Cesarean delivery at term
Technique, pre- and postoperative issues

Approved by the Danish Society of Obstetrics and Gynecology at the obstetrical guideline-meeting in January 2015.

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Summary of recommendations

Preoperative issues

↑ We suggest that scheduled cesarean delivery is performed at or after 39^{+0} weeks of gestation **(⊕⊕○○)**

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

↓↓
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 **(⊕○○○)**

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 **(⊕○○○)**

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

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. **(⊕○○○)**

√ 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 **(⊕⊕○○)**

√ 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 (⊕⊕○○**)**

Closure of peritoneum and the abdominal wall

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

√ 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 (⊕○○○)

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

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

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