Cesarean delivery at term
Technique, pre- and postoperative issues

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Summary of recommendations

Preoperative issues

↑  We suggest that scheduled cesarean delivery is performed at or after 39⁰ weeks of gestation (⊕⊕⊕⊕)

↓  We suggest against routine use of vaginal preparation with antiseptic solutions before cesarean delivery (⊕〇〇〇)

↓↓  We recommend against using a shaver for hair removal before cesarean delivery (⊕⊕⊕⊕)

√  If hair needs to be removed, we suggest that it is clipped or trimmed.

↓  We suggest against using an indwelling catheter and suggest instead that the woman is asked to void shortly before the procedure (⊕〇〇〇)

Opening the abdomen and uterus

√  For abdominal entry we suggest using the Joel-Cohen method rather than the Pfannenstiel method.

↑  Consider not to routinely create a bladder flap when cesarean is performed electively (⊕〇〇〇)

↑  We suggest extending the uterine incision transversely by pulling vertically (cephalocaudal) (⊕〇〇〇)

Fetal extraction, placenta extraction and prevention of post partum haemorrhage

↑↑  We recommend spontaneous extraction of the placenta by using gentle traction on the cord and possibly external uterine massage (⊕⊕⊕⊕)

↓  We suggest against using more than 5 IU of intravenous oxytocin. (⊕〇〇〇)

√  If prophylactic intramyometrial oxytocin is used we suggest that the dosage does not exceed 10 IU.
√ If oxytocin is administered intramyometrically we suggest that it is given before the extraction of the placenta.

Uterine closure

↑ We suggest intraabdominal (in situ) repair of the uterus when the circumstances allow it to reduce postoperative pain (⊕⊕ΟΟ)

√ We suggest closing the uterine incision using a continuous closure.

√ We suggest closing the uterine incision using a single layer closure.

↓↓ We recommend against using locked sutures for closing the uterine incision with a single-layer closure (⊕⊕ΟΟ)

Closure of peritoneum and the abdominal wall

↓ We suggest against closing the visceral and parietal peritoneum (⊕ΟΟΟ)

√ We suggest fascial closure using a continuous suture with slowly or delayed absorbable suture.

↑ We suggest closing the subcutaneous adipose layer if the layer is ≥2 cm (⊕ΟΟΟ)

↓ We suggest against closing the skin with staples rather than subcuticular absorbable sutures (⊕⊕ΟΟ)

Quality of evidence

The classification of evidence and estimation of strength of recommendations is based on GRADE (Grading of Recommendations Assessment, Development and Evaluation). [http://www.gradeworkinggroup.org](http://www.gradeworkinggroup.org)

High (⊕⊕⊕⊕)
We are confident that the true effect lies close to that of the estimate of the effect.

Moderate (⊕⊕ΟΟ)
The true effect is likely to be close to the estimate of the effect, but there is a possibility that it is substantially different.
Low (⊕⊕⊕⊕)
The true effect may be substantially different from the estimate of the effect

Very low (⊕⊕⊕⊕)
The estimate of effect is very uncertain, and often will be far from the truth

Strength of recommendations

Strong recommendation for using an intervention ↑↑
Weak recommendation for using an intervention ↑
Weak recommendation against using an intervention ↓
Strong recommendation against using an intervention ↓↓

Good practice √
We found no relevant evidence. Based on consensus in the working group we suggest for or against the intervention.