Women's Health Interest Society of Monash

MUMUS

WHISM

Practice OSCEs in Obstetrics & Gynaecology

2020

Disclaimer

These OSCE stems have been written by members Year 4C and 5D Monash medical students who are members of WHISM. They are intended as a study aid for students undertaking their Women's Health rotation and/or preparing for their Women's Health exams. Any relevance to faculty released OSCE stations is purely coincidental.

Title sheet

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Station title: Sasha's wanting some advice

Topic covered: VBAC vs. caesarean section

Station type: Counselling

Candidate instructions

Stem

Sasha is a 30-year-old G2P1 presenting for her antenatal visit at 7 weeks. Her last pregnancy was 2 years ago when she gave birth via caesarean section at 37^{+0} weeks. The consultant has discussed antenatal care and already ordered the necessary antenatal investigations.

You, a fourth-year student on their Women's Health rotation, arrive at clinic just as the consultant is finishing up this consult. However, before she leaves, Sasha would also like to discuss her options for delivery. The consultant, wanting to involve his new medical student in the consult, asks you to counsel Sasha regarding her options.

Tasks

1. Take a brief history from Mary to asses her suitability for VBAC vs ERCS (2 mins).
2. Counsel Sasha regarding her options for delivery and discuss the benefits and risks of an ERCS vs. VBAC (5 mins).
3. Answer Sasha's questions (1 min).

ERCS = elective repeat Caesarean section

VBAC = vaginal birth after Caesarean section

Patient and examiner instructions/Marking sheet

Patient name: Sasha Miller

Patient age: 30

Patient occupation: Travel agent

[History component]

History should be brief. It should be targeted towards assessing factors that will improve success with VBAC or contraindicate VBAC:

Contraindications to VBAC:

- Previous uterine rupture
- Classical caesarean scar
- Multiple previous Caesarean sections
- Any other absolute contraindication to vaginal birth
    - Cephalopelvic disproportion
    - Major placenta previa

Introduction	• **Opening statement:** I am interested in learning more about my options for delivery. • **Statement if asked for more:** Since I had a Caesarean section last time, I am worried that I might have to another Caesarean even though I would like to attempt a normally delivery if I can.
Obstetric Hx	• Previous pregnancy 2 years ago • Uncomplicated antenatal course • Breech presentation – successful external cephalic version at 36 weeks • Subsequently delivered via planned **lower uterine segment caesarean section** for breech presentation at 37 weeks • No postpartum complications, healthy baby boy born at 3kg • No previous pregnancies prior to the one two years ago • Nil significant
Gynae Hx	• Nil significant

	• Last CST? • No history of STI
PMHx	• No other medical conditions
SHx	• BMI 23 • Non smoker • No alcohol

[Counselling component, as per John Murtagh's 10-Step Management Plan]

Tell diagnosis	"I understand that you want to discuss your options for delivery for this pregnancy?"
Establish knowledge	"Do you have any particular questions or concerns that you would like me to talk about?" *My last pregnancy was a c/s and I really want a natural vaginal birth if possible. Is this an option for me?*
Educate patient	**Benefits of successful VBAC:** o Avoid major abdominal surgery o Earlier mobilisation and discharge from hospital o More gratification from vaginal birth compared to C/S o Option for future vaginal deliveries **Risks of VBAC** o Possibility of emergency C/S if VBAC fails (this is associated with the greatest risk of adverse outcomes) o Risk of pelvic floor trauma o Risk of uterine rupture – 1 in 200 (0.5%) as per RCOG o Thus, increased risk of HIE (hypoxic ischaemic encephalopathy aka "brain damage") in neonate **o** Risk of stillbirth >39 weeks higher compared to ERCS – 1.8 per 1000 pregnancies as per RANZCOG "During the delivery, you will be continuously monitored so we can identify any signs that suggest that baby is struggling or that we may need to deliver via emergency c/s as there is a significant risk of rupture." **Benefits of ERCS** o Not as risky as an emergency C/S o Reduced mortality and morbidity related to labour – e.g. no risk of uterine scar rupture, perineal trauma, pain of labour

	o Convenience – planned date to look forward to **Risks of ERCS** o Greater surgical morbidity and longer length of hospital stay o ERCS associated with lower rates of initiating breast feeding compared to VBAC o Small increase in risk of placenta praevia and/or accrete in future pregnancies o Small increase in risk of pelvic adhesions complicated future abdominopelvic surgery o Other risks – anaesthetic risks, infection risks o After 2x ERCS, future pregnancies via VBAC are strongly discouraged **Factors that favour successful VBAC** o Uncomplicated pregnancy without other risk factors o Spontaneous onset of labour o Previous successful VBAC o Previous safe vaginal birth **Factors that reduce success:** o Previous C/S for dystocia o Induction of labour o Co-existing maternal or fetal complications o Maternal BMI > 30 o Fetal macrosomia **o** More than one previous C/S Overall, rate of success of VBAC = 72-75% as per RCOG. This increases to 85-90% if previously successful VBACs.
Establish patient attitudes	**“**Does that all make sense?” “How do you feel about your options?”
Develop management plan	o Emphasise that a decision does not need to be made right now o Discuss with partner and family first o ULTIMATELY, the decision is up to the patient provided she has a good understanding of the risks involved o Will need to monitor throughout antenatal period to ensure there are no additional complications factors or potential contraindications (e.g. placenta praevia and/or accreta)

Preventative opportunities	o Maintaining a healthy pregnancy with a healthy lifestyle is important no matter which method of delivery you choose. o Ensure regular follow up with all antenatal visits o Healthy diet o Regular exercise (within limits) o Flu vaccine
Reinforce information	"There are benefits and risks with either method of delivery. Provided there are no contraindications to a VBAC, the final decision will be up to you and we will do our best to make sure you have the best outcomes."
Provide take-away information	o Pamphlet with take-away information o Referral to online websites
Evaluate consultation	"Does that all make sense?" "Is there anything else we can do for you?" "Do you have any questions?" *Patient to ask the following questions:* ***"I'm also a bit worried about the pain during labour. Is it still possible for me to have an epidural?"*** - **Answer:** Yes, epidural analgesia is not contraindicated in a planned VBAC (as per RANZCOG) ***"I think I am quite keen to proceed with a VBAC at this stage. But if my labour doesn't start spontaneously, can I be induced?"*** - **Answer:** Induction of labour is strongly discouraged in a VBAC due to increased risk of uterine rupture. - Needing an IOL is one of the factors that actually reduces the rate of success with a VBAC as it increases the risk of uterine hyperstimulation and thus rupture. - In such a case, the benefits and risks of each option need to be reconsidered. A Caesarean may be better option in that case, but it would need to be discussed with a senior obstetrician (It is okay for the student state that they are unable to give a definite answer other than that an IOL s strongly discouraged).
Arrange follow-up	"We will see you again after you have had your 12-week US and we can answer any further questions you have then."

References:

1. https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_45.pdf
2. https://ranzcog.edu.au/RANZCOG_SITE/media/RANZCOG-MEDIA/Women%27s%20Health/Statement%20and%20guidelines/Clinical-Obstetrics/Birth-after-previous-Caesarean-Section-(C-Obs-38)Review-March-2019.pdf?ext=.pdf