# Vaginal Birth After Cesarean Section

Clinical Practice Guideline from multiple sources including the American College of Obstetrics and Gynecology

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Recommendation</th>
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| **Indication for a labor or vaginal birth after cesarean section (VBAC):** | ✓ If no contraindications exist, a woman with one previous cesarean section with a low transverse incision should be counseled and encouraged to attempt labor in her current pregnancy.  

✓ Prior cesarean for “failure to progress” or “cephalopelvic disproportion” are not contraindications to a trial of labor.  

✓ If no contraindications exist, a woman with two or more previous cesarean sections with low transverse incision who wish to attempt vaginal birth, should not be discouraged from doing so.  

✓ When the decision is made to attempt labor, professional and institutional resources must be present and have the capacity to respond to acute intrapartum obstetrical emergencies such as performing a cesarean delivery within 30 minutes from the time the decision is made until the surgical procedure is begun. |

| **Contraindications to trial of labor (cesarean delivery recommended):** | ✓ A previous classical uterine incision is a contraindication to trial of labor  

✓ Women who have a complete placenta previa or transverse lie are not candidates for trial of labor  

✓ True cases of fetal distress appropriately observed on electronic fetal heart rate monitoring and interpreted by the obstetrician necessitate immediate operative delivery.  

✓ Elective repeat cesarean may be considered in cases in which the estimated fetal weight is greater than 5,000 grams in normal pregnancies or greater than 4,500 grams in diabetic patients (with consideration given to the perceived accuracy of sonographic estimates of fetal weight).  

✓ Cesarean delivery in cases of severe maternal PIH or systemic diseases should be evaluated individually utilizing prudent clinical judgment. |

| **Management considerations:** | ✓ Reference Prenatal / Perinatal Care Guideline (PHG-003)  

✓ Cesareans for failure to progress performed before the cervix has reached 4 cm. of dilation are generally not indicated.  

✓ Arbitrary time limits should not be placed on the second stage of labor especially if epidural anesthesia is being utilized.  

✓ Electronic fetal heart rate monitoring should be used appropriately and interpreted by qualified personnel to avoid over-interpretation of subtle monitor findings.  

✓ Epidural anesthesia is acceptable in a patient attempting VBAC.  

✓ Oxytocin used for induction or augmentation of labor in a patient with previous low transverse cervical cesarean section is not contraindicated.  

✓ Vaginal birth after cesarean section with twin gestation or breech presentation remains controversial. |

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DISCLAIMER
This guideline represents the recommendations of one or more of the following: published medical resources; the medical management of PacifiCare Health Systems, the Technology Assessment and/or Quality Management Committees of its respective health plans, its physicians and specialists that service its members or consult to it for such purposes. As a guideline, it is intended to provide information to aid physicians; it is NOT a substitute for physician judgment in treating individual patients.

The guideline is also subject to change, pending the release and review of additional data by the health plan and its internal review committees or as authorized by leading national accredited medical organizations and/or federal or state regulatory agencies. Updated guidelines will be distributed to contracting groups upon review and revision by the health plan. Should you have questions or concerns about these recommendations, please write, call or contact your PacifiCare/Secure Horizons Clinical Services Representative.

PacifiCare QI Committee Information

| Original Guideline Date:   | 8/27/97 |
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Clinical Practice Guideline has been reviewed for consistency with PacifiCare’s UM Criteria, Benefit Interpretation and Member materials.