

Pearls on cesarean

Even with its recent decline in occurrence, cesarean delivery remains the most frequently performed surgical procedure in the United States, accounting for approximately 21.5% of all deliveries. Here, obstetricians from across the country share pearls on various aspects of cesarean birth.

The difficult cesarean. When a difficult cesarean is predicted and the threat of obstetrical hemorrhage is imminent, I recommend that clinicians position the patient in low Allen stirrups, using a drape that provides vaginal access. This allows for proper elevation of the fetal head and better assessment of potential blood loss. Make sure a hysterectomy instrument tray is nearby and an experienced gynecologic scrub nurse is available. These steps should eliminate occult hemorrhage and allow for rapid response to any changes in the patient's clinical status.

—Richard Hill, MD, Kansas City, Mo

Cranial dystocia. A cesarean is often required when labor-arrest disorders occur. Cranial dystocia is sometimes found in these cases, making for a difficult delivery. When manual extraction of the fetal head fails, the surgeon typically has an assistant place a hand in the vagina to elevate and disengage the head. In these cases, I instead suggest surgeons remove their delivering hand from the uterine incision, cup the fetal head outside the lower uterine segment and bladder, and then pull upward. This will break the vacuum that spontaneously occurs, liberating the fetal head and allowing for successful cesarean delivery.

—Peter Napolitano, MD, Tacoma, Wash

Intact membranes. When a patient with unruptured membranes presents for a cesarean, avoid breaching the amniotic sac sharply or with a clamp. Instead, first approach the uterine muscle sharply through the outer layers, then bluntly dissect the remaining fibers with your fingertip, allowing the amniotic sac to bulge out through the incision. Complete the uterine incision sharply with bandage scissors prior to rupturing the membranes, then open the bulging membranes either bluntly or with an Allis clamp. These steps ensure that the fetus will not experience trauma from sharp surgical objects.

—Scott Resnick, MD, Taos, NM

Lowering the cesarean rate. To reduce the number of cesarean deliveries, try inducing labor of the unscarred uterus as follows:

8 AM: Insert 50 μ g of misoprostol deep in the vagina.

Noon: If the cervix is dilated, rupture membranes regardless of the Bishop score. Labor will almost invariably ensue within 1 to 2 hours. If the cervix is still closed at this time, insert another dose of misoprostol.

Noon to 5 PM: Observe for cervical dilation. If this does not occur, augment labor with oxytocin.

Some patients will achieve vaginal delivery by 5 PM, and most will deliver by midnight.

With this technique, selecting patients for induction prior to their due date and before macrosomia or fetal stress develop is key to successfully keeping the cesarean rate low.

—Susan Vicente, MD, Kailua, Hawaii ■