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Midwife-led Birth after Caesarean Pathway

SHIP LMS Pathways

Aims

- To enable midwives to feel confident to:
  - Appreciate why the named midwife is the right person to guide and reassure women.
  - Outline the potential complications of vaginal birth after caesarean.
  - Develop ways of tailoring discussions to the individual woman.
  - To understand what factors may influence the woman's choice.
  - How to care for women in labour following a previous caesarean

Why the community midwife?

- Earlier, ongoing and consistent advice
- The decision does not have to be made in one appointment.
- Less consultant clinic time taken up with discussions that midwives are capable of conducting
- Midwives are more likely to favour vaginal birth
- Midwives know what is important to their caseload of women

Advantages of VBAC

- Length of hospital stay
- Quicker recovery
- Thromboembolism:
  - with CS ≈ 1%
  - with vaginal birth ≈ 0.2%.

  This is a fivefold increase in risk (Lindqvist et al, 1999)
- Subfertility
- Placenta accreta
- Respiratory distress syndrome in the Newborn CS 4% vs VBAC 1%
- Women who have a vaginal birth are more likely to breastfeed than those who have a caesarean (Pasupathy & Smith, 2008)
- Asthma up to 12 years higher with CS 3.8% versus 3.1% (Keag 2018)
- Obesity at all ages up to 28 years higher with CS group up to 5 years 13% vs 9.2%

Uterine Rupture

Definition:

Symptomatic rupture of the uterine muscle requiring surgical repair, or the extrusion of fetal parts (NICE, 2004).

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Risks of VBAC

Probability of uterine rupture after caesarean

- Spontaneous onset of labour risk = 0.2%/2:1,000
- Induced with prostaglandins risk = 0.5%/5:1,000
- No significance evidence of difference in outcomes for baby between VBAC or LSCS
- 43% of stillbirths occur after 39 weeks gestation – so these are avoided by ERCS if carried out at this stage at this stage.
- Risks of needing an emergency caesarean in labour.

The *absolute* risk of perinatal death related to VBAC is comparable to the risk for primiparous women (Smith et al, 2002)

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No difference ERCS vs Successful VBAC

- Maternal mortality (Guise et al, 2004; Landon et al, 2004).
- The need for hysterectomy (Guise et al, 2004; Landon et al, 2004).
- Rates of genital tract injury i.e. extension of the uterine incision or cervical lacerations (as quoted by NICE, 2011).
- The incidence of dyspareunia (pain on sexual intercourse) at three months after birth (as quoted by NICE, 2011).
- The rate of faecal incontinence at three months after birth (as quoted by NICE, 2011).
- The rate of postnatal depression or post-traumatic stress disorder (as quoted by NICE, 2011).

Elective Repeat Caesarean Section

- Avoids the risk of needing an emergency caesarean
- Avoids the risk of stillbirth beyond delivery date
- Convenience
- Increased risk of PPH requiring blood transfusion
- Increased risk of infection
- longer hospital stay and recovery
- Complications for future pregnancy, placenta praevia and accreta
- Potential benefits of vaginal birth (microbiome)
- Human Microbiome and Birth

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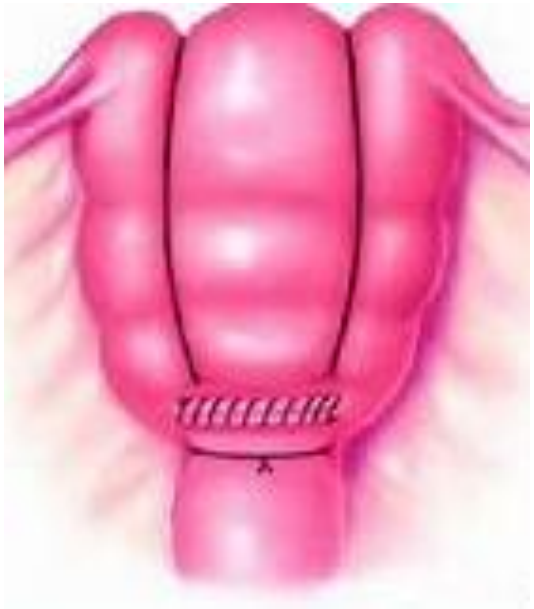
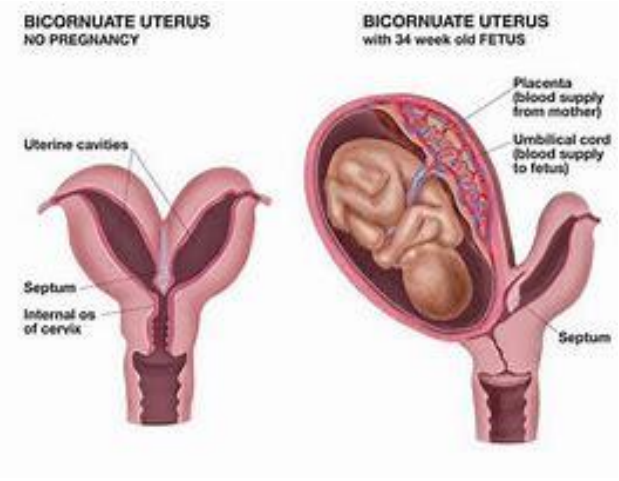
Women who may be unsuitable

- More than 1 previous caesarean
- B-lynch suture
- Pre-term caesarean
- Known uterine abnormality
- Previous uterine surgery





Are the statistics the same for everyone?

	Most likely	Slightly reduced	Reduced <50%
Previous Vaginal birth	Yes (85-90%)	No (72-75%)	No
Spontaneous onset of labour	Yes		No
BMI	<30	>30	>40
Age	<30	<35	>35
Reason for Caesarean Section	Malpresentation	Fetal distress	Labour dystocia following IOL with first baby
Gestation at onset of labour	≤40	>40	>42
Fetal weight	<4kg		

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Complex decision

PROS VBAC	PROS ERCS
Quicker recovery – I have to run around after young children	I can plan my childcare
I want to experience normal birth*	I want to make sure I don't have an emergency caesarean
It's safer for me	It's safer for the baby
I want to be in control -	I want to be in control– having a 'set plan'
I want my baby to have a healthy microbiome and long term health	I just want a healthy mum and baby
Normal birth is natural	VBAC is unpredictable
I want to have more children	This is my last baby
I want to prove I can do it	I can't fail again

Risk perception – putting the risk into perspective

Uterine Rupture	Placental Abruption	Umbilical Cord Prolapse	Shoulder Dystocia
2-5 out of every 1000 VBAC attempts*	11-13 out of every 1000 labours	14-62 out of every 1000 labours	6-14 out of every 1000 labours
The neonatal mortality rate associated with these emergencies			
6 out of every 100 uterine ruptures will result in a baby's death	1.25 out of every 750 placental abruptions will result in a baby's death	91 out of every 1000 babies with cord prolapsed will die	1 out of every 1000 babies with shoulder dystocia will die

Influencing factors on choice

- Personal philosophy
- Influence of family and friends
- Influence Health care professionals
- Social media
- Practicalities
- Risk perception

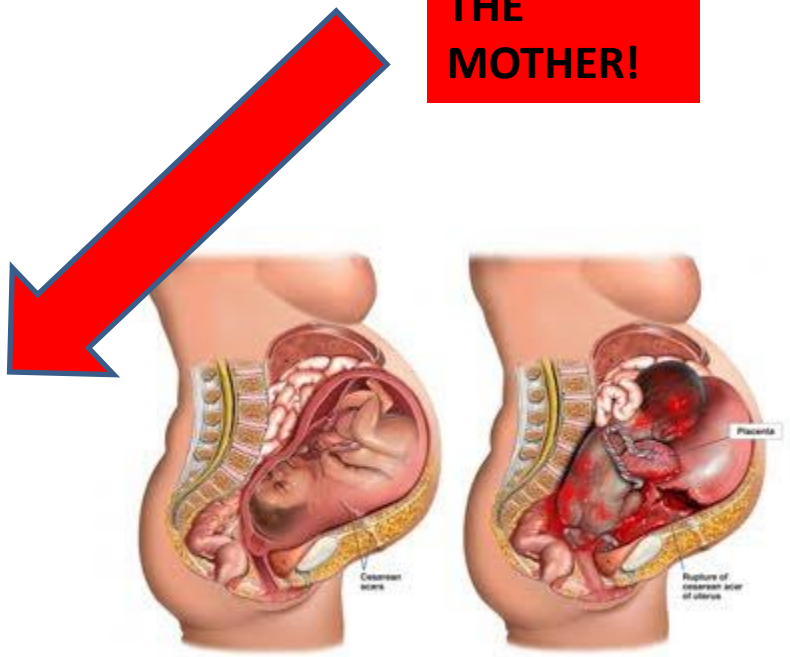
Konheim-Kalkstein et al 2017

Louise’s story

Labour care for birth after caesarean

- Latent phase
- Place of birth – consider transfer implications
- All methods of analgesia appropriate including water
- Fetal monitoring – NICE Vs RCOG
- Pelvic descent of PP and Cervical dilatation
- Maternal observations
- Signs of uterine rupture
  - Uterine tachysystole
  - Fresh PV bleeding
  - Maternal tachycardia
  - **Pain not associated with contraction**
  - Loss or presenting part
  - Loss or previous efficient contractions
  - Late decelerations in fetal heart rate
  - Profound bradycardia

LISTEN TO THE MOTHER!



Having the conversations

Self-Efficacy

- Self-efficacy is the individual's belief that they are able to perform a certain behaviour successfully in a particular context.
- Self-efficacy is influenced by individuals' past experiences in mastering the situation at hand, the vicarious experiences of others, verbal persuasion, and degree of emotional and physiological arousal.
- High self-efficacy scores have been associated with healthier psychosocial adaptation following childbirth and stronger identification with the role of motherhood
- Low self-efficacy has been reported in women experiencing potentially negative events such as a previous caesarean section
- In relation to birth choice, lower self-efficacy scores have been related to a stronger preference for Elective Repeat Caesarean Section

Schwartz et al (2015)

Key elements of counselling intervention:

Gamble et al (2007)

Therapeutic connection between midwife and woman.	Show kindness; affirm competence of the woman, simple non-threatening open questions about the birth, attentive listening and acceptance of the woman's perspective.
Accept and work with women's Perceptions.	Prompt the woman to tell her own story, listen with encouragement but not interruption.
Support the expression of feelings.	Encourage expressions of feelings by open questions, actively listening, reflecting back the woman's Concerns.
Filling in the missing pieces	Clarify misunderstandings, offer information, answer questions realistically and factually, ask questions about key aspects to check understanding. Do not defend or justify care provided.
Connect the event with emotions and behaviours.	Ask questions to determine if the woman is connecting current emotions and behaviours with prior birth experiences.
Acknowledge and validate emotions.	Gently challenge and counter distorted thinking such as self-blame and a sense of inadequacy, Encourage the woman to see that inappropriate or hasty decisions may be a reaction to the birth.
Review prior labour management.	Ask if the woman felt anything should have been done differently during labour. Offer new or more generous or accurate perceptions of the event. Realistically postulate how certain courses of action may have resulted in a more positive outcome. Acknowledge uncertainty.
Enhance social support.	Initiate discussion about existing support networks. Talk about ways to receive additional emotional support. Help the woman understand that her usual support people may be struggling with their own issues.
Reinforce positive approaches to coping.	Reinforce comments by women that reflect a clearer understanding of the situation, plan for the way forward or outline positive action to overcome distress. Counter oblique defeatist statements.
Explore solutions.	Support women to explore and decide upon potential solutions, e.g., support group(s), further one-to-one, counselling, seeking specific information.

Importance of the language that we use

- **Failure** to progress I can't do it Vs I didn't have the right conditions to do it
- Fetal **distress** the baby is suffering Vs the baby is having to use other resources to cope with the labour...as it is supposed to!
- **Emergency** Caesarean vs Unplanned caesarean
- The **Risk** of... The statistical probability of...


Control
Fear
Confidence
(self-efficacy)

Workshops

- Scenario – Faculty example

- Work in pairs - scenario

Questions