HUTT maternity
Hutt Valley Maternity Care

HUTT VALLEY DHB

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Facilitated by: Maria Cole, Midwife	Last reviewed: August 2012
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Vaginal Birth after Caesarean Section Policy

Hutt Maternity Policies provide guidance for the midwives and medical staff working in Hutt Maternity Services. Please discuss policies relevant to your care with your Lead Maternity Carer.

Purpose

The purpose of this guideline is to:-

- Establish a local approach to care, that is evidence based and consistent
- Inform good decision making
- Provide safe and effective care for women and their babies choosing planned vaginal birth after previous caesarean section.

Scope

- All obstetric staff employed by the Hutt Valley DHB
- All midwifery staff employed by the Hutt Valley DHB
- All Hutt Valley DHB maternity access agreement holders.
- Anaesthetic staff
- Neonatal staff

Abbreviations

HIE Hypoxic ishaemic Encephalopathy
C/S Caesarean Section
VBAC Vaginal birth after caesarean section
CTG Cardiotocograph
H**DC** Health and Disability Commission
RMO Registered medical officer

Introduction

Since the 1970s numerous studies have shown that it is safe to offer some women who had a previous C/S a planned vaginal birth. The New Zealand College of Midwives consensus statement states that it does not support routine repeat caesarean section (2004). The Royal Australian and New Zealand College of Obstetricians and Gynaecologists' (RANZCOG) current practise is to offer vaginal birth after a caesarean section as an option (New Zealand Guidelines group, 2004)

Service Specification

Women who choose a VBAC require ready access to obstetric, neonatal, anaesthetic RMOs and operating theatre with resuscitation services including availability of blood services. The delivery suite requires proper equipment to monitor these women and babies.

Risk associated with VBAC

- Uterine rupture rate 6.2 per 1000 trial of labour (RANZCOG, 2010). Royal College of Obstetricians and Gynaecologist (2007), report an overall risk of uterine rupture at term was 65 /10,000. It is a rare outcome but it is associated with significant maternal and perinatal morbidity and mortality.
- There is a greater risk of blood transfusion.
- Hypoxic Ischaemic Encephalopathy (HIE). RANZCOG(2010) reports on a study by Landon et al (2004) who found 12 cases of HIE among 17,898 women under going planned vaginal birth. There were no cases of HIE born by elective CS
- Uterine Dehiscence
- Hysterectomy
- Endometritis
- Fetal Death
- Maternal death

Contra indications to VBAC

Women with a history of a classical C/S
Previous uterine rupture
Previous scar dehiscence
Previous high vertical classical C/S
3 previous C/S
Woman declines
Morbid maternal obesity

Factors which may increase the possibility of a successful VBAC

In a 2008 retrospective analysis of longitudinally linked birth records relating to women who had attempted VBAC at term following a primary (meaning one prior) LSCS birth Algert et. al., (2008) concluded that having laboured was, in fact, protective against uterine rupture in the attempt for VBAC.
Another result from this cohort of 10,160 births was a 0.38% uterine rupture rate. Women were particularly likely to experience uterine rupture if their labours were induced or augmented, a finding which has been replicated many times elsewhere (Algert et. al., 2008).

Factors which may affect a successful VBAC

Baby weight above 4 kgs
Less than 18 months since previous section (RANZCOG, 2010)

Antenatal care

Midwives have a responsibility to:

- Discuss with a woman who is considering having a VBAC, the indications for the previous caesarean section
- Track and read the previous records (NZCOM, 2010)
- Intended place of birth as per service specification

Referral Guidelines Code 303 C/S referral category- consultation. (Appendix 1)

All discussion with the woman needs to include the advantages/disadvantages of both a VBAC and elective repeat caesarean section and recorded in the clinical records (Code of Rights no. 6 & 7 HDC, 2001).

- The plan of care is clearly documented in the clinical records after the three way conversation between the LMC, the woman and the obstetrician has occurred.
- This should include discussion of any need for and timing of specialist review e.g. labour.
- Written information is provided to the woman to consider her options in a timely manner
- It is recommended that a final decision is made by 36/40 (RCOG, 2007).
- Careplan should include the discussion that has occurred with the woman who presents in labour but has a booked elective caesarean section.

Intrapartum care

Maternal

- The care plan should be complete and include timing of consultant reviews.
- Vital signs taken and recorded on a partogram
- Bloods taken and sent for CBC and Group and Screen.
- It is prudent to have intravenous access
- Vaginal assessment at least 4 hourly in the active phase of labour

Specific observations of concern include:

- Abnormal fetal heart
- Loss of the presenting part
- Cessation of contractions
- Severe abdominal pain
- Chest pain
- Sudden onset shortness of breath
- Shoulder tip pain
- Acute onset of scar tenderness
- Abnormal vaginal bleeding
- Haematuria
- Maternal tachycardia
- Hypotension/shock

If there is concern of uterine rupture call for help. Ring 777 and state 'Code 2 Emergency, room number and place'

Fetal Monitoring

There are numerous guidelines that recommend continuous electronic fetal surveillance in labour. The most consistant sign of a rupture of the scar is an abnormal fetal heart tracing notably variable decelerations and then a prolonged bradycardia. (RANZCOG, 2010; Tracy, 2010 & RCOG, 2007)
There are no randomised controlled studies to provide evidence to show whether intermittent foetal auscultation or continuous EFM is better.
The Hutt Valley DHB supports continuous foetal monitoring.

Augmentation and Induction of previous c/s

Women should be informed that there is a higher risk of uterine rupture with induction of labour with prostaglandins (RCOG, 2007).
Women should be informed that there is an increased risk of uterine rupture and caesarean section in induced or augmented labours.
Due to increased risks the decision to induce should be consultant led only (RCOG, 2007).
If a woman is being induced or augmented with syntocinon it is prudent to keep her nil per mouth in case she requires an emergency section. This is because her risk of caesarean section is increased.

Pain Relief

Woman's choice. An epidural is not contraindicated.

Documentation

Careplan is clearly documented in the woman's records prior to the onset of labour.
Careplan is a living document and is updated regularly
Partogram
Fluid Balance chart
National Medication Chart

Associated Documents

Induction and Augmentation Policy
Electronic Fetal Monitoring

References

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Ministry of Health. (2012) Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines). Wellington: Ministry of Health

Royal College of Obstetricians and Gynaecologists (RCOG), (2007). Green-top Guideline No 45. Birth after Previous Caesarean Section. RCOG

Tracy, T. (2010). Interventions in pregnancy, labour and birth. In S. Pairman, S. Tracy, C.Thorogood & J. Pincombe (Eds.), Midwifery Preparation for Practise. (p p. 803- 969). Sydney, Australia: Elsevier

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The New Zealand College of Midwives NZCOM. (2004). NZCOM Consensus Statement. Vaginal Birth after a Caesarean Section. Christchurch: NZCOM

The New Zealand Guidelines Group. (2004). Care of Women with Previous Caesarean Birth. Author

Appendix 1

Referral Guidelines
See the Guidelines for Consultation with Obstetric and Related Medical Services (Referral Guidelines) MOH, 201

Informed Consent
The right of a consumer to make an informed choice and give informed consent, including the right to refuse medical treatment, is enshrined in law and in the Code of Health and Disability Consumers' Rights in New Zealand. This means that a woman can choose to decline treatment, referral to another practitioner, or transfer of clinical responsibility. If this occurs follow the process map on page 18 of the Referral Guidelines (Ministry of Health, 2012).