

DEPARTMENT OF THE ARMY
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Medical Services

**TRIAL OF LABOR FOR PATIENTS ATTEMPTING VAGINAL BIRTH AFTER
PREVIOUS CESAREAN DELIVERY**

- 1. HISTORY.** This issue revises paragraphs 4, 8a(2), and 8b(1) and updates publication/expiration dates and authentications.
- 2. PURPOSE.** This circular provides standardized guidance to promote maximum effectiveness and safety to the maternal-fetal unit during trial of labor (TOL) for vaginal birth after cesarean (VBAC) section delivery and to provide an optimal environment and psychosocial support to the patient.
- 3. APPLICABILITY.** This policy applies to all health care professionals in those U.S. Army Medical Command (MEDCOM) facilities that are eligible (by virtue of having qualified personnel, adequate staffing, and appropriate equipment/anesthesia/facilities) to provide VBACs.
- 4. REFERENCES.** American College of Obstetricians and Gynecologists Practice Bulletin Number 54 July 2004, Clinical Management Guidelines for Obstetrician-Gynecologists Vaginal Birth After Previous Cesarean Delivery.
- 5. EXPLANATION OF ABBREVIATIONS.**

BTL.....bilateral tubal ligation
 C/S.....cesarean section
 MEDCOM.....U.S. Army Medical Command
 OB/GYN.....obstetrics/gynecology
 TOL.....trial of labor
 VBAC.....vaginal birth after cesarean

* This circular supersedes MEDCOM Circular 40-18, 1 May 2003.

6. RATIONALE.

a. Recent data show that 60-80 percent of TOL patients deliver vaginally. TOL is a reasonable alternative to repeat cesarean sections (C/Ss) in those patients who meet criteria and elect to undergo a TOL.

b. Advantages for those who have a successful VBAC include fewer blood transfusions, fewer postpartum infections, shorter hospital stays, and more rapid healing.

7. RISKS. The two most common risks associated with TOL for patients attempting VBAC are listed below. Patients will be informed of these risks when MEDCOM Form 746-R (TEST) (Medical Record-Consent Form for Patients with Previous Cesarean Birth) is signed (see appendix A).

a. Uterine rupture or dehiscence.

b. Necessity for C/S.

8. PATIENT SELECTION.

a. Selection criteria. The patient has—

(1) A desire for TOL.

(2) One prior C/S or two prior C/Ss with a prior vaginal delivery.

(3) A clinically adequate pelvis.

(4) No evidence of classical uterine incision or extension of vertical uterine incision into the contractile portion of the uterine corpus.

(5) No other uterine scars.

(6) No previous uterine rupture.

(7) No maternal or fetal contraindications to labor.

(8) Available functioning fetal/uterine monitors in the treatment facility.

b. Potential contraindications include—

(1) More than one prior C/S (except as noted in 8a(2) above).

(2) Unknown uterine scar.

- (3) Breech presentation.
- (4) Multifetal gestation.
- (5) Suspected macrosomia.
- (6) Post dates pregnancy.
- c. Contraindications include—
 - (1) Patient does not desire TOL or requests C/S.
 - (2) Any contraindication to labor--medical or obstetric.
 - (3) Inability to perform emergency C/S due to surgeon, anesthesia, staffing, or facility constraints.
 - (4) Prior classical or t-shaped incision or other transfundal uterine surgery.
 - (5) Contracted pelvis.

9. OTHER PATIENT CONSIDERATIONS.

- a. Patients are strongly encouraged to participate in childbirth preparation classes.
- b. Pitocin augmentation or induction is not contraindicated.
- c. Patients who desire a BTL should be allowed a TOL if desired.

10. STANDARD PROCEDURES.

a. Appropriate personnel (anesthesia and obstetrical) will be notified that a TOL is in progress and remain in the hospital throughout the active phase of labor until delivery is accomplished.

(1) A physician who is independently privileged to monitor and evaluate labor and perform an emergency C/S delivery shall be immediately available in the hospital throughout active spontaneous/augmented labor or at the initiation of labor induction.

(2) Anesthesia and personnel for emergency cesarean delivery shall be available in the hospital throughout active spontaneous/augmented labor or at the initiation of labor induction.

b. Routine admission procedures will be followed, including type and screen for two units packed red blood cells.

c. A patient whose antepartum care has been provided by a family practice department or by a certified nurse midwife service, may continue to be managed by this service during labor. However, if the patient's intrapartum course is managed by a provider who is not independently privileged to perform cesarean delivery, then the obstetrician/gynecologist on call must be notified of the patient's admission and plan for VBAC attempt and this physician must remain in house throughout the active phase of labor until delivery is accomplished.

d. If non-obstetrics/gynecology (OB/GYN) providers (irrespective of their privileging status) managing a TOL patient, observe or consider any of the following procedures or conditions prior to or following admission, patient management should be reassessed in consultation with the OB/GYN provider on call:

- (1) Induction of labor.
- (2) Oxytocin augmentation of labor.
- (3) Chorioamnionitis.
- (4) Labor dystocia (abnormal labor course).
- (5) Nonreassuring fetal heart tracing (especially repetitive variable decelerations which are often the initial sign of uterine scar separation).
- (6) Meconium-stained amniotic fluid.

NOTE: This list is not all inclusive. While some circumstances may necessitate a repeat consultation with an OB/GYN physician, others may require a transfer of patient management to the OB/GYN service.

e. The patient will receive counseling and obtain consent using the VBAC consent form, MEDCOM Form 746-R (TEST).

f. Guidelines for routine labor care and/or care of patients with pitocin augmentation or induction will be followed.

g. Use of prostaglandin cervical ripening agents for induction of labor are not generally recommended and should not be considered unless in consultation with an obstetrician/gynecologist.

h. Continuous assessment of maternal/fetal status by a professional nurse and a privileged provider is mandatory.

i. The patient will be monitored with continuous electronic fetal monitoring during labor.

- j. The patient's oral intake may be restricted.
- k. Analgesics are offered as requested by the patient and epidural anesthesia is encouraged.
- l. Vaginal bleeding should be checked carefully to distinguish normal bloody show from excessive bleeding.
- m. The suprapubic area should be observed pre- and post-voiding for evidence of asymmetrical or abnormal contours indicating hematoma formation or fetal parts extruding from the uterus.
- n. Routine recovery care will be provided with particular attention paid to signs of uterine rupture including postpartum hemorrhage, hypotension, tachycardia, and abdominal pain.
- o. Should the patient require a C/S, care will be provided in accordance with the locally developed standard operating procedure addressing C/S care.

Appendix A

Appendix A contains the following "-R" form (authorized for local reproduction).

MEDCOM Form 746-R (Medical Record - Consent Form for
Patients with Previous Cesarean Birth)

MEDICAL RECORD - CONSENT FORM
For Patients With Previous Cesarean Birth
For use of this form see MEDCOM Cir 40-18

1. I understand that I have had one or more prior cesarean section(s) with an incision in the non-contracting part of my uterus.
2. I understand that I have the option of undergoing an elective repeat cesarean or attempting a vaginal birth after cesarean section(s) (VBAC).
3. I understand that approximately 60-80 percent of women who undergo a VBAC will successfully deliver vaginally.
4. I understand that the risk of uterine rupture during VBAC in someone such as myself who has had a prior incision in the non-contracting part of my uterus is around 1 percent.
5. I understand that whenever a woman is in labor, emergency complications can occur so quickly that the medical providers in attendance may not have sufficient time to intervene to prevent death or injury to my baby and/or me. These emergency complications can occur not only in VBAC trials, but also in normal vaginal deliveries.
6. I understand that the decision to have a VBAC is entirely my own and the option of an elective repeat cesarean section has been discussed with me.
7. I understand that VBAC carries a lower risk to me than does cesarean delivery.
8. I understand that if I have a vaginal delivery, I will most likely have fewer problems after delivery and a shorter hospital stay than if I have a cesarean delivery.
9. I understand that in a majority of cases, where an urgent cesarean section is needed, there will be no ill effects to me or my infant, but occasionally urgent surgery may increase blood loss requiring transfusions and in rare cases the removal of my uterus.
10. I understand that if I choose a VBAC and end up having a cesarean section during labor, I have a greater risk of problems than if I had originally chosen an elective repeat cesarean section.

This form has been fully explained to me and I have read the VBAC information provided to me and inquired about my risks or benefits of a vaginal birth after cesarean section. All questions have been adequately answered by the physician and staff.

ANTEPARTUM VISIT:

Please initial choice:

- I want to attempt VBAC I want a repeat Cesarean Section At this time I am not sure

Patient's Signature: _____

Provider's Signature: _____

(Date)

LABOR & DELIVERY:

Please initial choice:

- I want to attempt VBAC I want a repeat Cesarean Section

Patient's Signature: _____

Provider's Signature: _____

(Date)

The proponent of this publication is the Office of the Assistant Chief of Staff for Health Policy and Services. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, U.S. Army Medical Command, ATTN: MCHO-CL-Q, 2050 Worth Road, Fort Sam Houston, TX 78234-6010.

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