SUBJECT: Guidelines for Trial of Labor After Cesarean (TOLAC)

PURPOSE
The purpose of this policy is to develop consistent guidelines for the evaluation and management of patients with a previous cesarean delivery considering a trial of labor.

SCOPE
This policy applies to all providers of obstetrical care at the Hospital of the University of Pennsylvania (HUP) including residents, fellows, advanced practice nurses, midwives, and attending physicians.

IMPLEMENTATION
This policy will be implemented and monitored by the Director of Obstetrical Services.

PROCESS AND PROCEDURE
I. Statement of General Principles
   a. The operative report should be obtained and reviewed, ideally at first prenatal visit, and if unsuccessful, repeated efforts should be made to obtain an operative report. The operative note should be reviewed and TOLAC versus repeat cesarean as delivery options should be discussed as early as possible during prenatal care (ideally at the first visit and briefly at visits thereafter) with the patient.
   b. All prenatal providers are responsible for initiating this discussion at the screening visit and for addressing it at each prenatal visit.
   c. Counseling and discussions with the patient should be thoroughly documented in the prenatal chart.
   d. Plan may change depending on gestational age and onset of labor. This should be discussed with the patient ahead of time as part of counseling (see below under induction).
   e. Consent for TOLAC should be obtained at prenatal visit and placed in EMR.

II. Candidates for TOLAC
The following women are candidates for TOLAC:
   a. Women with one prior low transverse uterine incision.
   b. Women with one previous cesarean delivery with an unknown uterine scar type, unless there is a high clinical suspicion of a previous classical uterine incision (very preterm, preterm and malpresentation, etc.).
   c. TOLAC may be considered in women with 2 prior cesarean deliveries with a prior vaginal delivery (regardless of when the vaginal delivery occurred in the order of births) with MD consultation.
   d. TOLAC may be considered in women with two prior LTCS in the absence of prior vaginal deliveries with MD consultation.
III. Counseling for TOLAC
Counseling points to consider include,

a. Overall success rate is 60-80% but
b. Two biggest predictors of success are spontaneous labor and prior vaginal delivery
c. There is an increased risk of uterine rupture in women who have TOL compared to elective repeat CD (0.4-0.5% risk vs. 0.7-0.9% risk).
d. About 6% of uterine ruptures will result in perinatal death (0.6/1000 TOLAC patients). There is no reliable way to predict who will have a uterine rupture.
e. Plan for future pregnancies should play some role in counseling. The incidence of placenta previa significantly increases in women with each additional cesarean delivery as well as increase of placenta accreta, increta, and percreta.

IV. Induction of Labor (IOL)
Overall, induction of labor for maternal and fetal indications remains an option in women undergoing TOLAC (Level B ACOG Bulletin 2010).
Patients who are candidates for TOLAC and have consented for TOLAC during their prenatal care should be re-counseled if undelivered by 40 weeks gestational age or if expedited delivery is indicated for maternal or fetal indications prior to the onset of labor. Counseling should be reiterated and include:

- The small increased risk although still low absolute risk (0.9% versus 1.4%) of uterine rupture in the setting of induction of labor.
- The potential decreased success in conjunction with the potential increased morbidity.
- Factors that significantly affect the rate of successful TOLAC are a previous history of vaginal delivery and spontaneous labor.

Parameters to consider when deciding if a patient is a candidate for IOL versus Repeat Cesarean (note differences based on obstetric history)

- It is reasonable to consider an IOL in patients with Bishop’s score >4 with at least 1 centimeter cervical dilation in women without prior vaginal delivery and one prior cesarean delivery.
- It is reasonable to consider an IOL in patients with Bishop’s score >4 in women with a prior vaginal delivery.
- In women with a prior vaginal delivery and a Bishop’s score <4, an induction can still be considered.
- In women without a prior vaginal delivery and one prior cesarean delivery with a Bishop’s score <4 a repeat cesarean delivery is recommended.
- Women with two prior cesarean deliveries and no vaginal deliveries are not optimal candidates for IOL.

V. Amniocentesis prior to delivery
Amniocentesis prior to delivery should be considered when labor is contraindicated and may include patients with history of:

- Classical cesarean delivery
- Prior extensive myomectomy with cavity entry

In certain instances outright delivery at 37 weeks (without amniocentesis) may be considered (i.e. in women with extensive previous abdominal or uterine surgery, prior uterine rupture). The risks and benefits should be weighed for each individual patient. The delivering provider should be informed.

If amniocentesis is performed at 37 weeks, delivery should be scheduled two days following amniocentesis. If immature, delivery should be scheduled one week later without repeat amniocentesis.
VI. Summary of Prenatal Care Guidelines for Women considering TOLAC

First and Second Trimester

a. Obtain operative note
   i. Document in problem list and scan into chart
   ii. Even in patients who elect for cesarean section and those who have had multiple cesarean sections to improve preoperative surgical planning

b. Discussion of risks and benefits of TOLAC and repeat cesarean section and plans if IOL is needed (see IOL counseling points above)
   i. Would address at each visit to document patient’s consistency in her decision and other influences that may vary during pregnancy

c. Develop plan for delivery by 32 wks and sign consents

Third Trimester

a. Cervical exams starting at 37 wks

b. Membrane sweeping at 39 wks and beyond

c. If delivery plan is for TOLAC in the setting of spontaneous labor, then schedule repeat cesarean delivery at 41 weeks (or sooner if maternal/fetal status indicated delivery by EDC) if labor does not ensue.

Medically indicated induction prior to labor

a. Repeat discussion regarding decreased success rates and increased risks associated with induction

b. Discussion of case for induction with attending of the day if indicated before spontaneous labor and patient has a favorable cervix and/or highly desires TOLAC

c. Provider to send EPIC message to chief and attending of day if TOLAC IOL

Post dates

a. Repeat discussion regarding decreased success rates and increased risks associated with induction

b. Continued weekly cervical assessments and membrane sweeping

c. Discussion of case for induction with attending of the day if indicated before spontaneous labor and patient has a favorable cervix and/or highly desires TOLAC

d. Provider to send EPIC message to chief and attending of day if TOLAC IOL

It is imperative that a plan is discussed with the patient in advance of the day of delivery and documented in the medical record. It is unrealistic to expect that patients can be adequately counseled regarding the risks and benefits of TOLAC versus repeat cesarean delivery on the scheduled day of delivery. Specifically, patients should not be scheduled for a Cesarean Delivery with a possible discussion for IOL to occur on Labor Floor on the day of delivery. This discussion should take place in advance during prenatal care. Patients should not be scheduled for a repeat cesarean delivery or TOLAC without documented discussion with provider and consent in the medical record.