The Centre For Women's Reproductive Care
Baringa Private Hospital, Mackays Rd
Coffs Harbour NSW 2450

Harvey Ward
MB ChB, BSc(Med), FCOG (SA), Mmed (O&G), FRANZCOG
Obstetrician & Gynaecologist
LSPN: 004001
Phone: 0266521266
Fax: 0266 509566

Guidelines for Trial of Scar (or Vaginal Birth after Caesarean – VBAC)

1. Patients are counselled that VBAC is not appropriate if:

   - There is a classical, T-shaped or unknown uterine incision
   - More than one CS has been performed
   - The previous CS was performed for failure to progress in the active phase of labour i.e. >4 cm dilated
   - Their BMI is >35

2. In the absence of other specific contraindications to a trial of scar all patients who have had one previous CS are told by their GP and/or obstetrician that there is considerable medical controversy about the risks and benefits to the baby and mother from VBAC and elective repeat Caesarean section. They are invited to:

   - Read on the subject
   - Defer any decision until they have booked at the hospital and discussed their birth plan with a midwife and their obstetrician

3. Patients who wish to pursue the option of VBAC are referred for specific counselling to a class or for one-to-one education.

4. Induction of labour by amniotomy +/- oxytocin infusion in safe working hours is recommended at 39 – 41 weeks gestation if the fetal head is engaging (no more than 3/5 palpable) and the cervix is ripe (less than 1 cm long and dilated >2 cm). A sweep of membranes >36 hours prior to the formal induction of labour is recommended.

   A Foley catheter but not prostaglandins is acceptable for cervical ripening.

5. If the pregnancy is normal and the patient declines induction of labour, observation until the end of the 41st completed week is acceptable.

6. When a patient who is deemed suitable for a trial of scar (including those who were intending to undergo elective CS) is admitted in spontaneous labour the supervising obstetrician or registrar attends within two hours of the admission to assess and counsel the patient.

7. Epidural anaesthesia is acceptable for analgesia according to the usual criteria.

8. Continuous fetal monitoring is required when oxytocin infusion or epidural anaesthesia is in use. Patients undergoing a trial of scar may be otherwise monitored by intermittent auscultation or intermittent CTG according to current guidelines. If intermittent auscultation is used for monitoring then this shall occur no less frequently than ¼ hourly and for not less than one minute at a time during the active phase of labour.

9. Caesarean section is recommended if there is failure to progress or fetal distress occurs.

   "Fetal distress" is defined as a scalp lactate of >4.8 or CTG changes of such severity that a scalp lactate is deemed inappropriate.

   "Failure to progress" in the first stage is defined as <1 cm per hour dilatation for not less than 4 hours despite adequate uterine activity and the cervix is >3 cm dilated.

   "Failure to progress" in the second stage is defined as failure to descend to a low pelvic station within 60 minutes of effective maternal pushing.

   Assisted delivery including trial of forceps/ventouse is recommended according to standard obstetric dictates.