

# West Virginia Perinatal Partnership

## Committee to Improve the Statewide Perinatal System

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### GUIDELINES FOR VAGINAL BIRTH AFTER CESAREAN

The VBAC Guidelines are intended for use in situations where a pregnant woman is considered clinically appropriate for a Trial of Labor After Cesarean Section (TOLAC). This document represents collaboration among perinatal providers in West Virginia resulting from discussion and presentations during the 2009 and 2010 West Virginia Perinatal Partnership Summits. The document is based on an earlier collaboration document by the Northern New England Quality Improvement Network's (NNEPQIN) for hospitals in Vermont and New Hampshire, and was altered to reflect West Virginia specific needs. The collective recommendations for Vaginal Birth After C-section (VBAC) care are based upon thorough and thoughtful review of the literature. It incorporates American College of Obstetrics and Gynecology (ACOG) guidelines, and presents a regional definition of provider's "immediate availability" based upon patient risk status. The goal is to maintain the availability of VBAC services throughout the state, while ensuring patient and provider safety. These recommendations apply to VBAC candidates only, and recognize the need to adapt care to the unique circumstances of each case.

Each hospital needs to have a system in place for competency review and protocol verification. This can be accomplished several ways including but not limited to: set drills several times per year for staff or ongoing individual review of each emergency section. These activities will provide ongoing opportunities for quality improvement.

#### Definitions:

- **Labor:** Regular rhythmic, progressive uterine contractions that produce effacement and dilatation of the cervix.
- **Active Labor:** The cervix is 4-5 cm dilated and there are regular, rhythmic, progressive uterine contractions that produce further effacement and dilation of the cervix
- **Adequate Labor:** Contractions every 3 minutes with a 50 torr rise above baseline or contractions every 3 minutes lasting at least 45 seconds that palpate strong, or uterine contractions of any duration and frequency that continue to produce effacement and dilatation of the cervix.
- **Provider capable of performing a cesarean section:** An obstetrician, surgeon, or family practitioner who is credentialed to perform a cesarean delivery.
- **Admission:** Occurs when labor has been diagnosed, or when decision is made to deliver the patient. Observation to determine if the patient is in labor is not considered admission.
- **Anesthesia:** Refers to a CRNA or anesthesiologist who is privileged by the hospital.
- **OR Team:** One person competent to scrub for a cesarean section and one person competent to circulate during a cesarean section. These may be OR technicians, LNA, CNA, LPN, or RN.

- **Low risk VBAC Candidate:**
  - 1 prior low transverse cesarean section
  - Spontaneous onset labor
  - No need for augmentation
  - No repetitive fetal heart rate abnormalities
  - Patients with a prior successful VBAC are especially low risk. However, their risk status escalates the same as other low risk patients.
- **Medium Risk VBAC Candidate:**
  - Induction of labor
  - Pitocin augmentation
  - 2 or more prior low transverse cesarean sections
  - < 18 months between prior cesarean section and current delivery.
- **High Risk VBAC Candidate:**
  - Repetitive non-reassuring fetal heart rate abnormalities not responsive to clinical intervention.
  - Bleeding suggestive of abruption
  - 2 hours without cervical change in the active phase despite adequate labor

**Prenatal Management:**

- Records of prior delivery reviewed, including type of cesarean section.
- Appropriate patient education brochure given to patient and reviewed with patient (NNEPQIN sample available).
- Risk level of patient the institution is typically capable of caring for is reviewed with the patient, and anticipated management if risks status changes. The possible referral centers that would be used if higher level services are needed and transfer is safe should also be reviewed with the patient.
- Appropriate VBAC consent reviewed during prenatal care and signed. (NNEPQIN sample available)
- Anesthesia consultation/evaluation per institution guidelines.
- If the primary OB provider cannot perform a cesarean section, consultation with provider privileged to perform a cesarean section.

**Basic Interventions for all VBAC Patients:**

- Review with patient the benefits and risks of proceeding with VBAC on admission.
  - Determine if the patient's if risk level has changed. This review should be documented in the medical record.
  - Determine if the patient's choice has changed. Document in the medical record.
- Lab/Blood Bank Preparation
  - Type and Screen or Type and Cross depending on blood bank availability in off hours
  - Anesthesia personnel notified of admission.
  - Pediatric personnel notified of admission.
  - OR Team notified of admission and plan in place if cesarean delivery needed.

- Does not mean an OR is kept open for patients at low risk.
- In Active Labor (4-5 cm dilated)
  - Continuous Electronic Fetal Monitoring
  - Large Bore IV (18 gauge or larger)
  - Provider on hospital campus who is credentialed to perform a cesarean section.
    - If the primary obstetric provider is not credentialed to perform a cesarean section, the cesarean delivery provider will be consulted.
- Labor progress monitored so that arrest disorders can be detected in timely fashion.
- Institution meets the following standards for care:
  - ACOG Guidelines for Prenatal Care
  - The Joint Commission standards for Obstetrical Care
  - NRP Guidelines for pediatric care

### **Patient Classification**

Each hospital needs to evaluate the resources that they typically have available for the care of laboring women with prior cesarean deliveries. Women should be counseled as to their anticipated risk status and the institutional resources. Cesarean section may be recommended if a woman's risk status increases and provider services cannot be increased and maintained until delivery.

#### **Low Risk Patient:**

- No additional interventions other than those listed above.
- Cesarean delivery provider may have other acute patient care responsibilities.

#### **Medium Risk Patient:**

- Cesarean delivery provider in the hospital during the active phase of labor. Cesarean delivery provider may have other acute patient care responsibilities.
- An open and staffed operating room is available or there is a plan in place if immediate delivery is required. This may be a room where there are adequate lighting, instruments, and general anesthesia can be administered if needed.
- An anesthesia provider is present in the hospital during the active phase of labor.
- Anesthesia staff may have other acute patient care responsibilities.
- There is an established back up protocol for anesthesia services during busy times.

#### **High Risk Patient:**

- The cesarean delivery provider is present in the hospital and does not have other acute patient care responsibilities
- Anesthesia staff is present and does not have other acute patient care responsibilities.
- An open and staffed operating room is available.

#### **Caveats:**

- Misoprostil is associated with a high rate of uterine rupture and should not be used when a living fetus is still in-utero. It may be used after delivery for uterine atony.
- Women with 2 or more cesarean deliveries are at approximately 2.5% risk of uterine rupture. ACOG now states that these women are not VBAC candidates unless they have had a prior vaginal delivery. For women with 2 prior cesarean deliveries and a vaginal delivery, the risk of uterine rupture is about ¼ the risk for women without prior vaginal deliveries.

- Transfer during the active phase of labor typically holds little benefit for the patient as access to timely delivery is not present during transport.
- This protocol does not address the issue of twins, as there is insufficient data to determine their risk of uterine rupture.
- Women may present to hospitals that have chosen not to offer VBAC services. Transfer to a hospital providing VBAC services necessitates evaluation of the patient to determine safety and must comply with federal and state law. Hospitals not offering VBAC services should meet the following standards:
  - Protocol in place for women with prior cesarean sections who present in labor
  - Institution complies with ACOG Guidelines for Prenatal Care and The Joint Commission Standards for Obstetrical Care.
  - Referral and counseling practices established so that women desiring VBAC may be referred to an appropriate center based upon their risk status.
  - Meets NRP Guidelines for infant care.

#### References:

Extensive References are posted on the WV Perinatal Partnership Web site: [www.wvperinatal.org](http://www.wvperinatal.org) and can also be found at the following sites.

NIH Consensus Development Conference: Vaginal Birth After Cesarean: New Insights March 8–10, 2010 Bethesda, Maryland [Abstracts with references](#)

**<http://consensus.nih.gov/2010/vbacabstracts.htm>**

Final statement- NIH Consensus Development Conference: VBAC

**<http://consensus.nih.gov/2010/vbacstatement.htm>**

#### Reference Information

Individuals who wish to cite this statement should use the following format:

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