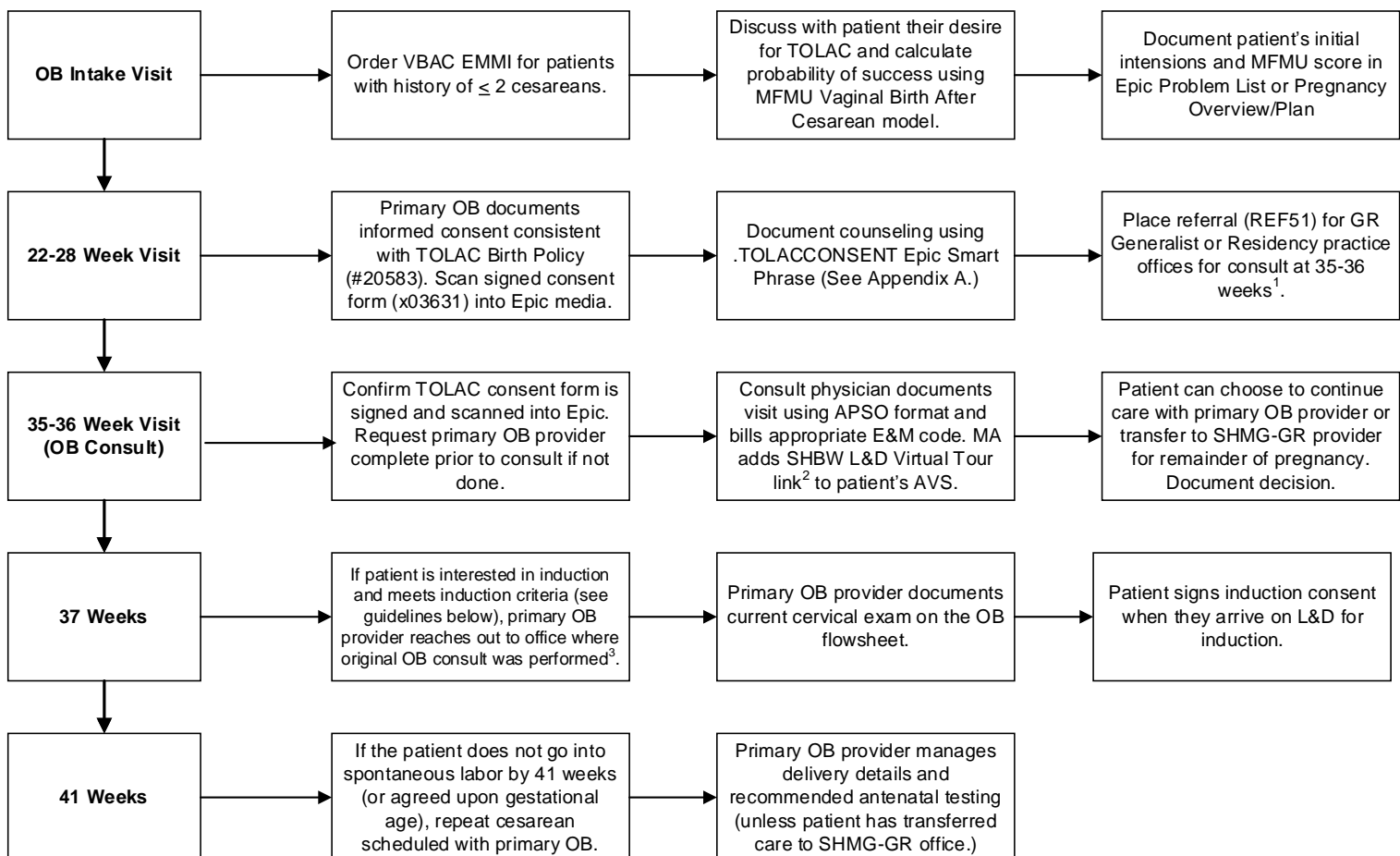


Guideline: Trial of Labor After Previous Cesarean (TOLAC) Referral Process, Outpatient/Inpatient

Updated: October 28, 2021

Clinical algorithm:



1. The following offices do TOLAC consults: SHMG OBGYN 3800, SHMG OBGYN 2750 ICCB, SHGR OBGYN Residency 330, SHMG OBGYN 221. If the patient is being referred after 32 weeks, please call the office directly. Encourage the patient to consult virtually.

2. Link: <https://www.spectrumhealth.org/patient-care/womens-health/obstetrics>

3. Date of induction may be up to two weeks AFTER OB consult is notified patient desires induction. Timing of induction is dependent on availability of induction spots on L&D.

Clinical pathway/guideline summary

CLINICAL PATHWAY/GUIDELINE NAME: Trial of Labor After Previous Cesarean (TOLAC) Referral Process, Ambulatory

PATIENT POPULATION AND DIAGNOSIS: Pregnant patient requests attempted vaginal delivery after previous cesarean delivery.

APPLICABLE TO: Spectrum Health Medical Group – Generalist and Residency practice offices in Grand Rapids with birth planned at the Spectrum Health Butterworth campus

BRIEF DESCRIPTION: This guideline outlines the referral process for our regional and CNM colleagues to the Spectrum Health Medical Group – Generalist and Residency practice offices in Grand Rapids to facilitate birthing people attempting a planned vaginal birth after cesarean at the Spectrum Health Butterworth campus.

We are concerned about the barriers birthing people face in gaining access facilities able to offer a trial of labor after a previous cesarean. Therefore, we support antenatal referral of candidates to Spectrum Health Butterworth Hospital. There is a desire by the providers in SHMG to keep practice standards consistent across our Grand Rapids and regional practices.

OVERSIGHT TEAM LEADER(S): Sue West, MD

OWNING EXPERT IMPROVEMENT TEAM (EIT): Women's Health Ambulatory

MANAGING CLINICAL PRACTICE COUNCIL (CPC): Women's Health

CPC APPROVAL DATE: August 24, 2021

OTHER TEAM(S) IMPACTED (FOR EXAMPLE: CPCs, ANESTHESIA, NURSING, RADIOLOGY): none

IMPLEMENTATION DATE: September 1, 2021

LAST REVISED: October 28, 2021

FOR MORE INFORMATION, CONTACT: Sue West, MD

Clinical pathways clinical approach

A. TOLAC Candidates:

“Good candidates for planned TOLAC are those women in whom the balance of risks (as low as possible) and chances of success (as high as possible) are acceptable to the patient and health care provider.”

“Although there is no universally agreed on discriminatory point, evidence suggests that women with a least a 60-70% chance of VBAC have equal or less maternal morbidity when they undergo chance of TOLAC than women undergoing elective repeat cesarean delivery. Similarly, because neonatal morbidity is higher in the setting of a failed TOLAC than in VBAC, women with higher chances of achieving VBAC have lower risks of neonatal morbidity.”
(ACOG Practice Bulletin No 205, 2019).

Patients who are considered optimal candidates for a trial of labor include:

- a. One prior low-transverse or low-vertical uterine incision
- b. Clinically adequate pelvis
- c. No other uterine scar or previous rupture
- d. History of previous cesarean delivery with an interdelivery interval of > 18 months
- e. The probability that the birthing patient attempting TOLAC will achieve VBAC of 60% or more using the MFMU Vaginal Birth after Cesarean model (<http://www.bsc.gwu.edu/mfmu/vagbirth.html>). This model was developed specifically for birthing patients undergoing TOLAC at term with one prior low transverse cesarean delivery incision, singleton pregnancy, and cephalic fetal presentation.
- f. Indication for prior cesarean section other than arrest of dilation or descent

Patients who are considered good candidates for a trial of labor include:

- a. Two prior low-transverse or low-vertical uterine incision
- b. Unknown uterine scar type with low suspicious for classical uterine incision
- c. Twin gestation
- d. Preeclampsia
- e. The probability that the birthing patient attempting TOLAC will achieve VBAC of 60% or more using the MFMU Vaginal Birth after Cesarean model (<http://www.bsc.gwu.edu/mfmu/vagbirth.html>). This model was developed specifically for birthing patients undergoing TOLAC at term with one prior low transverse cesarean delivery incision, singleton pregnancy, and cephalic fetal presentation.
- f. Indication for initial cesarean was labor dystocia

Patients who are considered poor candidates for a trial of labor because of the increased maternal and perinatal morbidity and TOLAC will be strongly discouraged:

- a. Pre-pregnancy BMI ≥ 50
- b. Three or more prior cesarean sections regardless of a prior vaginal delivery
- c. The probability that the birthing patient attempting TOLAC will achieve VBAC of less than 60% using the MFMU Vaginal Birth after Cesarean model (<http://www.bsc.gwu.edu/mfmu/vagbirth.html>).
- d. Previous classical or T-shaped incision

- e. Extensive transfundal uterine surgery
- f. Previous uterine rupture
- g. History of previous cesarean delivery with an interdelivery interval of ≤ 18 months
- h. Medical or obstetric complications that preclude vaginal delivery

B. Induction and Augmentation:

Induction – Induction by mechanical means or Pitocin increases the risk of uterine rupture by an additional 1-2% when compared to spontaneous labor. The risk of uterine rupture is no more likely to occur when labor is induced with an unfavorable cervix compared to when labor is induced with a favorable cervix. Labor induction at 39 weeks is associated with lower odds of cesarean delivery when compared to expectant management. VBAC rates are higher among birthing patients undergoing induction of labor at 39 weeks compared with expectant management. Based on the available data, pregnant patients without spontaneous labor by 39 weeks will be considered for an induction of labor only if they meet the following criteria:

- a. One prior low-transverse or low-vertical uterine incision
- b. Pre-pregnancy BMI ≤ 50
- c. The probability that the birthing patient attempting TOLAC will achieve VBAC of 60% or higher using the MFMU Vaginal Birth after Cesarean model (<http://www.bsc.gwu.edu/mfmu/vagbirth.html>).
- d. History of previous cesarean delivery with an interdelivery interval greater than 18 months
- e. No history of transfundal uterine surgery or prior uterine rupture.

Augmentation – A strong association between augmentation with Pitocin and increased risk of uterine rupture has not been documented. Therefore, Pitocin for augmentation will be considered in all birthing patients who present in spontaneous labor if they meet the following criteria:

- a. One prior low-transverse or low-vertical uterine incision
- b. History of previous cesarean delivery with an interdelivery interval greater than 18 months
- c. No history of transfundal uterine surgery or prior uterine rupture.

References:

1. ACOG Practice Bulletin No. 205: Vaginal Birth After Cesarean Delivery. AU SO Obstet Gynecol. 2019;133(2):e110.
2. Obstetric outcomes in women with two prior cesarean deliveries: is vaginal birth after cesarean delivery a viable option? AU Macones GA, Cahill A, Pare E, Stamilio DM, Ratcliffe S, Stevens E, Sammel M, Peipert J SO Am J Obstet Gynecol. 2005;192(4):1223.
3. Can uterine rupture in patients attempting vaginal birth after cesarean delivery be predicted? AU Macones GA, Cahill AG, Stamilio DM, Odibo A, Peipert J, Stevens EJ SO Am J Obstet Gynecol. 2006;195(4):1148.

4. Maternal-Fetal Medicine Units Network. Vaginal birth after cesarean [calculator]. <https://mfmunetwork.bsc.gwu.edu/PublicBSC/MFMU/VGBirthCalc/vagbirth.html>

Appendix:

TOLACCONSENT Smartphrase

“The risks of TOLAC (trial of labor after cesarean) and repeat cesarean were discussed at length with the patient. The risks of TOLAC include the risk of uterine rupture with permanent damage to the patient, baby, or both. Discussed the fact that we cannot predict uterine rupture so we cannot prevent it. For the birthing patient, the risk of uterine rupture may include but is not limited to risk of infection, blood transfusion, damage to bowel, bladder and surrounding structures, hysterectomy, blood clotting issues and in rare cases, death. For the fetus, the risk of uterine rupture includes but is not limited to permanent neurological impairment, the need for lifelong care or death. The major risks of a repeat cesarean include but are not limited to increased risk of respiratory disease in newborn, increasing risk of injury to intraabdominal structures with each subsequent cesarean and an increased risk of placenta accreta with possible loss of uterus. Patient is aware that a successful TOLAC has a lower risk to her than a planned repeat cesarean, but a failed TOLAC carries a higher risk than a repeat cesarean. We discussed that not all patients attempting TOLAC are candidates for induction or augmentation using Pitocin and the decision is ultimately up to the provider on call. All questions answered.

The patient's success rate for TOLAC via the MFMU VBAC calculator is ***% based on prior cesarean done for {prior cesarean indications:59739}. **I recommended {Delivery recommendation:59740}**. The patient desires {desired delivery:59741}. Consent form signed {yes date/no:50604}. Patient given a copy and original scanned into Epic. Backup cesarean scheduled for {weeks gestation:59742} weeks.”

TOLACPitocinCONSENT Smartphrase

“Patient counseled that the use of Pitocin with a TOLAC may increase risk of rupture to 1.1% (approximately double baseline risk). Patient is further aware that oxytocin doses >10 mu/min are also associated with increased risk of rupture. The maximum oxytocin dosing that is recommended is 20 mu/min.

Patient expresses understanding and agreement with this and is accepting of the increased risk of uterine rupture as well as the limitations on oxytocin dosing. All questions answered.”