Health Services
LOS ANGELES COUNTY

POLICIES AND PROCEDURES

SUBJECT: VAGINAL BIRTH AFTER CESAREAN SECTION (VBAC) GUIDELINES

POLICY NO: 330

PURPOSE:

To provide guidelines for evaluation and management of women candidates for vaginal birth after cesarean section (VBAC).

POLICY:

I. OVERVIEW:

1. VBAC is a safe and appropriate choice for most women who had prior cesarean delivery, including appropriate candidates who had two previous cesarean deliveries.

2. VBAC avoids major abdominal surgery, lower's a woman's risk of hemorrhage and infection, shortens postpartum delivery stay and avoids multiple cesarean deliveries.

3. Maternal morbidity is low for those women who have successful trial of labor compared to elective cesarean delivery. However, failed trial of labor after Cesarean (TOLAC) has more complications than elective repeat cesarean.

4. The risk of uterine rupture is low, but if it occurs, it requires emergent intervention.

II. SELECTION CRITERIA

1. VBAC encouraged
   Most women with one previous cesarean delivery with a low-transverse incision are candidates for and should be counseled about VBAC and offered TOLAC.

2. VBAC allowed
   a. Women with two previous low transverse cesarean deliveries may be considered candidates for TOLAC.

b. Women with one previous cesarean delivery with a low transverse incision, who are otherwise appropriate candidates for twin vaginal delivery, may be considered candidates for TOLAC.

3. VBAC-Relative contraindications (VBAC only considered based on patient's request).
   a. Breech presentation
   b. Estimated fetal weight > 4500 grams
   c. Low vertical incision

4. VBAC-Contraindications (VBAC usually not allowed).
   Those at high risk for complications (e.g., those with previous classical or T-incision, prior uterine rupture, or extensive transfundal uterine surgery) and those in whom vaginal delivery is otherwise contraindicated (e.g., those with placenta previa) are not generally candidates for planned TOLAC.

III. STAFFING AND ANCILLARY SUPPORT

Note: TOLAC should only be attempted in facilities capable of emergency deliveries

1. A physician capable of evaluating labor and able to perform a Cesarean delivery in close proximity
2. Anesthesiologist readily available
3. Experienced nursing staff in labor, delivery, operating room and recovery room.
4. 24 hour blood bank capabilities.

IV. OBSTETRIC MANAGEMENT

1. Antepartum – The following should be completed during prenatal clinic visits, if possible. If any or all of the following is not done or available upon admission, it must be completed upon admission to Labor and Delivery.

   a. Attempt to verify type of previous uterine scar and reason for prior Cesarean delivery.

   b. Perform and document early counseling and ongoing discussion with the patient.

   c. Complete and document informed consent for VBAC and if cesarean section chosen, complete Operative Consent Form.

2. Intrapartum

   a. Provide fetal surveillance by continuous electronic fetal heart rate and uterine activity monitoring throughout active labor. Review and evaluation of the tracing shall be recorded according to facility policies/protocols.

   b. Ensure that patient blood is typed, screened and readily available.

   c. Establish intravenous line with large bore needle capable of infusing blood.

   d. Carefully observe the progress of labor.

   e. Take note of the following:
      - Epidural anesthesia for labor may be used as part of TOLAC
      - Induction of labor for maternal or fetal indications remains an option in women undergoing TOLAC
      - Misoprostol should not be used for 3rd trimester cervical ripening or labor induction in patients who have a cesarean delivery or uterine surgery.

   f. Perform amnioinfusion, forceps, and vacuum extraction as indicated obstetrically.

REFERENCES:

American of Obstetricians and Gynecologists. Vaginal Delivery After Previous Cesarean Delivery (Practice Bulletin #115). Washington, D.C.: ACOG, August 2010.

National Institute of Health. Consensus Development Conference Statement, Vaginal Delivery after Cesarean: New Insights. Bethesda, Maryland: NIH, March 2010