DEPARTMENT OF THE ARMY
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MEDCOM Regulation
No. 40-57

16 June 2014

Medical Services

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

Supplementation of this regulation and establishment of forms other than MEDCOM forms are prohibited without prior approval from HQ MEDCOM, ATTN: MCHO-CP-A.

1. History. This issue publishes a revision that updates paragraph 10 and appendix A.

2. Purpose. This regulation 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 healthcare 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. References are listed in appendix A.

5. Explanation of abbreviations. Abbreviations used in this regulation are explained in the glossary.

6. Rationale

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

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*This regulation supersedes MEDCOM Regulation 40-57, 3 February 2012.

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 are listed below. Patients will be informed of these risks when MEDCOM Form 746 (Medical Record - Consent Form for Patients with Previous Cesarean Birth) is signed. This form is available electronically through normal forms Websites (that is, Army Knowledge Online and Enterprise Web AMEDD Electronic Forms Support System).

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) A history of one or two prior C/S.

(3) A clinically adequate pelvis.

(4) No evidence of a prior classical uterine incision or extension of a 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) Clinical suspicion that a prior uterine scar entered the contractile portion of the uterus.

(2) Breech presentation.

(3) Suspected macrosomia.

(4) Postdates 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. Oxytocin augmentation or induction is not contraindicated.

c. Patients who desire a bilateral tubal ligation 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 will remain in the hospital throughout the active phase of labor until delivery is accomplished. These procedures are the same for a patient who has already had a successful VBAC.

(1) A physician who is independently privileged to monitor and evaluate labor and perform an emergency C/S delivery will 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 will 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 procedures in (1)-(7), below, or conditions prior to or following admission, patient management should be reassessed in consultation with the OB/GYN provider on call. *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.

(1) Induction of labor.

(2) Oxytocin augmentation of labor.

(3) Chorioamnionitis.

(4) Labor dystocia (abnormal labor course).

(5) Category II or III fetal heart tracing (especially repetitive variable decelerations which are often the initial sign of uterine scar separation).

(6) Meconium-stained amniotic fluid.

(7) History of two prior cesareans.

e. The patient will receive counseling and obtain consent using the VBAC consent form, MEDCOM Form 746 (see para 7). VBAC counseling is documented in the electronic medical record if available. This includes AHLTA and Essentris documentation.

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/or 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
References

Section I
Required Publications

This section contains no entries.

Section II
Related Publications
The following references provide additional information to the user of this regulation.

American College of Obstetricians and Gynecologists (ACOG) Practice Bulletin No. 115, Vaginal Birth After Cesarean Delivery

The 2008 National Institute of Child Health and Human Development workshop report on electronic fetal monitoring: update on definitions, interpretation, and research guidelines
(Macones GA, Hankins GD, Spong CY, Hauth J, Moore T. Obstet Gynecol. 2008 Sep-Oct;112(3):661-6.)

NIH Consensus Development Conference Statement Vaginal Birth After Cesarean: New Insights

Section III
Prescribed Forms

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

Section IV
Referenced Forms

This section contains no entries.

Glossary

Section I
Abbreviations

C/S
cesarean section

MEDCOM
United States Army Medical Command

OB/GYN
obstetrics/gynecology

TOL
trial of labor

VBAC
vaginal birth after cesarean

Section II
Terms
This section contains no entries.

The proponent of this publication is the Quality Management Directorate. 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-CP-A, 2748 Worth Road, JBSA Fort Sam Houston, TX 78234-6026.

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