Greater Manchester and Eastern Cheshire SCN

Vaginal Birth After Caesarean Section Guideline

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Document Control

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I would also like to thank the wider clinical and midwifery community for the contribution in ensuring that this guideline provides safe and effective care for women and their babies.

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1 Introduction

Women with a prior history of one uncomplicated caesarean section require information in order to make an informed decision regarding the mode of birth in subsequent pregnancies, including the option of Vaginal Birth after Caesarean Section (VBAC) or Elective Repeat Caesarean section (ERCS). This can be done in a variety of ways. Some women and their partners will be offered written information at booking and see their named consultant obstetrician for review and to discuss their options, whilst others will first be offered information in a group setting, such as a VBAC workshop, prior to 24 weeks gestation. A VBAC workshop can be facilitated by a midwife who has the appropriate skills and knowledge to inform women of their options. This approach will be sufficient for the majority of women eligible for VBAC and is an efficient way to provide good information and facilitate an environment conducive to further discussion, whilst reducing the burden on obstetric consultant clinics.

Women might receive relevant information but remain undecided as to mode of birth, or require further information and discussion in order to make a decision. If so, the woman should be referred to her named consultant obstetrician or to a Birth Options clinic - where established. The aim is to offer women who have undergone one previous uncomplicated caesarean section optimal, personalised care and this guidance describes how this might be achieved.

2 What is this guideline for?

This guideline applies to women with a prior history of one uncomplicated lower segment transverse Caesarean Section (CS) in an otherwise uncomplicated pregnancy at term, with no contraindication to vaginal birth. Those women with two or more previous Caesarean Sections must be referred to the consultant obstetrician before 24 weeks gestation to discuss the care pathway.

Good practice point – Following a CS all women should have the opportunity to discuss labour and delivery events before discharge home (see Appendix 3 - Post Caesarean Section Discussion Proforma).

3 Philosophy of this guideline

This is a woman-centered pathway, ensuring that women receive current information and have the opportunity to discuss their options in order to make the right choices for themselves and their families. This information will reflect RCOG Guideline CG45 (2015):

- To facilitate Shared Decision Making
- To identify a plan of care and mode of birth by 36 weeks

4 Responsibilities

The role of each health professional is to ensure the woman is at the centre of all discussion and decision making when planning care and mode of delivery.

Shared Decision-Making principles should be facilitated; using the 'Ask 3 questions' approach can achieve that:

What matters to you?
What are your options?
What do you want to happen?

Any discussions or decisions must be documented in the Personal Maternity Records (PMR) and/or Hospital record.

5 Content of the guideline

The guideline provides information for clinicians to use in discussion with the woman about the merits and risks associated with VBAC versus ERCS and describes ways of providing that information and facilitating discussion.

Planned VBAC is appropriate for and may be recommended to the majority of women with a singleton pregnancy of cephalic presentation at 37+0 weeks or beyond who have had a prior history of one previous lower segment caesarean section, with or without a history of previous vaginal birth.

5.1 Contraindications to Vaginal Birth After Caesarean Section

- Previous classical uterine scar
- Previous hysterotomy
- Previous uterine rupture
- Indication for caesarean section in current pregnancy such as placenta praevia

5.2 Antenatal Care

- At first contact give or signpost the woman to current VBAC information leaflets https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pregnancy/pi-birth-options-after-previous-caesarean-section.pdf (see Appendix 2) and the Birth Options Decision Aid (Appendix 4).
- Refer for Obstetric review as per local guidance OR:
- Invite all suitable women to attend a VBAC Workshop (where available) preferably before 24 weeks gestation. At the workshop, the information can be discussed in a group setting, exploring the information given on the risks and benefits of each potential option and allowing time for questions

- A decision should be reached by the woman with the help and support of the obstetrician/midwife by 36 weeks gestation. The woman and the clinician should complete local documentation e.g. Decision proforma (see appendix 5). Providers should make local arrangements to ensure there is clear documentation and safe storage of the documentation
- If the woman has chosen to have a VBAC following completion of the Decision proforma, she will then return to routine antenatal schedule of care. An appointment should be made for no later than 41 weeks with the Obstetric team, should the woman not birth spontaneously
- The woman should be made aware that emerging risk factors may change the recommendations made/decision and subsequent management plan at any time
- Offer membrane sweep as per local guidelines – this should be documented in the PMR/hospital record so that it is communicated to the maternity team
- By 41 weeks a discussion with the consultant obstetric team should take place with the woman regarding birth options
- Referral to a birth options clinic supported by a suitably experienced and knowledgeable practitioner during the antenatal period might be considered for further discussion and to facilitate a multidisciplinary and robust individualized care plan
- Should the woman decline IOL following expected date of delivery, a detailed management plan should be discussed with consultant obstetric team and documented in the PMR/hospital record by 41 weeks and documented in the PMR/hospital record.

6 Psychological Support

6.1 Psychological Impact

To support a woman's decision regarding place of birth following VBAC the psychological impact of that previous birth should also be considered and discussed during the consultation.

When discussing place of birth, consider:

- Birth options
- Birth trauma

6.2 Women who choose to birth outside guidelines

Some women may choose a different mode of birth to that clinically suggested or decline intervention, and for those women it is important to ensure the following:

- The woman has been seen by a consultant obstetrician or suitably experienced and knowledgeable practitioner

- A detailed individualised care plan is in place including:
  - Type of birth chosen
  - Chosen place of birth
  - Choice of/advice on maternal observations and monitoring in labour
  - Recommended plan of care in the event of scar rupture, likely transfer times

and associated maternal and neonatal outcomes
  - Choice of/advice on fetal observations/monitoring in labour
  - Interventions in labour
  - Management of third stage

- Ensure the care plan is documented and cascaded to senior obstetric, midwifery and other key teams such as an anaesthetic or neonatal team
- Staff caring for women opting to give birth in midwife led setting can contact their Professional Midwifery Advocate/Senior Midwife for support and advice
- Appropriate and local escalation/referrals e.g. perinatal mental health/care outside of routine guidance must be in place and followed

7 Intrapartum Care

7.1 Intrapartum care

- All women who have had a previous caesarean section must be recommended to birth their baby in an obstetric led delivery suite
- An obstetrician of appropriate grade/experience should review the woman and record management plan as per local guidance. Any additional changes to original plan to be discussed with consultant obstetrician and documented in intrapartum records as per local guidance
- Manage as high risk during intrapartum period
- Site 16G IV cannula, take bloods for full blood count (FBC), group and save when in established labour
- Continuous electronic fetal monitoring once labour is established as per local guideline
- If woman declines continuous electronic fetal monitoring, ensure plan of care includes intermittent auscultation as per NICE Intrapartum guidance
- Epidural anesthesia is not contraindicated
- Monitoring of maternal condition as per local intrapartum care guideline and regular checks of vaginal loss. All observations should be recorded on the partogram in the hospital record
- Regular assessment of progress of labour when labour is established. Vaginal examinations should be no longer than 4 hours apart. Close monitoring of the length, strength and frequency of the contractions and observation for signs of scar dehiscence
- If suspicious CTG identified, labour fails to progress at the determined rate, scar tenderness, or abnormal maternal vital signs, escalate to an obstetrician of appropriate grade/ experience as per local guidance
- Augmentation needs senior obstetric input in the decision making and risks and benefits must be discussed
- The discussion and subsequent plan of care must be clearly documented in the PMR/hospital records.

Keep the woman and her partner fully informed at all times.

7.2 Induction of labour (IOL)

- On the day of induction check that a plan is in place and documented. If there is no plan in place the woman should be examined and informed by an obstetrician of appropriate grade/experience. This should be documented in the PMR/hospital records dependent on location
- IOL planned as per GMEC Induction/local guidance
- On admission, if the risk factors have changed inform an obstetrician of appropriate grade/experience to review the woman prior to IOL and document management plan
- If the woman is unsuitable for ARM following cervical priming, discuss with consultant obstetrician and record plan of care in hospital records

7.3 Possible signs of uterine rupture

- Abnormal CTG
- Severe abdominal pain, especially if persisting between contractions
- Acute onset scar tenderness
- Abnormal vaginal bleeding
- Haematuria
- Cessation of previously efficient uterine activity
- Sudden or new onset maternal tachycardia and/or hypotension
- Loss of station of the presenting part
- Change in abdominal contour and inability to pick up fetal heart rate at the old transducer site.
- Maternal shock / collapse (see standards for maternal observations in practice (including maternity early warning score (MEWS)

7.4 Immediate postpartum observations

Close monitoring of the maternal condition, including blood pressure, pulse, respirations, conscious levels and vaginal blood loss. As a minimum MEWS assessment should be performed immediately post-delivery, prior to transfer, and within one hour of admission to the postnatal ward.

8 Postnatal Discussion

All women should be offered a debrief prior to discharge home to include mode of birth and outcomes of recent birth and recommendations for future pregnancy and birth.

Complete the Post Caesarean Discussion Form (appendix 3) prior to discharge where appropriate.

9 Abbreviations and Definitions of terms used

Abbreviation	Definition
ARM	Artificial Rupture of Membranes
BMI	Body Mass Index
BOC	Birth Options Clinic
CS	Caesarean Section
CTG	Cardiotocograph
EDD	Expected Date of Delivery
ERCS	Elective Repeat Caesarean Section
FBC	Full Blood Count
G&S	Group and Save
IOL	Induction of Labour
IV	Intravenous
LSCS	Lower Segment Caesarean Section
MEWS	Maternity Early Warning Score
MLC	Midwifery Led Care
PMR	Personal Medical Record
T	Term
VBAC	Vaginal Birth After Caesarean
VE	Vaginal Examination
%	Percentage
<	Less than
>	More than

Term	Definition
Suitably experienced and knowledgeable practitioner	Obstetrician determined to have the experience to make clinical decisions as agreed by the local provider

10 References

10.1 Supporting References

- National Institute for Health and Clinical Excellence (2013). Caesarean section Quality standard [QS32] Published date: June 2013, NICE, London
- National Institute for Health and Clinical Excellence (2012). Clinical Guideline 132 Caesarean Section Published date: November 2011, Last updated: August 2012 NICE, London
- NHS Institute for Innovation and Improvement (2005) Delivering quality and value: focus on caesarean section DOH London
- Royal College of Obstetricians & Gynaecologists Green Top Guideline No. 45. Birth after Previous Caesarean Section February 2015
- Society of Obstetricians and Gynaecologists of Canada (SOGC) clinical practice guidelines 155, February 2005

Appendices

Appendix 1: Equality Impact Assessment (EIA) Tool
Appendix 2: VBAC patient Information leaflet from RCOG
Appendix 3: Post caesarean section discussion proforma
Appendix 4: Birth Options: Decision Aid
Appendix 5: Birth Options: Decision Proforma
Appendix 6: Post dates: Decision Proforma
Appendix 7: Quick Reference Guide
Appendix 8: Suggested Monitoring Arrangements

Appendix 1 - Equality Impact Assessment (EIA) Tool

[INSERT LOCAL EQUALITY IMPACT ASSESSMENT TOOL]

Appendix 2 – VBAC Patient Information from RCOG

Information for you

Published in July 2016

Birth options after previous caesarean section

About this information

This information is for you if you have had one caesarean section and want to know more about your birth options when having another baby. It may also be helpful if you are a relative or friend of someone who is in this situation.

How common is it to have a caesarean section?

More than one in five women in the UK currently give birth by caesarean section. About half of these are as a planned operation and the other half are as an emergency. Many women have more than one caesarean section.

What are my choices for birth after one caesarean section?

If you have had a caesarean section, you may be thinking about how to give birth next time. Planning for a vaginal birth after caesarean (VBAC) or choosing an elective repeat caesarean section (ERCS) have different benefits and risks.

In considering your options, your previous pregnancies and medical history are important factors to take into account, including:

- the reason you had your caesarean section
- whether you have had a previous vaginal birth
- whether there were any complications at the time or during your recovery
- the type of cut that was made in your uterus (womb)
- how you felt about your previous birth
- whether your current pregnancy has been straightforward or whether there have been any problems or complications
- how many more babies you are hoping to have in future; the risks increase with each caesarean section, so if you plan to have more babies it may be better to try to avoid another caesarean section if possible.

To help you decide, your healthcare professionals will discuss your birth options with you at your antenatal visit, ideally before 28 weeks.

What if I have had more than one caesarean section?

If you are considering a vaginal birth but have had more than one caesarean section delivery, you should have a detailed discussion with a senior obstetrician about the potential risks, benefits and success rate in your individual situation.

What is VBAC?

VBAC stands for 'vaginal birth after caesarean'. It is the term used when a woman gives birth vaginally, having had a caesarean section in the past. Vaginal birth includes normal delivery and birth assisted by forceps or ventouse (vacuum cup).

What is an ERCS?

ERCS stands for 'elective (planned) repeat caesarean section'. You will usually have the operation after 39 weeks of pregnancy. This is because babies born by caesarean section earlier than this are more likely to need to be admitted to the special care baby unit for help with their breathing.

What are my chances of a successful VBAC?

After one caesarean section, about three out of four women with a straightforward pregnancy who go into labour naturally give birth vaginally.

A number of factors make a successful vaginal birth more likely, including:

- previous vaginal birth, particularly if you have had previous successful VBAC; if you have had a vaginal birth, either before or after your caesarean section, about 8–9 out of 10 women can have another vaginal birth
- your labour starting naturally
- your body mass index (BMI) at booking being less than 30.

What are the advantages of a successful VBAC?

Successful VBAC has fewer complications than ERCS. If you do have a successful vaginal birth:

- you will have a greater chance of a vaginal birth in future pregnancies
- your recovery is likely to be quicker, you should be able to get back to everyday activities more quickly and you should be able to drive sooner
- your stay in hospital may be shorter
- you are more likely to be able to have skin-to-skin contact with your baby immediately after birth and to be able to breastfeed successfully
- you will avoid the risks of an operation
- your baby will have less chance of initial breathing problems.

What are the disadvantages of VBAC?

- You may need to have an emergency caesarean section during labour. This happens in 25 out of 100 women. This is only slightly higher than if you were labouring for the first time, when the chance of an emergency caesarean section is 20 in 100 women. An emergency caesarean section

carries more risks than a planned caesarean section. The most common reasons for an emergency caesarean section are if your labour slows or if there is a concern for the wellbeing of your baby.

- You have a slightly higher chance of needing a blood transfusion compared with women who choose a planned second caesarean section.
- The scar on your uterus may separate and/or tear (rupture). This can occur in 1 in 200 women. This risk increases by 2 to 3 times if your labour is induced. If there are warning signs of these complications, your baby will be delivered by emergency caesarean section. Serious consequences for you and your baby are rare.
- Serious risk to your baby such as brain injury or stillbirth is higher than for a planned caesarean section but is the same as if you were labouring for the first time.
- You may need an assisted vaginal birth using ventouse or forceps. See the RCOG patient information *An assisted vaginal birth (ventouse or forceps)* (www.rcog.org.uk/en/patients/patient-leaflets/assisted-vaginal-birth-ventouse-or-forceps).
- You may experience a tear involving the muscle that controls the anus or rectum (third or fourth degree tear). See the RCOG patient information *A third- or fourth-degree tear during birth* (www.rcog.org.uk/en/patients/patient-leaflets/third--or-fourth-degree-tear-during-childbirth) for more information.

When is VBAC not advisable?

VBAC is normally an option for most women but it is not advisable when:

- you have had three or more previous caesarean deliveries
- your uterus has ruptured during a previous labour
- your previous caesarean section was 'classical', i.e. where the incision involved the upper part of the uterus
- you have other pregnancy complications that require a planned caesarean section.

What are the advantages of ERCS?

- There is a smaller risk of uterine scar rupture (1 in 1000).
- It avoids the risks of labour and the rare serious risks to your baby (2 in 1000).
- You will know the date of planned birth. However, 1 in 10 women go into labour before this date and sometimes this date may be changed for other reasons.

What are the disadvantages of ERCS?

- A repeat caesarean section usually takes longer than the first operation because of scar tissue. Scar tissue may also make the operation more difficult and can result in damage to your bowel or bladder.
- You can get a wound infection that can take several weeks to heal.
- You may need a blood transfusion.
- You have a higher risk of developing a blood clot (thrombosis) in the legs (deep vein thrombosis) or lungs (pulmonary embolism). See the RCOG patient information *Reducing the risk of venous thrombosis in pregnancy and after birth* (www.rcog.org.uk/en/patients/patient-leaflets/reducing-the-risk-of-venous-thrombosis-in-pregnancy-and-after-birth).
- You may have a longer recovery period and may need extra help at home. You will be unable to drive for about 6 weeks after surgery (check with your insurance company).
- You are more likely to need a planned caesarean section in future pregnancies. More scar tissue occurs with each caesarean section. This increases the possibility of the placenta growing into

the scar, making it difficult to remove during any future deliveries (placenta accreta or percreta). This can result in bleeding and may require a hysterectomy. All serious risks increase with every caesarean section you have.

- Your baby's skin may be cut at the time of caesarean section. This happens in 2 out of every 100 babies delivered by caesarean section, but usually heals without any further harm.
- Breathing problems for your baby are quite common after caesarean section but usually do not last long. Between 4 and 5 in 100 babies born by planned caesarean section at or after 39 weeks have breathing problems compared with 2 to 3 in 100 following VBAC. There is a higher risk if you have a planned caesarean section earlier than 39 weeks (6 in 100 babies at 38 weeks).

What happens when I go into labour if I'm planning a VBAC?

You will be advised to give birth in hospital so that an emergency caesarean section can be carried out if necessary. Contact the hospital as soon as you think you have gone into labour or if your waters break.

Once you start having regular contractions, you will be advised to have your baby's heartbeat monitored continuously during labour. This is to ensure your baby's wellbeing, since changes in the heartbeat pattern can be an early sign of problems with your previous caesarean scar. You can choose various options for pain relief, including an epidural.

What happens if I do not go into labour when planning a VBAC?

If labour does not start by 41 completed weeks, your obstetrician will discuss your birth options again with you. These may include:

- continue to wait for labour to start naturally
- induction of labour; this can increase the risk of scar rupture and lowers the chance of a successful VBAC
- ERCS.

What happens if I have an ERCS planned but I go into labour?

Let your maternity team know what is happening. It is likely that an emergency caesarean section will be offered once labour is confirmed. If labour is very advanced, it may be safer for you and your baby to have a vaginal birth. Your maternity team will discuss this with you.

Key points

- If you are fit and healthy, both VBAC and ERCS are safe choices with very small risks.
- 3 out of 4 women who have had one caesarean section and then have a straightforward pregnancy and go into labour naturally give birth vaginally.
- 9 out of 10 women will have a successful VBAC if they have ever given birth vaginally. Successful VBAC has the fewest complications.
- Giving birth vaginally carries small risks for you and your baby but, if you have a successful vaginal birth, future labours are less complicated with fewer risks for you and your baby.
- Having a caesarean section makes future births more complicated.
- Most women who have a planned caesarean section recover well and have healthy babies, but it takes longer to get back to normal after your baby is born.

Making a choice

Shared Decision Making

If you are asked to make a choice, you may have lots of questions that you want to ask. You may also want to talk over your options with your family or friends. It can help to write a list of the questions you want answered and take it to your appointment.

Ask 3 Questions

To begin with, try to make sure you get the answers to three key questions if you are asked to make a choice about your healthcare.

1. What are my options?
2. What are the pros and cons of each option for me?
3. How do I get support to help me make a decision that is right for me?

https://www.aquanw.nhs.uk/SDM

Further information

- NICE guidance on caesarean section: www.nice.org.uk/guidance/cg132
- RCOG patient information *A third- or fourth-degree tear during birth*: www.rcog.org.uk/en/patients/patient-leaflets/third--or-fourth-degree-tear-during-childbirth
- RCOG patient information *An assisted vaginal birth (ventouse or forceps)*: www.rcog.org.uk/en/patients/patient-leaflets/assisted-vaginal-birth-ventouse-or-forceps

Sources and acknowledgements

This information has been developed by the RCOG Patient Information Committee. It is based on the RCOG Green-top Clinical Guideline *Birth after Previous Caesarean Birth* which you can find online at: www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg45.

This leaflet was reviewed before publication by women attending clinics in Raigmore Hospital, King's College Hospital, Queen's Hospital, St Mary's Hospital, University Hospital Lewisham and Wrexham Maelor Hospital, by the RCOG Women's Network and by the RCOG Women's Voices Involvement Panel.

The RCOG produces guidelines as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant health professionals. This means that RCOG guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management.

A glossary of all medical terms is available on the RCOG website at: www.rcog.org.uk/en/patients/medical-terms.

Appendix 3 - Post Caesarean Section Discussion Proforma

(This form to be incorporated in caesarean section or postnatal guidelines)

Congratulations on the birth of your baby. Your baby was delivered by caesarean section because: (Please use terminology easily understood by the woman)

____

	Tick box
Your consultant team thinks you have a good chance of a vaginal birth if your next pregnancy is straightforward. Most health professionals agree that a vaginal birth is better for healthy mothers and babies. You will be given the opportunity to discuss any issues should you become pregnant again.	
Because of your individual circumstances, your consultant team recommends that your next baby is born by caesarean section. You will be given the opportunity to discuss this with your obstetrician if this is not your choice or you have any other concerns.	

Specific questions you have raised / and subjects discussed

____

____

____

____

____

____

Completed by: Name: ______________________ Signature ______________________

Grade ___________ Date: _______________ Time: ____________

Discussion conducted by a doctor of appropriate grade/experience. Yes ☐ No ☐

Appendix 4 - Birth Options Decision Aid

Comparison of Vaginal Birth and Planned Caesarean Section

What is it?

Planned vaginal birth: This is when a pregnant woman who previously had a caesarean section plans to deliver her next baby vaginally. This is called vaginal birth after caesarean section or VBAC for short. It is recommended that the woman has her baby in hospital, so both she and her baby can be monitored for any problems during labour.

Planned caesarean section: This is when a pregnant woman who previously had a caesarean section plans to have another caesarean section. A caesarean section is a surgical way of delivering a baby through a cut in the mother's abdomen. Most babies that are delivered by caesarean section are delivered through a horizontal (side-to-side) cut low on the mother's abdomen. In a repeat caesarean section, doctors will usually deliver the baby by cutting along the previous caesarean section scar.

The following sections summarise the risks and merits:

Maternal Outcomes/Risks and Merits from 39+0 weeks gestation

Infant Outcomes/ Risk and Merits from 39+0 weeks gestation

Chance of other health problems for the baby

Chance of serious health problems for the mother

Hospital stay and home recovery

Effect on choice in future childbirth

Maternal Outcomes/Risks and Merits from 39+0 weeks gestation

Planned vaginal birth after caesarean	**Planned caesarean section**
Between 72-75 in 100 (72% - 75%) women who plan a vaginal birth after a caesarean section are able to have one. The same chance as a woman who has not had a baby before. • If a woman has also had a previous vaginal birth, the chance of having another vaginal birth is around 9 out of 10 (90%) • Difficulties with the pregnancy or during labour might mean that a woman needs to have a caesarean section • The rate of instrumental delivery is increased with VBAC (can be up to 39%) • There is a reduced chance of having a vaginal birth if: a woman has a raised Body Mass Index (equal to or over 30); labour is induced; a woman has never had a vaginal birth, if there was previous labour dystocia – which means the cervix stopped dilating past a certain level. Risk increases up to 3-fold if oxytocin is used • 1 in 200 (0.5%) risk of having uterine rupture. Risk increases 2 - 3 times if labour induced • If successful shorter recovery period • Risk of anal sphincter injury 3rd/4th degree tear 5 in 100 (5%, and birth weight is the strongest predictor of this) • Reduced risk of venous thrombosis • Risk of maternal death 4/100 000 • Successful VBAC has the fewest complications and increases likelihood of future vaginal births • Unsuccessful VBAC resulting in emergency caesarean section has the greatest adverse outcomes associated • Around 25 in 100 women (25%) who choose a vaginal delivery will have an unplanned caesarean section during labour • A caesarean section will be performed if there is any immediate danger to a woman or her baby, or if the labour is not progressing	About 98 in 100 (98%) women who plan a repeat caesarean section are able to have one. • Able to plan delivery date however this may change due to clinical circumstances • Small increased risk of placenta previa/accreta and adhesions with successive caesarean /abdominal surgery • Virtually avoids risk of ruptured uterus (0.02%) • Reduces risk of pelvic organ prolapse and urinary incontinence in short term • Option for sterilisation if fertility no longer required. NB this should not be a determining factor for caesarean section. • Risk of bladder ureteric /bowel damage (1/1000) • There is no risk of obstetric anal sphincter injury with ERCS • If a woman goes into labour before her caesarean section date, and labour is advanced by the time she reaches the hospital, it may be safer for the woman and her baby to continue with a vaginal delivery • Around 10 in 100 (10%) women who plan a repeat caesarean section go into labour before their scheduled caesarean section date. Unless a woman is in advanced labour, she should still be able to have a caesarean section if she wishes • Longer hospital stay and recovery • Risk of maternal death with ERCS 13 /100 000 • If BMI is raised there is an increased risk of surgical/venous thromboembolic complications • Anticoagulant is required for CS for 7-10 days for all women • If BMI is raised an anti-coagulant injection should be taken up to 6 weeks post operation

Infant Outcomes/ Risk and Merits from 39+0 weeks gestation

	Planned vaginal birth	Planned caesarean section
RDS	• Respiratory distress syndrome. A temporary breathing problem occurring in some mature babies (born after 37 weeks) - happens to less than 1 in 1,000 babies born by vaginal births after caesarean section	• RDS happens to around 4 in 1,000 to 6 in 1,000 babies born by repeat caesarean section and is limited by ensuring the caesarean section is booked for no earlier than the 39th week of pregnancy
Infant death	• The chance of a baby dying during or after a planned vaginal birth after a caesarean section is very small (1/1000, the same risk as a first-time mother giving birth after 39 weeks of pregnancy). The chances of a baby dying are about the same as the chances of that happening during a vaginal birth when a woman gives birth for the first time • Planned VBAC associated with 10/10 000 prospective risk of antepartum still birth beyond 39 +0 weeks • 4/10 000 (0.04%) risk of delivery related perinatal death	• The chance of a baby dying during or just after a planned repeat caesarean section after 39 weeks is virtually nil
HIE	• HIE (hypoxic ischaemic encephalopathy) is 8 times higher in relative terms at VBAC (8/10 000) compared to 1/10 000 at ERCS while absolute risk is minimal	• <1/10 000 risk of delivery related perinatal death or HIE

Chance of other health problems for the baby

	Planned vaginal birth	**Planned caesarean section**
Transient Tachypnoea of the Newborn:	• This is a condition where the baby breathes abnormally fast. It may happen if the baby is delivered before the 39th week of pregnancy. Often treated by giving the baby oxygen or antibiotics. It is not life threatening and usually stops after a day or two • Babies with transient tachypnoea may need a short stay in a neonatal unit (NNU) for observation • Occurs in about 26 in 1,000 babies delivered vaginally	• Occurs in about 36 in 1,000 babies delivered by caesarean
Accidental cuts		• Between 7 in 1,000 and 31 in 1,000 babies are accidentally cut by the doctor during caesarean delivery. This is more likely during an unplanned caesarean section (when the waters have gone) than a planned caesarean section • The cuts can occasionally leave scars.

Chance of serious health problems for the mother

The rates of hysterectomy and co morbidities of thromboembolic disease, transfusion and endometriosis did not differ significantly between planned VBAC V ERCS. It is very rare for a woman to die during childbirth, or from problems related to childbirth, in the United Kingdom. Overall, the numbers are 7 in 100,000 births; the difference between deaths after a planned caesarean section and deaths after a vaginal birth is small enough to be down to chance.

Chance of other health problems for the mother

	Planned vaginal birth	**Planned caesarean section**
Endometritis	• An infection of the lining of the womb. It occurs in nearly 3 in 100 women (3%) who have a planned vaginal birth after a caesarean section • The condition is treated with antibiotics, and in 90 in 100 (90%) of cases, it clears up within three to four days	• Occurs in nearly 2 in 100 women (2%) who have a planned repeat caesarean section • The condition is treated with antibiotics and usually clears up within one week. Women having a caesarean section are generally given antibiotics when the caesarean section is being carried out
Stress incontinence	• Where urine leaks while coughing, laughing, sneezing, or exercising. This usually improves within a few weeks of giving birth, but sometimes lasts for several months • Having several pregnancies increases a woman's chances of getting stress incontinence • About 12 in 100 (12%) women who have a vaginal birth get stress incontinence	• About 7 in 100 women (7%) who have a caesarean section get stress incontinence • A caesarean section operation won't cause stress incontinence, but being pregnant might
Abdominal discomfort		• About 9 in 100 (9%) women experience continuous wound and abdominal discomfort in the first few months after surgery.

Hospital stay and home recovery

If a mother or her baby is unwell, they may have to stay in hospital longer. Recovery after a vaginal delivery or a caesarean section varies from person to person.
A woman's age and health (before childbirth) will affect how quickly she recovers.

Planned vaginal birth	Planned caesarean section
• Babies are given a thorough check (neonatal examination) by a nurse, midwife, or doctor within 48 hours of being born • This may be in hospital or at a woman's home if she has been discharged • If a woman had stitches or other problems, recovery could take several weeks. Women should be able to get back to their normal activities, including looking after other children, driving, and normal social activities, as soon as they feel well enough to do so	• The same check-up will be given within 24 hours of being born • Following an uncomplicated CS, mother and baby usually go home within 24 hours • It can take four to six weeks to fully recover from a caesarean section. This can affect ability to drive. The woman is advised to contact her vehicle insurance provider to receive advice for when she can recommence driving • While the wound is healing, a woman should not drive, do strenuous exercise or household chores, lift anything heavier than her baby, or have sex • A woman can start doing these things again once she feels able to do them and they do not cause pain. For some women, this may be in a few weeks. For others, it may be longer • Some women have abdominal pain following a caesarean section. The pain from the caesarean section wound may last six to eight weeks

Effect on choice in future childbirth

Planned vaginal birth	Planned caesarean section
• Women who choose a vaginal birth are likely to be able to choose either another vaginal birth or a planned caesarean section in future pregnancies • If a woman has a successful vaginal birth this time, her chance of having a successful vaginal birth in the future with a straightforward recovery will be higher. About 94 in 100 (94%) women who have a successful vaginal birth after a caesarean section, have a successful second vaginal birth • If a woman has an assisted vaginal delivery (with forceps or ventouse), the chance that she will need an assisted delivery next time will be much lower • Having an unplanned caesarean section or changing to a planned caesarean section may affect a woman's chances of having a vaginal birth next time • Women who have had two or more prior lower segment caesarean deliveries may be offered VBAC after counselling by a consultant obstetrician. (RCOG 2015)	• Having multiple CS increases the risks of placenta preavia /accreta/adhesions and increases the likelihood of further CS.

Appendix 5 - Birth Options: Decision Proforma

Gestation: BMI Consultant

Addressograph

Gravida Para EDD

No. of previous caesarean sections ______________________

Post CS discussion form in notes Yes / No / Not Applicable

Previous notes reviewed Yes / No (If no, why not?) ______________________

Reason for discussion ____

Contraindications to VBAC:

Previous classical scar Yes / No Previous myomectomy Yes / No

Previous uterine rupture Yes / No Placenta praevia Yes / No

Is VBAC contraindicated Yes/ No. If yes action taken _________________________

If any co-morbidities present refer to Consultant. Date of appointment: ________________

Shared Decision-Making Questions:

Q. What matters to you? ____

Q. What are your options? ____

Q. What do you want to happen? ______________________________________

Information given Decision Aid Yes/No Other (please note):_________________

What mode of delivery has the woman expressed a preference for?

VBAC ☐ ERCS ☐ Undecided ☐

Signatures: Midwife /Dr. ________________________ Date: ______________

Woman ________________________ Date: ______________

Interpreter ________________________ Date: ______________

Appendix 6 – Post Dates: Decision Proforma

To be completed by obstetrician

Addressograph

Gestation: BMI Consultant

____

Gravida Para EDD ______________

No. of previous caesarean sections ______________

Previous notes reviewed Yes / No (if no, why not?) ______________

Shared Decision-Making Questions:

Q. What matters to you? ______________

Q. What are your options? ______________

Q. What do you want to happen? ______________

Membrane sweep offered Yes / No Performed on (date) ______________

Vaginal examination findings? ______________ ARM possible / not possible?

Discussion

Merits and risks of Induction (as per RCOG guidance) ☐ Merits and risks of ERCS ☐

Is VBAC contraindicated Yes / No If yes action taken ______________

What mode of delivery has the woman expressed a preference for?

VBAC ☐ ERCS ☐ Undecided ☐

Possible outcomes:

- Plan for Elective CS (date) ______________
- Plan for IOL by ARM +/- Oxytocin (date) ______________
- Plan for IOL using Prostaglandin ______________
  (Type and maximum number to be documented).
- Plan for using cervical balloon ______________

If undecided, personalised plan of care:______________

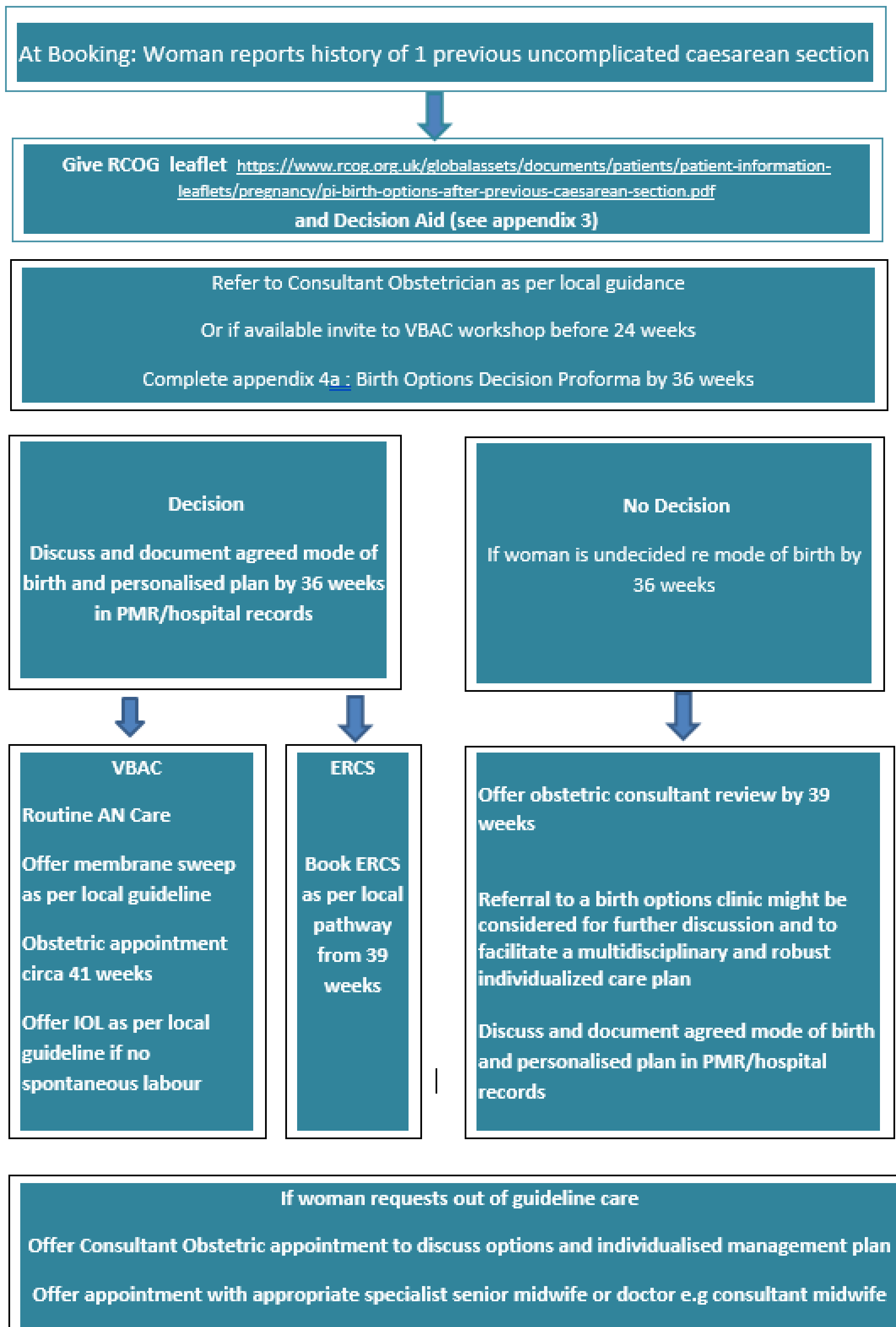
____

Signatures: Obstetrician______________ Date: ______________

Woman ______________ Date: ______________

Interpreter ______________ Date: ______________

Appendix 7 – Quick Reference Guide



Document your discussion - see Post Dates Decision Proforma (Appendix 6)

Appendix 8 – Suggested Monitoring Arrangements

Key Standard	Process for Monitoring	Team responsible	Frequency of Monitoring	Process for reviewing results and ensuring improvements in performance
RCOG CG 45 Standard Suggested auditable standards Post caesarean section discussion form completed				
Pregnant women who have had one caesarean section have a documented discussion of the option to plan a vaginal birth				
Documented antenatal discussion on the mode of delivery, including risks and benefits				
Documented individual management/ care plan for labour including fetal heart monitoring in labour				
Documented plan for labour should labour start early				
If there is a change in documented plan, was this discussed with a consultant obstetrician				
Birth options clinic (where established) outcomes audited				