No. 155 (Replaces guideline No 147), February 2005 (Reaffirmed March 2018)

No. 155-Guidelines for Vaginal Birth After Previous Caesarean Birth

This guideline has been prepared and reviewed by the Clinical Practice Obstetrics Committee and approved by the Executive and Council of The Society of Obstetricians and Gynaecologists of Canada.

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Key Words: Vaginal birth after Caesarean, trial of labour, uterine rupture, induced labour, oxytocin, prostaglandins, misoprostol

J Obstet Gynaecol Can 2018;40(3):e195–e207

https://doi.org/10.1016/j.jogc.2018.01.014

Abstract

Objective: To provide evidence-based guidelines for the provision of a trial of labour (TOL) after Caesarean section.

Outcome: Fetal and maternal morbidity and mortality associated with vaginal birth after Caesarean (VBAC) and repeat Caesarean section.

Evidence: MEDLINE database was searched for articles published from January 1, 1995, to February 28, 2004, using the key words "vaginal birth after Caesarean (Cesarean) section." The quality of evidence is described using the Evaluation of Evidence criteria outlined in the Report of the Canadian Task Force on the Periodic Health Exam.

Recommendations:

1. Provided there are no contraindications, a woman with 1 previous transverse low-segment Caesarean section should be offered a trial of labour (TOL) with appropriate discussion of maternal and perinatal risks and benefits. The process of informed consent with appropriate documentation should be an important part of the birth plan in a woman with a previous Caesarean section (II-2B).
2. The intention of a woman undergoing a TOL after Caesarean section should be clearly stated, and documentation of the previous uterine scar should be clearly marked on the prenatal record (II-2B).
3. For a safe labour after Caesarean section, a woman should deliver in a hospital where a timely Caesarean section is available. The woman and her health care provider must be aware of the hospital resources and the availability of obstetric, anesthetic, pediatric, and operating-room staff (II-2A).
4. Each hospital should have a written policy in place regarding the notification and (or) consultation for the physicians responsible for a possible timely Caesarean section (III-B).
5. In the case of a TOL after Caesarean, an urgent laparotomy should be set-up immediately to facilitate delivery as quickly as possible (III-C).

6. Continuous electronic fetal monitoring of women attempting a TOL after Caesarean section is recommended (II-2A).
7. Suspected uterine rupture requires urgent attention and expedited laparotomy to attempt to decrease maternal and perinatal morbidity and mortality (II-2A).
8. Oxytocin augmentation is not contraindicated in women undergoing a TOL after Caesarean section (II-2A).
9. Medical induction of labour with oxytocin may be associated with an increased risk of uterine rupture and should be used carefully after appropriate counselling (II-2B).
10. Medical induction of labour with prostaglandin E2 (dinoprostone) is associated with an increased risk of uterine rupture and should not be used except in rare circumstances and after appropriate counselling (II-2B).
11. Prostaglandin E1 (misoprostol) is associated with a high risk of uterine rupture and should not be used as part of a TOL after Caesarean section (II-2A).
12. A Foley catheter may be safely used to ripen the cervix in a woman planning a TOL after Caesarean section (II-2A).
13. The available data suggest that a trial of labour in women with more than 1 previous Caesarean section is likely to be successful but is associated with a higher risk of uterine rupture (II-2B).
14. Multiple gestation is not a contraindication to TOL after Caesarean section (II-2B).
15. Diabetes mellitus is not a contraindication to TOL after Caesarean section (II-2B).
16. Suspected fetal macrosomia is not a contraindication to TOL after Caesarean section (II-2B).
17. Women delivering within 18 months of a Caesarean section should be counselled about an increased risk of uterine rupture in labour (II-2B).
18. Postdatism is not a contraindication to a TOL after Caesarean section (II-2B).
19. Every effort should be made to obtain the previous Caesarean section operative report to determine the type of uterine incision used. In situations where the scar is unknown, information concerning the circumstances of the previous delivery is helpful in determining the likelihood of a low transverse incision. If the likelihood of a lower transverse incision is high, a TOL after Caesarean section can be offered (II-2B).

Validation: These guidelines were approved by the Clinical Practice Obstetrics and Executive Committees of the Society of Obstetricians and Gynaecologists of Canada.