scar rupture risk) or “T” uterine scar (2 per 100)
- Previous uterine rupture
- Placenta praevia
- Malpresentations (e.g. transverse, breech or oblique lie)
- Five or more previous caesarean sections (there is only very limited evidence concerning VBAC after more than four CSs)
- Recurrent obstetric factors requiring repeat caesarean section (e.g. True cephalo-pelvic disproportion)

Previous surgery to the uterus where the uterine cavity has been entered or where there have been multiple uterine incisions, however, there is insufficient and conflicting information on whether the risk of uterine rupture in women with previous myomectomy or prior complex uterine surgery. Each case should be considered on an individual basis.

However, it is recognised that, in certain extreme circumstances (such as miscarriage, intrauterine fetal death) for some women in the above groups, the vaginal route (although considered higher risk) may not necessarily be contraindicated. The decision must therefore be made on a case by case basis.

Neonatal risks *(these issues are covered in detail in the patient information leaflet)*
It may be helpful to emphasise to women that the absolute risks of birth-related perinatal death associated with VBAC are comparable to the risks for nulliparous women (NICE, CG132).

Women considering the options for birth after a previous caesarean should be informed that planned VBAC carries a slightly higher 8/10,000 risk of serious risk to the baby such as brain injury or stillbirth than for a planned caesarean section however this figure is the same as if they were labouring for the first time. (RCOG, Patient Information Leaflet)

Women considering the options for birth after a previous caesarean should be informed that attempting VBAC probably reduces the risk that their baby will have respiratory problems after birth: rates are 2–3% with planned VBAC and 3–4% with ERCS.

Other risks *(these issues are covered in detail in the patient information leaflet)*
Women considering the options for birth after a previous caesarean should be informed that the risk of anaesthetic complications is extremely low, irrespective of whether they opt for planned VBAC or ERCS.

Women considering the options for birth after a previous caesarean should be informed that ERCS may increase the risk of serious complications in future pregnancies.

Women who are preterm and considering the options for birth after a previous caesarean should be informed that planned preterm VBAC has similar success rates to planned term VBAC but with a lower risk of uterine rupture.

A cautious approach is required when considering planned VBAC in women with twin gestation, fetal macrosomia and short inter-delivery interval (again there is limited data and absolute risks appear low if the interval is over twelve months), as there is uncertainty in the safety and efficacy of planned VBAC in such situations. A clear management plan must be documented in the notes for these cases by the consultant obstetrician.

Women should be advised that planned VBAC should be undertaken on delivery suite, where there is the facility for continuous electronic fetal monitoring. Resources should be readily available for immediate caesarean section and advanced neonatal resuscitation.

Women should be supported in their choice of analgesia. Epidural anaesthesia is not contraindicated in planned VBAC neither should it be regarded as essential.

Management of Labour in Vaginal Birth after Caesarean (VBAC)

The Royal College of Obstetricians & Gynaecologists (RCOG) Birth after Previous Caesarean Birth Green-top Guideline No. 45 recommends:

- Women should be advised that planned VBAC should be conducted in a suitably staffed and equipped delivery suite with continuous intrapartum care and monitoring with resources available for immediate caesarean delivery and advanced neonatal resuscitation.
- Women with an unplanned labour and a history of previous caesarean delivery should have a discussion with an experienced obstetrician to determine feasibility of VBAC.

• 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 an impending uterine rupture.

The traditional approach to VBAC labour involves:

- IV cannulation
- Group and save
- Continuous electronic fetal heart rate monitoring

NICE (NICE, 2019) having reviewed the evidence for these interventions have concluded that the evidence is weak or non-existent. Despite this, these interventions will continue to be our default approach however if any woman prefers to avoid any or all of these interventions she should be supported in that choice.

In the absence of a clear specific contraindication, all VBAC cases should be considered appropriate for labour +/- birth in the pool.

Partogram- Following admission in spontaneous labour for planned VBAC a standard assessment including vaginal examination should be performed and recorded. A partogram should be commenced if labour is diagnosed.

Vaginal Examinations- Thereafter further vaginal assessments should be performed at four hourly intervals – more frequently if there is any concern or progress has been slow.

Consultant Review- The woman should be seen by the consultant obstetrician at least at every hand-over.

If full dilatation has not been reached by eight hours after admission in labour or onset of established labour if already an in-patient there should be a review by a consultant. The consultant should then determine (and document) after discussion with the woman what the plan of management thereafter should be.

Second Stage- In the second stage of labour it is appropriate to allow a passive hour for descent and up to one hour of active pushing. Thereafter there should be a review by an experienced obstetrician (and if not a consultant carrying out the review, the case should be discussed with a consultant) – unless delivery seems imminent or if delivery can be accomplished by lift-out or low-cavity instrumental delivery.

Augmentation for slow progress or failure to progress after labour has been confirmed should be considered only exceptionally and on a case by case basis after a discussion between the woman (and her partner) and a consultant obstetrician. If augmentation is to be commenced the risks must be discussed (and documented), there needs to be a clear management plan and the consultant needs to continue to be involved in supervising management.

Maternal Choices in Labour – Fetal Auscultation

Until further evidence, continuous electronic fetal monitoring should be recommended during labour as the most common sign of uterine rupture is a non-reassuring fetal heart rate. A plan for monitoring the fetal heart must be documented in the management plan following informed decision-making by the woman. Maternal choices for fetal auscultation should be respected. Use of water in labour and waterbirths can be supported in the delivery suite, if the pool is available, with the use of continuous electronic fetal monitoring by telemetry device or hand held doppler if this is the woman's wish.

One to one care in labour is necessary to increase the likelihood of the woman achieving a VBAC and enable prompt identification and management of uterine scar rupture should it occur.

Fetal Blood Sampling

Any decision regarding FBS (fetal blood sampling) should be taken at a senior level as emergency CS may in such circumstances be more appropriate. An abnormal fetal heart rate trace followed by a prolonged bradycardia may indicate impending or actual uterine rupture and requires an emergency (Category 1) caesarean section.

Induction and augmentation of labour for VBAC

Women planning VBAC must be informed that membrane sweeps can be offered from 40 weeks. This intervention has the potential to initiate labour by increasing local production of prostaglandins and thereby reduce pregnancy duration or pre-empt formal induction of labour with either oxytocin, prostaglandins or amniotomy. These can be offered by the community midwife as a 'series of three' in line with local guidance as a method of cervical ripening and labour induction using standardised methodology (See CG283 Induction of Labour Guideline).

Induction or augmentation are not usually recommended for VBAC with expectant management being the preferred option however, induction of labour (IOL) may be offered to selected women with previous CS. This should be a consultant obstetrician decision. Women should be informed of the two- to three-fold increased risk of uterine rupture and around 1.5 fold increased risk of caesarean section in induced and/or augmented labours compared with spontaneous labours. Discussions should be clearly documented on the VBAC documentation tool and placed in the woman's hand-held notes.

Women should be informed that there is a higher risk (two to three fold increased risk) (0.5 – 1.5%) of uterine rupture with induction of labour with prostaglandins. Despite the increased risks however, induction of labour may be an appropriate course of action in some cases as opposed to a repeat caesarean section. IOL in such circumstances should be a consultant decision and a clear plan for induction should be documented in the mother's hand-held notes and in the labour notes. The option of ERCS should also be discussed.

Generally all the following criteria should be fulfilled before offering IOL:

- Women with a previous history of either a previous caesarean section for non-recurrent indication i.e. Breech presentation.
- A favourable cervix on cervical assessment (Bishop's score >4).
- (This is a strong requirement – IOL should not generally be undertaken with an unfavourable cervix as the likelihood of emergency caesarean section is significantly increased).
- A clear indication for IOL and/or post-dates.
- Particular caution should be applied before 40 completed weeks and preterm induction is usually best avoided.

There should be careful serial cervical assessments, preferably by the same person, for both augmented and non-augmented labours, to ensure that there is adequate cervicometric progress, thereby allowing the planned VBAC to continue.

The decision for induction of labour or augmentation with woman having a VBAC must be made with the consultant obstetrician, and management plan put in place for this, setting out further actions.

Due to the increased risk of uterine scar rupture:

- Induction of labour in such cases should be undertaken near to delivery suite and should be monitored closely – ideally on WARD 31.

- Use of PGE_2 gel should be avoided if possible or **limited to a single 1mg dose** (at the discretion of an obstetric Consultant).
- If amniotomy is not possible after a single dose of PGE_2 gel then delivery should be considered by caesarean section. (There must be an individual plan discussed with a Consultant)
- The induction method chosen, including if the decision is made to augment with oxytocin, must be clearly set out by the obstetric consultant. This must include clear guidance on the time intervals for serial vaginal examination and the selected parameters of progress that would necessitate and advise on discontinuing VBAC. The obstetric consultant must review the patient every 4 hours while they are being induced with oxytocin.

As a rule, Oxytocin should not be used for more than 8 hours total without consultant review.

These considerations equally apply to women who experience pre-labour membrane rupture at term. Subject to consultant review (face-to-face or telephone review according to on-site consultant availability) Oxytocin may be continued for up to four more hours provided that there is satisfactory progress, evidence of fetal well-being and agreement of the woman.

The additional risks in augmented VBAC mean that:

- Although augmentation is not contraindicated it should only be preceded by careful obstetric assessment discussion with the woman of risks and benefits and by a consultant-led decision
- Oxytocin augmentation should be titrated such that it should not exceed the maximum rate of contractions of four in 10 minutes; the ideal contraction frequency would be three to four in 10 minutes using the standard Oxytocin regime.
- Careful serial cervical assessments, preferably by the same person, are necessary to show adequate cervicometric progress, thereby allowing augmentation to continue.

The intervals for serial vaginal examination and the selected parameters of progress that would necessitate discontinuing VBAC labour should be consultant-led decisions.

Weekend and out-of-hours issues

Consultant on-site presence is currently not available 168 hours per week. Resident consultants are available from 08.30 on Monday until 21.00 on Friday. Over the weekend there is a daytime presence but not 24/24. The on-call consultant will not routinely return to the hospital to conduct

the timed reviews referred to above. At such times the review shoud be conducted by the most senior on-site obstetrician who will discuss the management of individual cases with the consultant on-call.

Responsibilities of obstetricians and midwives during a VBAC

- All women should be admitted in labour under the care of their named consultant.
- The antenatal consultant-led management plan must be reviewed by the midwife and discussed with the woman on admission in labour.
- The midwife must liaise with the consultant led obstetric team on duty and inform them of the woman's admission.
- The consultant led obstetric team on duty must review the woman, her antenatal management plan and document/confirm in the maternity notes an individual management plan for labour that is discussed with the woman and her midwife.
- Intrapartum care is provided by midwives with guidance from the consultant led obstetric team.
- Review Antenatal Management Plan for women's choice regarding IV access and blood samples being sent for full blood count and group and save. If further risk factors present this discussion should be revisited.

Uterine rupture or Scar dehiscence

- **Suspected uterine rupture or Scar dehiscence**

The most significant risk of a vaginal birth after caesarean (VBAC) is uterine scar rupture with the associated increased morbidity and mortality of the mother and child. Awareness of the signs that indicate uterine scar rupture and early recognition are key.

Uterine rupture can occur at any stage in labour.

Management of the second stage should include allowance of a maximum of 1 hour for passive descent and considering assistance if delivery is not imminent after 1 hour of active pushing.

The midwife should be alert to the classic symptoms and signs of uterine rupture and the registrar should be informed urgently for review if any of the following develop:

- **Signs of uterine rupture or Scar dehiscence**

1 Apparent **decrease in uterine contraction** by palpation

2 A **pathological CTG** in a woman who has had a previous caesarean section needs to be treated with caution as it may be a sign of scar rupture. Abnormalities of the fetal heart (present in 70-80% of cases). This could include a rising baseline, decelerations, loss of contact with difficulty in locating FHR (in this case confirm FH quickly with sonic aid/portable scan avoid delays in decision to proceed to CS). In these instances, Fetal Blood Sampling (FBS) may be inappropriate. *In this case, there must be a decision made by the consultant*.

3 **High presenting part** or change of lie/presentation

4 **Vaginal bleeding**

5 **Haematuria**

6 **Reduced frequency or cessation of uterine activity**

7 **Abnormal maternal observations** - Maternal tachycardia (hypotension is a LATE sign)

8 **Bleeding** may be concealed (i.e. intra-abdominal) and the usual signs of tachycardia and hypotension are likely to be absent in a young woman. Look for shoulder tip pain.

9 **Acute scar pain and/or tenderness** (this may occur despite an effective epidural)

10 **Difficulty controlling pain, particularly if there is pain in the presence of a previously effective epidural.** Women with no epidural may present with acute pain or become very distressed. This may present as shoulder-tip pain (referred from blood irritating the diaphragm). This should prompt consideration of the presenting clinical picture.

Management of uterine rupture/scar dehiscence – Follow <u>all</u> steps below

This is an obstetric emergency – Dial 2222 stating **"Emergency Caesarean Section" and location (See CG264 Non-elective Caesarean Section)**

1 Stop oxytocin (Syntocinon) infusion if in use

2 Transfer the patient IMMEDIATELY to theatre. If it occurs on the ward contact delivery suite to inform them that a woman is being transferred to theatre

3 It is not usually appropriate to try and locate the fetal heart with a scan to confirm its presence – valuable time may be wasted by using ultrasound

4 Four units of blood must be cross matched

5 It is the responsibility of the obstetric registrar to ensure that the consultant on call be notified that the woman has been transferred to theatre.

6 Paired cord blood samples should be obtained for acid-base assessment.

Postnatal Care

A full explanation of events should be given as soon as practicable to the mother and her partner. This discussion may need to be repeated subsequently, prior to the woman's discharge from hospital in order that the woman is debriefed following the event and understands how it will affect a future pregnancy and birth.

In accordance with the postnatal guidelines:

- Routine monitoring of maternal vital signs: pulse, BP and vaginal loss
- Digital examination of scar should not routinely be performed.
- If there is a suggestion of concealed bleeding (tachycardia, hypotension, oliguria etc) or if vaginal loss is excessive, early examination under anaesthesia (EUA) should be considered to exclude uterine rupture. The consultant should be involved early.
- Women who have needed a caesarean section should be informed at discharge that it is best that at least TWELVE months elapse before the next pregnancy is planned (shorter periods may well increase the chance of scar rupture).

Subsequent Labours

The scar rupture rate does not decrease with each subsequent labour. Women with a previous LSCS (lower uterine segment caesarean section) who have been successful in achieving a vaginal delivery should have all subsequent labours managed as above.

References

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Audit

Standards to be audited	Lead for the audit	Frequency, audit Tool and Methodology	Reporting arrangements	Acting on recommendations and Lead (s)	Change in practice and lessons to be shared Dissemination of results/action plans.
1. Discussion of risks and benefits of vaginal delivery and ERCS 2. Mode and place of labour 3. Continuous electronic fetal monitoring in labour. 4. Outcome of mother and baby 5. Plan (discussed with consultant) when labour does not commence spontaneously as planned and if decision to wait longer to perform ERCS or induce and/or augment labour. 6. Plan if decision to induce and augment labour to include method of induction (maximum dose of prostaglandin if method of induction) and criteria needed to discontinue labour and proceed to emergency caesarean section. 7. Plan should labour commence early (for women who have planned ERCS)	Will be nominated by the maternity audit leads (Consultant or Midwife) according to the Maternity Governance Audit plan.	This will be performed according to audit plan. Data will be collected using an audit proforma (designed by the auditors and approved by the maternity audit leads. The auditors will analyse the data and develop recommendations and action plans from the audit results.	The audit results, recommendations and action plans will be presented either at an audit meeting, a Clinical Governance day or at a Risk and Audit meeting.	The O & G Risk and Governance Committee will approve recommendations and action plans to be implemented within a specific time frame. The auditors will implement and monitor action plans with support from the clinical leads, senior midwives and pertinent groups. There will be six-monthly update of action plans. The O & G Risk and Governance Committee will oversee the implementation and monitoring of the action plans.	The audit results and approved action plans will be disseminated by the maternity audit team to all relevant staff groups, pertinent meetings and through the Delivery Suite newsletter, Risk and Governance newsletter, the Senior Staff meetings, the Delivery Suite Forum and by email. The Trust Audit and Clinical Effectiveness Group will be updated regularly by the maternity audit team.

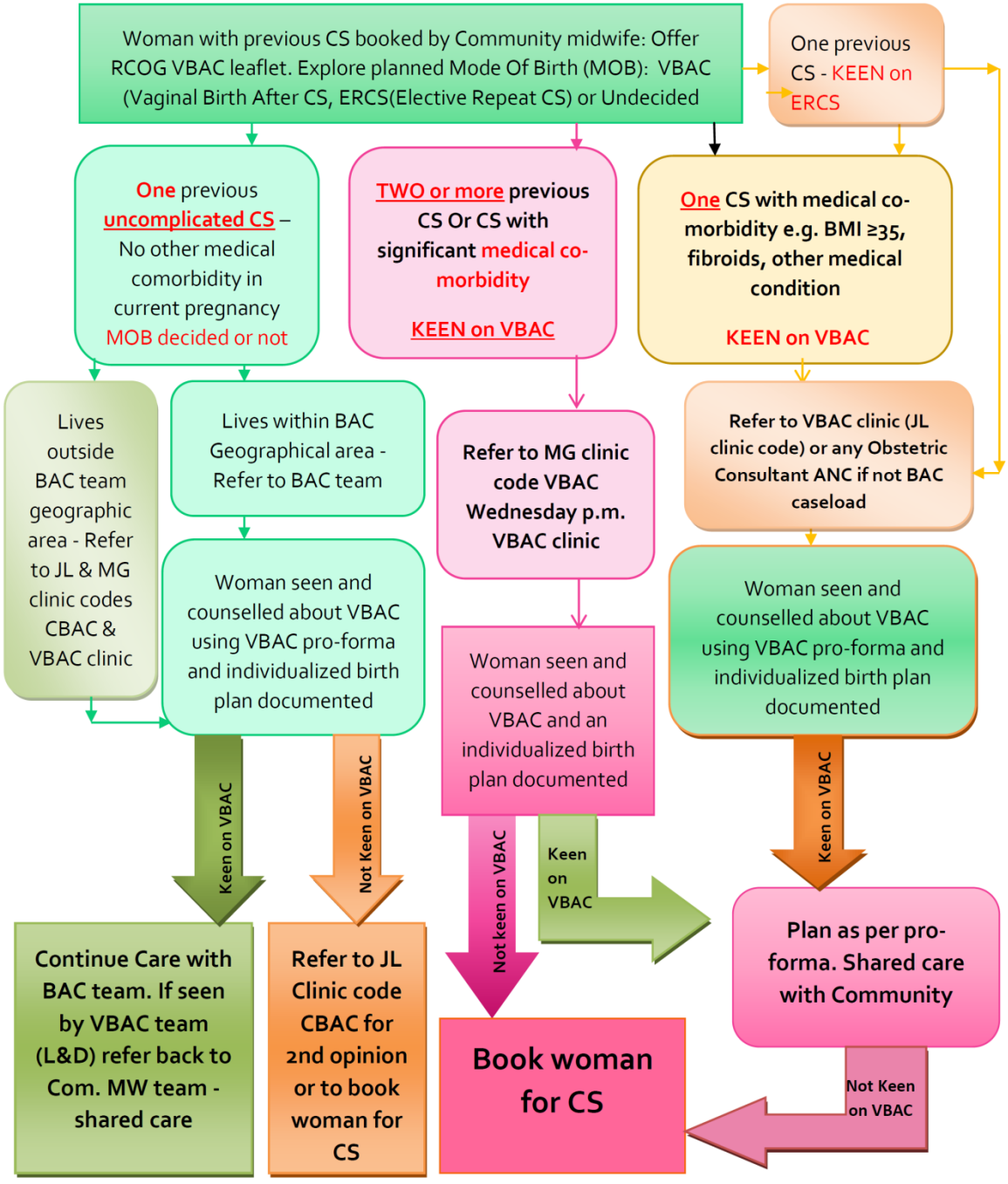
APPENDIX 1

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

APPENDIX 2

LUTON & DUNSTABLE – MATERNITY SERVICES
VAGINAL BIRTH AFTER CAESAREAN (VBAC) BIRTH REFERRAL PATHWAY

Referral of pregnant women with previous Caesarean Section (CS) booked to have their care at the Luton & Dunstable Hospital should follow the pathway illustrated:



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APPENDIX 3

Vaginal Birth after Caesarean - Counselling checklist

For women with one previous uncomplicated lower segment Caesarean section, we support and encourage VBAC. It is important to ensure that there are no contraindications to VBAC and that women wishing VBAC are aware of our advice regarding management around delivery.

Please complete this checklist for all women who may be considering VBAC, or for women who wish a planned CS but who may labour **before the ELCS** (**where suitable for VBAC**).

At the first discussion with an experienced midwife or Consultant at ≥16 weeks

One previous uncomplicated lower segment caesarean section only	YES/NO
Was the caesarean done at full dilatation	YES/NO/NOT DOCUMENTED
If YES please book cervical length scan at anomaly scan	YES/NOT NEEDED
Previous operation notes reviewed	YES/NO
(If notes unavailable, requested from previous hospital)	YES/NO
Review of placental site after anomaly scan to exclude placenta praevia +/- accrete	YES/NO
No other obstetric contraindications to vaginal delivery*	YES/NO
RCOG VBAC information leaflet provided	YES
Woman wishes VBAC*	YES/NO/UNDECIDED
If wishes elective caesarean aware <u>10% risk of labour before ELCS</u>	YES

If labour spontaneously with planned caesarean wishes VBAC/EmLSCS/Decide at the time

- 72 – 76% success of VBAC if woman's first vaginal delivery — YES
- 80 – 90% success of VBAC if has had a previous vaginal delivery

1/200 (0.5%) risk of scar rupture in spontaneous, non-augmented labour — YES

No later than 36 weeks: Birth Plan discussed: — YES

Delivery should be on the Labour Ward

- Options for IV access discussed, IV access recommended but woman's choice to be respected YES/NO/DECLINES

Fetal heart monitoring in labour:

- Continuous cordless recommended YES/NO
- Intermittent Auscultation should be supported if woman wishes YES/NO

No augmentation in labour except following individual discussion and agreement with obstetric consultant (The ideal is to anticipate spontaneous onset of labour)

40 week appointment made with Consultant to discuss post-dates options (can be earlier if obstetric complexities) YES

*see contraindication and referral checklist within VBAC guidelines

Name and Designation:……

Date ……