

Modifying the caesarean, contemporary approach: A Short Communication

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The Aim:

To highlight difficulties that now lying on the path of CS. Not to mention that a vaginal delivery is always preferable to the procedure. To design a contemporary approach with every step analysed and improved. To use lapsed techniques from the past and modifications that can lead to a safe CS, aesthetically a sublime surgical procedure that one could tell the difference by only watching it. To improve parental couples' perception and create positive women feelings.

Introduction: Caesarean carries the legacy of an emperor. It is the procedure that more than any other complicated by bleeding and infection. Modifying the procedure in several areas came out of necessity to respond to new challenges that appear over last decades. Are we learning as fast as Midwifery changing, we should move to modern obstetrics, supporting ideas old and new ones, till we find those that work.

Methods:

- Formulate an easier procedure for the assistant and theatre staff to follow. The use of retraction tapes in obese women allows to operate with a single assistant. Tapes such as Leukoplast sleek SF tapes, now replaced with traxi™ Panniculus, hypoallergenic latex free. Those latest reviewed in Contemporary OB/GYN. Considering a caesarean section rate up to 50 percent in the USA for women with BMI between 35 and 39.9, the operating times do not differ from other caesareans, and the tapes can remain for 24 hours post the procedure.
- Eliminate bleeding and create a calmer environment. Bleeding during CS can still be ferocious. Blood loss can be underestimated. Such bleeding is associated with increased morbidity. Large intrabdominal gauze packs, size 45, into either, or both paracolic gutters at the beginning of the CS apply a mild uterine compression onto large vessels and the uterus and isolate the surgical field from bowel loops and also collect amniotic fluid and blood intraoperatively. If applied dry, they soon become wet during the procedure.
- Delivery of the head with flexion so to present under the uterine incision with the occipito-bregmatic diameter. That prevents extension of the scar downwards to the cervix, the uterine vessels and the broad ligament.
- The foetal impacted head is associated with prolonged obstructed labours, failed instrumental and more. The use of a foetal pillow was introduced in recent years. However, there is limited availability or application is by senior personnel only. The use of tocolysis and experienced assistant to push up and flex head should facilitate delivering the head. In other cases, a reverse breech extraction with tocolysis and extension of uterine incision laterally can be used.
- Tocolysis is paramount feature of management for the foetal impacted either head or breech, very prolonged and obstructed labours. The same goes for preterm labours at fully dilatation to avoid difficult deliveries in otherwise fragile preterm babies. Tocolysis should be administered from the delivery room on the way to theatres in the form of terbutaline 250 mcg subcutaneous. Such a relaxation of the uterine muscle to facilitate delivery of the baby did not cause major bleeding and could be easily reversed with Syntocinon.
- Placenta delivery with uterine contraction showed minimal bleeding and the uterine cavity was empty from tissues or membranes. Uterine contractions gained through draining the amniotic fluid at beginning of the procedure, administration of oxytocics in the form of syntocinon at the appearance of shoulders, and further delaying delivery by attempting natural birth stimulation. Not to mention that in cases where there was a difficult head delivery or even reverse breech delivery, extensions of the uterine scar laterally should be anticipated. Therefore, inspection of integrity of lower segment is critical to apply delay in placenta delivery. A stage stitch onto the lower counterpart of the uterine incision before head delivery at the midline can help to check quickly the condition, by lifting the stage stitch and inspecting the incision scar.
- Repair of the uterine incision is important to achieve haemostasis in the known appropriate ways with continuous stitching in two layers with the second layer overlapping the first one. Another way is with continuous stitching in one layer only, with the second series of stitching applied within the first layer, to ensure robust repair of the incision.
- Broad ligament growing hematomas should be treated intraoperatively. One or two interrupted stitches from uterine muscle across the broad ligament with care not to

include adnexa tissues should be used to encircle the hematoma. More difficulties were met when repairing tears that extended downwards and teared the cervix apart.

- Uterine compression was the most effective feature to prevent or arrest bleeding. Mild compression is applied with abdominal packing at the beginning of the procedure. This keeps the uterus dry from amniotic fluid and blood, also with effective contractions at the time of placenta delivery. Syntocinon administration can occur at delivery of the shoulders. Such a mild compression of the uterine muscle is a wonderful preventable feature. Moderate compression can be applied with exteriorisation of the uterus and further oxytocics.
- Uterine compression staging, whether mild, moderate and severe, guides the appropriate application in the management of postpartum hemorrhage (PPH). Severe compression carries the risk of infection and uterine ischaemia and subsequent necrosis. Such a compression can be avoided if bleeding remains minimal through preventable features only.
- A dry and very well controlled procedure is always welcomed by theatre staff. The amniotic fluid is collected with suction along with further fluid and blood collections absorbed from intrabdominal packs. The delay in the first stage of the CS and dry and empty uterine cavity allows for stronger contractions and prevents bleeding.
- Natural birth simulation of the baby is still preferred. Minimal fundal pressure should be applied (for example by using the kiwi cup over the flexion point to assist head delivery). The baby's chest compression through tight incisions and relevant delay in delivery allows the lung fluid to be seen from the baby's nostrils alongside the torso delivery. The baby often cries before delivery. In cases of foetal compromise, where resuscitation is needed, it became easier with no fluid in the baby's lungs.

Conclusion: Caesarean still remains a ferocious procedure that can claim lives. Should we do not recognize the challenges from a changing world, the furies could become the Nemesis of our practice. Let's credit the future with success.

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