Saint Luke's Women's Health East
VBAC Guidelines-Recommendations

Low Risk Patient: Risk for uterine rupture approximately 0.3-0.7%.

- 1 prior low transverse cesarean section(s)
- Spontaneous onset labor
- No need for augmentation
- No repetitive FHR 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 Patient: Risk for uterine rupture is likely greater than 0.7%.

- Induction of labor (using AROM)-ok to allow VBAC
- Oxytocin augmentation- case by case basis
- < 18 months between prior cesarean section and current delivery-case by case assessment
- 2 prior low transverse cesarean sections.-NO VBAC

High Risk Patient: Patients who have intra-partum signs or symptoms that may be associated with uterine rupture or failure of vaginal delivery (4).

- Recurrent clinically significant deceleration (variable, late or prolonged fetal heart rate decelerations) – NO VBAC
- Significant bleeding of uterine origin-NO VBAC
- New onset of intense uterine pain-NO VBAC
- 2 hours without cervical change in the active phase despite adequate labor-discontinuation of attempt at VBAC-case by case assessment
- 3 or more prior low transverse cesarean sections.-NO VBAC

Prenatal Management:

- Records of prior delivery reviewed, including type of uterine incision and method of closure. Single layer closure of the uterus with an interlocking chromic type suture has been reported to be associated with an increased risk of uterine rupture. Operative records should be reviewed for the method of closure.
    - Patients with a previous classical uterine incision, previous extensive transfundal surgery (including significant myomectomy surgery) or prior uterine rupture are not candidates for VBAC. (4) (Level B)
- Patients that have a BMI of greater than 40 or a fetus with an EFW of greater than 4000 grams should be counseled against VBAC and scheduled for an elective repeat cesarean section- case by case assessment.

- Appropriate patient education brochure given to patient and reviewed with patient and signed by patient
- Appropriate VBAC consent reviewed during prenatal care and signed

Basic Intra-partum Care Recommendations for all VBAC Patients:

- Review with the patient the risks/benefits of proceeding with VBAC on admission. Determine if the patient's risk level has changed, or patient choice has changed. This review should be documented in the medical record.
- Lab/Blood Bank Preparation
  - Type and Screen, or Type and Cross depending on the institution's 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.
- In Active Labor (4-5 cm dilated).
  - Continuous Electronic Fetal Monitoring.
  - Place 18 gauge IV.
- All patients attempting VBAC should have their labor progress monitored carefully to ensure adequate progress.

Intra-partum Management:

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.

Caveats:

- Misoprostol is associated with a high rate of uterine rupture and should not be used when a living fetus is still in-utero (4) (Level A). It may be used after delivery for uterine atony.