I. Purpose:

To outline the procedures to be followed, 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, and who choose a trial of labor and a vaginal delivery.

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, and who choose a trial of labor and a vaginal delivery.

III. Specific Information:

A. When patients who have had a previous cesarean section present for care, they are counseled regarding appropriate options for delivery. This counseling should be performed by a provider who attends births and begins at the first prenatal visit and should be completed by 36 weeks gestation. 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 VBAC, the alternatives to VBAC and their risks and benefits and should include the calculated percentage chance of success. The consent signed at the time of admission to Labor & Delivery (L&D) should also contain an updated percent success calculation. This discussion must be documented in the medical record. Patients who present to L&D for care and have not been previously seen as outpatients are counseled regarding appropriate delivery options upon admission to L&D.

“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. Patients who should be considered candidates for a trial of labor include:

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; and
5. Interdelivery interval greater than or equal to 18 months

In any of the above clinical situations, the health care provider determines if VBAC is an acceptable option for delivery.

C. Patients who may be considered candidates for a trial of labor and are acknowledged to be at a higher risk of a failed trial of labor and/or of complications from the trial of labor include:

1. Macrosomia and increased neonatal birth weight
   “It remains appropriate for health care providers and patients to consider past and predicted birth weights when making decisions regarding TOLAC, but suspected macrosomia alone should not preclude the possibility of TOLAC” (ACOG, 2010, p. 454).
2. Gestation beyond 40 weeks
   “Although chances of success may be lower in more advanced gestations, gestational age of greater than 40 weeks alone should not preclude TOLAC” (ACOG, 2010, p. 454).
3. Unknown uterine scar type;
4. Twin gestation;
5. Preeclampsia;
6. Recurrent indication for initial cesarean delivery (labor dystocia);
7. Previous low vertical incision; and
8. Patients with a history of 1 or 2 previous cesarean deliveries and BMI less than 50.

In any of the above clinical situations, the health care provider determines if the VBAC option is an acceptable delivery alternative.

D. Patients for whom a trial of labor is not recommended, but is not considered against medical advice (AMA), due to the patients thorough understanding of the increased risk of failed trial of labor and/or complications from the trial of labor and/or special circumstances on presentation to L&D include:

1. Patients with a history of 1 previous cesarean delivery and BMI ≥50 at the time of prenatal care or admission for delivery; and
2. Patients with a history of 1 previous cesarean delivery and whose interdelivery interval is ≤18 months

“The use of a prediction model for TOLAC success could be useful in the prediction of TOLAC success and perinatal morbidity…. Neither maternal nor neonatal morbidity are increased with a TOLAC when the probability of VBAC success is at least 70%” (Chaillet, Bujold, Dubé, & Grobman, 2012)

E. Patients who are not candidates for a trial of labor include [TOLAC is against medical advice (AMA)]:

1. Previous classical or T-shaped incision;
2. Extensive transfundal uterine surgery;
3. Previous uterine rupture;
4. Medical or obstetric complications that preclude vaginal delivery;
5. Patients with a history of 2 previous cesarean deliveries and BMI ≥50 at the time of prenatal care or admission for delivery; or
6. Patients with a history of 2 previous cesarean deliveries and whose interdelivery interval is ≤18 months.

In the above clinical situations, the health care provider will not offer VBAC but discusses a planned cesarean birth.

“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).
F. 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

G. 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 Hold and PCV sent on admission;
   c. The MD attending in house is notified by either the resident or Certified Nurse Midwife when 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.
   d. Consent for cesarean section are 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 on admission.
   f. Epidural placement may be done per patient and/or provider request.
   g. VBAC patients who are in active labor have continuous electronic fetal monitoring. For the purpose of this guideline, active labor is defined as regular, painful uterine contractions and cervical dilation of 4 or more centimeters.
   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).
   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.
H. Augmentation and Induction:

1. Patients are informed of the increased risk of complications from labor induction or augmentation.
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, number of previous vaginal deliveries, number of previous cesarean sections, and Bishop Score (see below).
4. Summary:

<table>
<thead>
<tr>
<th>BMI</th>
<th>&lt;30</th>
<th>≥30 &lt;40</th>
<th>≥40 &lt;50</th>
<th>≥50</th>
</tr>
</thead>
<tbody>
<tr>
<td>h/o vaginal del &amp; 1 prev C/S</td>
<td>Induce or augment</td>
<td>Induce or augment</td>
<td>augmen</td>
<td>Augment not recommended but NOT AMA</td>
</tr>
<tr>
<td>1 prev C/S’s</td>
<td>Induce or augment</td>
<td>Induce or augment</td>
<td>augmen</td>
<td>Augment not recommended but NOT AMA</td>
</tr>
<tr>
<td>h/o vaginal del &amp; 2 prev C/S</td>
<td>Induce or augment</td>
<td>Induce or augment</td>
<td>augmen</td>
<td>No Induction or Augmentation</td>
</tr>
<tr>
<td>2 prev C/S’s</td>
<td>Induce or augment</td>
<td>Induce or augment</td>
<td>augmen</td>
<td>No Induction or Augmentation</td>
</tr>
</tbody>
</table>

h/o=history of

I. Any sign of uterine rupture requires immediate attention and evaluation by the nursing staff and the health care provider managing 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.

J. Labor progress is monitored and lack of progress is managed as indicated by the health care provider.

K. Reassessment of TOL for VBAC candidacy are considered if:
i. After 2 hours with lack of progress in the active phase of labor, if \( \geq 5 \) cm or a prolonged second stage of labor with adequate uterine activity by palpation or IUPC;

ii. After 1 prolonged deceleration (>2 min) if benign and correctable etiologies are not apparent;

iii. After recurrent late decelerations for 30 minutes (late decelerations occurring with 50% or more of uterine contractions);

iv. After bleeding greater than show;

v. After a marked increase of upper or lower abdominal pain;

vi. After patient request.

L. 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:


V. Approval:

OB-PCC Committee
Frank Boehm, MD
Vice Chair, Department of OB/GYN
Bennett Spetalnick, MD
Medical Director, Labor & Delivery
Sandra Smith, RN
Nurse Manager, Labor & Delivery
Robin Mutz, RNC, MPPM, NEA-BC
Administrative Director, Women’s Patient Care Center