UNM HEALTH SCIENCES CENTER

TRIAL OF LABOR AFTER CESAREAN (TOLAC)	Policy

POLICY STATEMENT
Trial of labor after cesarean (TOLAC) is safe for women meeting criteria and offers the opportunity for a vaginal birth after cesarean (VBAC). About 75% of women who undergo TOLAC will deliver vaginally; rates are higher when the prior cesarean was for a nonrepeating indication, such as malpresentation, rather than for arrest of labor.

PURPOSE
To describe best practices for TOLAC counseling and intrapartum management.

APPLICABILITY
This policy applies to women who have had one or more prior cesarean births.

Guidelines for vaginal birth after cesarean section

1. The initial decision for a TOLAC or repeat cesarean should be determined during antepartum care using a shared decision making process; the physician or midwife counsels individually about risks and benefits including prior obstetrical history, future childbearing, and personal preference.
2. A woman with one previous low transverse cesarean section (LTCS) and no contraindications may be encouraged to consider TOLAC.
    a. Women with a prior C/S and a prior vaginal birth have close to a 90% likelihood of a successful VBAC and a slightly lower risk of uterine rupture, compared to women without a prior vaginal birth.
    b. Women with a single prior LTCS who plan additional pregnancies should be encouraged to attempt a TOLAC to prevent complications of multiple repeat cesarean births.
5. A woman with two previous LTCS may be a candidate for TOLAC. As risks may be elevated, physicians with C/S privileges should perform the counseling for candidates, ideally before or early in the third trimester; for OB-GYN Department, this can be performed by a third or fourth year OB-GYN resident (with attending attestation) or the attending. The risk of uterine rupture after two prior cesarean deliveries is about 1 in 100 compared to 1 in 200 for women with a single prior cesarean. The revised estimate should be entered on the UNM TOLAC consent form.

6. When specific data on risks are lacking (e.g., women with a history of more than two prior cesarean births), the physician with C/S privileges should counsel and employ shared decision-making on a case-by-case basis.
7. Contraindications to TOLAC:
    a. Previous classical uterine incision
    b. Vertical extension of a uterine incision into the contractile segment of the uterus
    c. High transverse incision into the contractile segment of the uterus
    d. Myomectomy that enters the uterine cavity
8. Women with contraindications should be scheduled for repeat cesarean birth at 36-38 weeks per ACOG guidelines (1).
9. The L&D unit must have the capacity to respond to acute intrapartum obstetric emergencies and perform cesarean birth within 30 minutes from decision to incision.
10. Women who choose TOLAC may continue normal activity during the latent phase of labor; there is no need for early admission and continuous monitoring before active labor has begun.
11. A physician who is capable of evaluating labor and performing a cesarean should be readily available.

Counseling for TOLAC vs. repeat cesarean

1. Women should undergo counseling before signing the information/consent form for TOLAC or repeat cesarean birth. Ideally, the form should be signed prior to 30 weeks gestation. For women with a history of two or more prior cesarean births, this counseling should be performed by a physician with cesarean privileges.
2. Patient should have a clear understanding of the risks and benefits:
    a. Risk of uterine rupture (see information/consent)
    b. Current data indicate
        i. maternal mortality rates for VBAC are lower than those for repeat cesarean births.
        ii. neonatal morbidity and mortality rates are higher for women attempting VBAC than those for repeat cesarean births.
    c. Benefits of VBAC include elimination of operative complications and shorter hospital stay.

Women should have ongoing consultation regarding mode of delivery based on individual circumstances. Examples are women planning TOLAC who require labor induction with an unripe cervix or women planning repeat cesarean who present in advanced labor.

Intrapartum procedures for TOLAC

1. Continuous fetal monitoring is standard throughout active labor. An internal fetal scalp monitor should be used if a continuous monitor strip of acceptable

quality is not possible with an external monitor, as may occur due to maternal habitus. Telemetry is acceptable for fetal monitoring.

2. An intrauterine pressure catheter (IUPC) is desirable when oxytocin is used for augmentation or induction with rupture of membranes. An IUPC is not required for all women having a TOLAC on oxytocin, but should be strongly considered with inadequate labor progress with oxytocin induction or augmentation.
3. An attending physician with cesarean privileges, anesthesia provider, and operating room team (nurse, scrub tech) should be immediately available during active labor. If uterine rupture occurs, good neonatal outcomes are increased when the time from decision to delivery is eighteen minutes or less.

Intrapartum management guidelines

1. Upon admission:
    a. Obtain T&S
    b. Obtain intravenous access with an 18 gauge or larger catheter.
    c. Continuous fetal monitoring if patient is in active labor, or a reactive NST if patient is not in active labor.
    d. Notify attending maternity care provider and the covering cesarean provider (if not the same) of patient's admission for TOLAC.
    e. Obtain formal consultation from attending OB/GYN or the Family Medicine MCH faculty with cesarean privileges for women with more than 1 prior C/S if not done prior to admission. Documentation should include a clear plan for co-management between the CNM and Obstetrics services, including active-involvement in assessing the patient's progress through labor. Notify attending physician of admission. For the OB-GYN Department, the counseling may be done by a third or fourth year resident (attested by the attending) or by the attending.
    f. Confirm the presence of a UNM TOLAC consent form in the chart and complete it on L&D if not present after counseling.
    g. Re-counsel the patient upon admission or during labor if the clinical scenario changes.
2. Use oxytocin for labor induction or augmentation per the "slow" oxytocin regimen, which starts at one mU/minute and increases by one mU/minute every 30 minutes until 10 mU/minute then by 2 mU/minute every 30 minutes until an adequate contraction pattern is reached.
3. Foley or Cook Catheter are generally considered safe mechanical methods for cervical ripening for induction of labor in women with a history of cesarean birth.
4. **Misoprostol is strictly contraindicated.**
5. Document vital signs, FHT, and contractions per unit protocols and clinical circumstances on the nursing flow sheet until the patient is in active labor.
6. Once in active labor, nursing responsibilities include:

a. Continuous fetal monitoring.
b. Nursing care appropriate to the clinical scenario.
c. Ensuring complete newborn resuscitation equipment is available.
d. Documentation of vital signs, fetal heart, and quality/quantity of contractions per unit protocols with frequency based on clinical circumstances.

REFERENCES

Graseck A, Tuuli M, Roehl, K et al. Fetal Descent in Labor. Obstet Gynecol. 2014:123; 521-6.

Cheng Yw, Shaffer BL, Nicholson JM and Caughey AB. Second Stage of Labor and Epidural Use. Obstet and Gynecol. 2014; 123:527-535.

Roberts J and Hansen L. Best Practices in second stage of labor care: maternal bearing down and positioning- an analysis of current second stage labor management. JNWH 2007

Kelly et al Delayed versus immediate pushing in second stage of labor. MCN Am J Matern Child Nursing 2010:35: 81-88

Rouse DW Seond stage labor duration in nullipara women:relationship to maternal and perinatal outcomes. AJOG 2009;357 e1-e7

Zhang J, Troendle J, Mikolajczyk et al. The natural history of the normal first stage of labor. Obstet Gynecol 2010; 115:705-710.

Sprague AE, Oppenheimer L, McCabe L et al. The Ottava Hospital Clinical Practice Guideline for the second stage of labour. J Obstet Gynaecol Can 2006: 28:769-79.

Caughey, A, et al. Safe prevention of the primary c-section. AJOG March 2014 p, 179

Laughon SK, Berghella C, Reddy UM et al. Neonatal and maternal outcomes with prolonged second stage of Labor. Obstet Gynaecol. 2014;124:57-67

Committee Opinion No. 560: Medically Indicated Late-Preterm and Early-Term Deliveries. (2013). Obstetrics and gynecology -New York-, 121(4), 908-910.

APPROVAL

Prepared by: Andrews, Nardini, Leeman

Approved by: _____

Approval: _____ 11/28/16

Chair, Department of Obstetrics & Gynecology — Date

SOP # / Version #	Effective Date	Supersedes	Review Date	Summary of Change(s)
1	6/30/15			
2	11/28/16	Version 1	11/28/16	Yearly review and update of procedure