

Trial of labor after cesarean guidelines  
Alaska Native Medical Center – OB/GYN Services

## Background

Approximately 10% of our obstetric patients at ANMC have had a prior cesarean delivery. About 60% of the women in our population who have had a prior cesarean will elect a trial of labor after cesarean (TOLAC). The rate of uterine rupture in women who attempt a trial of labor after cesarean in the existing studies is 0.4 - 0.8%, or approximately 1 /200. We wish to continue to honor patient choice, and assure patient safety, deliver quality services and avoid dangerous situations for both women and staff. These guidelines are derived from best practices and are part of a comprehensive plan to achieve those goals.

Women with one previous low transverse cesarean delivery, who are otherwise appropriate candidates for twin vaginal delivery, may be considered candidates for trial of labor after cesarean delivery.

## Procedure

1. Consent
  - a. Most women with one or two prior cesarean delivery(s) with low transverse uterine incision are candidates for TOLAC and should be counseled about the risks, benefits, alternatives and offered a trial of labor.
  - b. The patient may be counseled by a midwife, but should have a physician visit as well to sign the consent at around 20-32 weeks gestation. (see Consent Form).
  - c. The prior operative note documenting a low transverse uterine incision should be sought.
  - d. The patient's desire for TOLAC should be re-confirmed when the patient presents in labor. This conversation can be documented in the Progress Notes. No new consent form signature is needed
2. Stratification of TOLAC patients – applies to patient admitted in active labor
  - a. all patients undergoing TOLAC should have:
    1. a large bore 1V in place
    2. type and screen, CBC
    3. continuous monitoring in active labor
    4. the option of epidural analgesia
    5. provider who has privileges to perform cesarean delivery in-house
  - b. Patients agreeing to a TOLAC should be categorized as low, intermediate, or high risk on the basis of the following:

Low risk:

    1. one or two prior low transverse cesarean delivery(s)

2. spontaneous onset of labor
3. Category I fetal heart rate tracing

Intermediate risk:

1. augmentation or induction of labor
2. Category II FHR tracing – not Category III

High risk:

1. no change in dilation or descent after 2 hours of adequate labor
2. bleeding (considered not to be cervical ‘show’)
3. Category III FHR tracing

3. Management in Labor by Risk Category

Low risk:

1. Midwife in-house
2. Obstetrician in-house and has confirmed patient’s desire for TOLAC\*
3. Anesthesia aware of and has interviewed patient

Intermediate risk:

1. Midwife on L&D
2. Obstetrician readily available
3. Obstetrician made aware of change in risk levels and reassesses patient
4. Anesthesia aware of and has interviewed patient, and available in-house
5. Non-prostaglandin methods including a low dose oxytocin regimen are acceptable for augmentation or inductions. A low dose oxytocin regimen starts at 0.5-2.0 mU of oxytocin per minute and may be increased by 1-2 mU/min q 15-40 minutes intravenously.

High risk:

1. Both midwife and obstetrician on L&D with no other patient care responsibilities
2. Anesthesia available to L&D with no other patient care responsibilities

## References

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Northern New England Perinatal Quality Improvement Network  
<http://www.nnepqin.org/>

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