SOGC Statement on Trial of Labour after Cesarean (TOLAC) Birth during the COVID-19 Pandemic

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The coronavirus pandemic disease 2019 (COVID-19) has affected over 29 million people globally, with more than 925,000 deaths attributable to SARS-CoV-2 infection. Although there is limited data on the prevalence and the effects of COVID-19 in pregnancy, it has significantly affected obstetrical care and the decisions pregnant women make. The lack of clarity with pandemic protocols (i.e., masking/no-masking, the definition of a person under investigation) and non-evidence-based changes in birth plans (i.e., restriction of visitors and support persons) have been a major stressor for health care providers (HCP), pregnant women and their families.

Since the onset of the pandemic, individuals, some HCP and institutions have recommended that pregnant women, who have planned a trial of labour after cesarean (TOLAC) birth should seriously consider a planned elective repeat cesarean section (ERCS). The main reason for this recommendation is the strain on finite health care personnel and resources, such as shortages of personal protective equipment (PPE) during the COVID-19 pandemic.[1, 2] In addition, the added risk of COVID-19 transmission to staff has been postulated as a cause for delayed access to emergency cesarean delivery (CD) in the event of a uterine rupture leading to life threatening consequences for the pregnant woman and fetus. Therefore, ERCS have been promoted by (some) HCP despite the evidence that a successful TOLAC offers numerous benefits to the pregnant woman, including reduced length of hospital stay; reduced recovery time compared to CD and decreased risk of admission to neonatal intensive care unit.

The SOGC recognizes that safety and protection of HCP, provision of adequate PPE and the responsible use of resources are top priorities; however, not at the expense of best practice. Planning for birth in the COVID-19 era should be the same without a risk to the pregnant woman's autonomy. **COVID-19 is not an indication for ERCS in the absence of obstetrical indications for repeat CD and HCP should continue to offer TOLAC.** The clinical management of TOLAC during the pandemic should be identical to management in the pre-pandemic era. The SOGC remains supportive of TOLAC in eligible pregnant women during the COVID-19 pandemic .[3-7]

Readers are referred to the recent SOGC Clinical Practice Guideline "No. 382: Trial of Labour After Cesarean", which reviews in detail the bodies of evidence about the safety of TOLAC,[3-7] as well as the recommendations regarding patient selection, conduct of labour and induction and access to emergency delivery.[4] We reinforce the process of shared decision-making as paramount to planning the mode of birth after CD.[8] Pregnant women should be supported in their decision to undergo a TOLAC based on their beliefs and personal preferences. The likelihood for success, as well as the risks and benefits of TOLAC to both the pregnant woman and the fetus, should be reviewed to support an informed choice during the antenatal period. Access to emergency CD is key to optimal outcomes in TOLAC. Pregnant women and their HCP must be aware of the available local resources when offering TOLAC.[3, 4] The SOGC recommends that pregnant women who live in areas where local hospitals cannot provide emergency access to CD be transferred to facilities where these services can be provided.

The availability of PPE including gloves, gowns, masks (surgical and N95, where indicated), and eye protection have been a challenge in most hospitals. To conserve PPE, only necessary HCP should be present in the operating room during CD for patients with suspected or confirmed COVID-19 infections.[2] The use of regional anaesthesia is not considered an aerosol generating medical procedure,[9, 10] therefore the use of an N95 mask is not required. Epidural anaesthesia is not a contraindication in pregnant women with planned TOLAC. However, pregnant women may require general anaesthesia in labour,[11] which poses an increased risk of aerosolization than does regional anaesthesia and further depletion of PPE. Pregnant women undergoing TOLAC should be identified as at increased risk of requiring emergency access to CD. The obstetrical team should be aware of the women in labour who are planning a TOLAC. A team huddle is recommended to ensure readiness in the event of suspected uterine rupture.

Key messages

- TOLAC is safe and the risk of uterine rupture is not increased by COVID-19 infection. The risk of vertical transmission of COVID-19 is extremely low. Pregnant women should continue to minimize their exposure to COVID-19 by strictly adhering to preventive measures.
- Pregnant women should be supported in their choice for TOLAC if there are no known contraindication to labour and vaginal birth.

References

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