I. Purpose:

To outline the procedures to be followed, and to provide appropriate counseling between patient and health care provider when determining whether or not the trial of labor after previous cesarean delivery (TOLAC) and vaginal birth after cesarean (VBAC) option for delivery is an appropriate option.

II. Policy:

To outline the protocol to be followed when counseling patients regarding their options for delivery. To describe the care of patients for whom TOLAC and VBAC is determined to be an appropriate option.

III. Specific Information:

A. When patients who have had a previous cesarean section present for care, they are counseled regarding appropriate options for delivery. Discussion begins at the first prenatal visit and should be completed by 36 weeks gestation, when possible. This allows adequate time for discussion with the patient regarding her options, and allows for scheduling a repeat cesarean section when that option is chosen.

Counseling includes the risks and benefits of TOLAC/VBAC, the alternatives to TOLAC/VBAC and their risks and benefits, and should include the calculated percentage chance of success utilizing currently available tools for patients with a
single previous Cesarean delivery. The consent at the time of admission to Labor & Delivery (L&D) should also contain an updated percent success calculation utilizing these same tools based on current clinical situation including cervical exam findings; this is to be documented in the patient’s chart. Patients who present to L&D for care and have not been previously seen as outpatients should be counseled regarding appropriate delivery options upon admission to L&D; this is to be documented in the patient’s chart.

“Good candidates for planned TOLAC are those women in whom the balance of risks (as low as possible) and chances of success (as high as possible) are acceptable to the patient and health care provider” (ACOG, 2010, p. 453).

“Although there is no universally agreed on discriminatory point, evidence suggests that women with a least a 60-70% chance of VBAC have equal or less maternal morbidity when they undergo chance of TOLAC than women undergoing elective repeat cesarean delivery. Similarly, because neonatal morbidity is higher in the setting of a failed TOLAC than in VBAC, women with higher chances of achieving VBAC have lower risks of neonatal morbidity” (ACOG, 2010, p. 453).

B. These patient histories and findings provide candidates for an optimal TOLAC outcome:

1. One previous low-transverse incision;
2. Clinically adequate pelvis;
3. No other uterine scars or previous rupture;
4. Two previous low-transverse cesarean section deliveries if they have had a previous vaginal delivery (must have MD chart review);
5. Two previous low-transverse cesarean section deliveries without previous vaginal delivery (pending MD consultation);
6. Interdelivery interval greater than or equal to 18 months from previous CD;
7. BMI less than 50;
8. Undocumented uterine scar type;
9. Patients with a probability of VBAC success of >70%.

In any of the above clinical situations, the health care provider determines if TOLAC/VBAC is an acceptable option for delivery. The provider informs the patient that any calculation of the patient’s predicted chance of having a successful VBAC is currently based on a tool designed to predict only with a single previous Cesarean delivery. There is no tool currently available that is validated for greater than one previous Cesarean delivery.

If the clinical situation is not covered in this list, the health care provider will either not offer a TOLAC/VBAC and discuss a planned cesarean birth, or offer the patient consultation with an attending physician in the out-patient setting.
“Individual circumstances must be considered in all cases, and if, for example, a patient who may not otherwise be a candidate for TOLAC presents in advanced labor, the patient and her health care providers may judge it best to proceed with TOLAC” (ACOG, 2010, p. 453). Similarly, if a patient has a unique clinical condition or situation and her attending MD provider has deemed her a candidate for TOLAC, it is expected that her labor course will be managed and attended by that provider or specified designee. If there is a change in the clinical situation the patient is offered consultation with the L&D generalist MD on call.

C. Once a patient has been counseled, the health care provider completes the VUMC Vaginal Birth After Cesarean Section consent form. This form includes both patient and provider signatures. The document is scanned into the Obstetric Electronic Medical Record (OB-EMR) if completed in the outpatient setting, or placed in the patient chart if completed after inpatient admission. This includes interpreter services documentation if applicable per policy:
   Interpreter Services: Hard of Hearing and Deaf, Blind and Visually Impaired, and Limited English Proficiency (LEP) Communication Policy OP 10-50.01

D. Procedures:

1. When VBAC candidates present for a trial of labor, care includes the following:
   a. IV access with an 18 gauge catheter;
   b. Type and Screen and PCV sent on admission;
   c. The MD attending in house for every shift is notified for consultation by either the resident or Certified Nurse Midwife when TOLAC/ VBAC patients present in labor and participates in a face-to-face discussion of the VBAC process, and its risks and benefits, and introduces him/herself to the patient per shift as the attending who will perform a cesarean, if indicated. That consultation must be documented in the patient’s chart.
   d. Consent for cesarean section is completed on all VBAC patients utilizing appropriate interpreter services when necessary Interpreter Services: Hard of Hearing and Deaf, Blind and Visually Impaired, and Limited English Proficiency (LEP) Communication Policy OP 10-50.01
   e. Anesthesia consultation is performed for all VBAC patients upon admission.
   f. Epidural placement may be done per patient and/or provider request. Discussion regarding general anesthesia in the event of emergent cesarean delivery without regional anesthesia should be documented.
   g. Patients presenting to triage or Labor and Delivery with history of previous cesarean delivery or transmural uterine surgery and at risk
for uterine contractions will have continuous electronic fetal monitoring.

h. Category II or Category III fetal heart rate tracings are evaluated by the health care provider. One of the most common signs of uterine rupture is an indeterminate or abnormal fetal heart rate pattern (decelerations and/or bradycardia). Category II and III EFM tracings must be reviewed and documented by attending physician.

i. Internal fetal monitoring devices, both intrauterine pressure catheters and fetal scalp electrodes, may be utilized but are not required for either patients in spontaneous labor or those undergoing oxytocin induction or augmentation of labor.

j. Serial vaginal exams are needed to assess & document progress & should not be deferred at times that could become critical for decision making. These exams are expected to be documented every 2-3 hrs along with EFM assessment for all patients attempting TOLAC beginning at 4 cm dilation or in the setting of oxytocin administration.

E. Augmentation and Induction:

1. Patients are informed of the increased risk of complications associated with labor induction or augmentation. When oxytocin is utilized, patients are specifically informed that this will double their risk of uterine rupture. That discussion is documented in the patient’s chart. If oxytocin is considered, then consultation with the in house MD attending is indicated. That consultation is documented in the patient’s chart when oxytocin is initiated.

2. If cervical ripening is clinically indicated, mechanical methods and/or oxytocin may be used. Prostaglandin preparations are not used for cervical ripening.

3. Decisions regarding whether to augment or induce labor are based on: patient’s BMI.
   a. With one prior CD & a BMI < 40, oxytocin may be used for IOL or augmentation.
   b. With one prior CD & a BMI > 40 but < 50, oxytocin may be used for augmentation only, not for IOL.
   c. With two prior CD, oxytocin use is contraindicated.

F. Any sign of uterine rupture requires immediate attention and evaluation by the nursing staff and the attending physician overseeing the patient’s care. These signs may include:

   i. Complaints of uterine or abdominal pain;
   ii. Vaginal bleeding;
iii. Signs/symptoms of hypovolemia (increased heart rate, increased respiratory rate, decreased blood pressure);
iv. Loss of station of the presenting part;
v. Increased uterine tone; and/or
vi. Recurrent fetal heart rate variables or late decelerations.

G. Labor progress is monitored and lack of progress is managed as indicated by the health care provider. When oxytocin is utilized, the patient’s cervical change is expected to be at least 1 cm with each 2 hour exam beginning at 4 cm dilation.

H. Reassessment of TOL for VBAC candidacy are considered and documented if:
   i. After 2 hours with lack of progress beginning at 4 cm, with adequate uterine activity by palpation or IUPC;
   ii. After 1 prolonged deceleration (>2 min) if benign and correctable etiologies are not apparent; correctable etiologies include changes in EFM with correctable hypotension, not recurrent variables and use of IUPC;
   iii. After recurrent decelerations for 30 minutes;
   iv. After bleeding greater than show;
   v. After a marked increase of upper or lower abdominal pain; or
   vi. After patient request, which has been communicated to attending physician.

I. External Cephalic Version (ECV)

ECV is not contraindicated in women at low risk of adverse maternal or neonatal outcomes from ECV and TOLAC and the chance of success is similar in women with and without a prior cesarean delivery.

IV. References:


THOMAS D. SHIPP, MD, CAROLYN M. ZELOP, MD, JOHN T. REPKE, MD,
AMY COHEN, AND ELLICE LIEBERMAN, MD, DrPH. Interdelivery Interval and Risk of Symptomatic Uterine Rupture. Obstetrics and Gynecology, 97 (2): 175-177  Feb 2001

V. Approval:

OB-PCC Committee

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