Caesarean Birth Guideline

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People who need to have a broad understanding of this document	*As above*
People who need to know that this document exists	*As above*

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If the review date of this document has passed please ensure that the version you are using is the most up to date version either by contacting the author or CTM_Corporate_Governance@wales.nhs.uk

Guidelines Definition
Clinical guidelines are systemically developed statements that assist clinicians and patients in making decisions about appropriate treatments for specific conditions.

They allow deviation from a prescribed pathway according to the individual circumstances and where reasons can be clearly demonstrated and documented.

Minor Amendments
If a minor change is required to the document, which does not require a full review please identify the change below and update the version number.

Type of change	Why change made	Page number	Date of change	Version 1 to 1.1	Name of responsible person
In line with NICE guidance	3 year update		June 2025	1 to 2	George Haroun

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1. Introduction

Decision for caesarean birth is a multi-factored decision based on clinical need and woman's choice. Women have the right to be involved in discussions and make informed decisions about their care. This guideline has been developed to help ensure consistent quality care for women who:

- have had a previous caesarean birth (CS) and are now pregnant again, or,
- have a clinical indication for a Caesarean birth or
- are considering a Caesarean birth when there is no other indication.

It provides evidence-based information for healthcare professionals and women about:

- The risks and benefits of planned Caesarean birth compared with planned vaginal birth
- Specific indications for Caesarean birth
- Effective management strategies to avoid Caesarean birth
- Anaesthetic and surgical aspects of care
- Interventions to reduce morbidity from Caesarean birth

This guidance uses the term 'woman' (pronouns 'she' or 'her') to describe individuals whose sex assigned at birth was female, whether they identify as female, male or non-binary. It is important to acknowledge it is not only people who identify as women for whom it is necessary to access women's health and reproductive services. Therefore, this should include pregnant people who do not identify themselves as women and are considering a planned caesarean birth.

2. Provision of information to Women

- Addressing the woman's views and concerns should be recognised as being integral to the decision-making process.
- Offer evidence-based information and support to enable informed decisions about childbirth.
- Provide evidence-based information about Caesarean birth (CB) during the antenatal period and include information such as:
    - Indications for Caesarean birth
    - What the procedure involves
    - Associated risks and benefits
    - Implications for future pregnancies and birth following CB.
- Provide information in a form that is accessible, taking into account the cultural needs of minority communities and women whose first language is not English or who cannot read, together with the needs of women with disabilities or learning difficulties.

- A CB leaflet should be given to each woman having an elective CB.
- A pregnant woman is entitled to decline the offer of treatment such as CB, even when the treatment would clearly benefit her or her baby's health. Refusal of treatment needs to be one of the woman's options. This should be explained to the expectant woman.

When a decision is made to perform a CB, a record should be made of all the factors that influence the decision, and which of these is the most influential.

3. Maternal choice for Caesarean Birth

When a woman or pregnant person with no medical indication for a caesarean birth requests a caesarean birth:

- Offer to discuss and explore the reasons for the request
- Ensure they have balanced and accurate information
- Offer to discuss alternative birth options (for example, place of birth, continuity of midwifery care where available, pain relief options), which may help address concerns they have about the birth
- Offer discussions with a consultant midwife or senior midwife, ideally in a birth options clinic or at a birth options appointment.
- Offer discussions with a consultant or senior obstetrician and other members of the team (for example an anaesthetist) if necessary or requested by the woman or pregnant person. Discuss the overall risks and benefits of Caesarean birth and vaginal birth taking into account their circumstances, concerns, priorities and plans for future pregnancies. Ensure there is a record that this discussion has taken place (Appendix 1).
- If a woman or pregnant woman requests a caesarean birth because they have tokophobia or other severe anxiety about childbirth, offer referral to a healthcare professional with expertise in providing perinatal mental health support to help with their anxiety in a supportive manner.
- Ensure health care professionals providing perinatal mental health support for women or pregnant people with tokophobia or other severe anxiety about childbirth are able to access the planned place of birth with the woman or pregnant person during the antenatal period, as part of the support offered to help them overcome fears and concerns about the labour and birth.
- If after an informed discussion about the options for birth (including the offer of perinatal mental health support if appropriate) the woman or pregnant woman requests a caesarean birth, support their choice.
- If a woman or pregnant person requests a caesarean birth this should be offered within their obstetric unit.

4. i) Factors reducing the likelihood of caesarean birth

- Offer external cephalic version (ECV) if breech at 36 weeks (see breech presentation guideline)
- Facilitate continuous support during labour
- Offer induction of labour after 41 weeks
- Use a partogram with a 4-hour action line to monitor progress of women in spontaneous labour with an uncomplicated singleton pregnancy at term to reduce the likelihood of caesarean birth
- Involve Consultant Obstetricians in decision making for elective and emergency caesarean births
- Support women in choosing vaginal birth after CS (see CTMUHB Vaginal Birth After Caesarean guideline)
- Electronic fetal monitoring is associated with an increased likelihood of CB. When CB is contemplated because of an abnormal fetal heart rate pattern, the consultant obstetrician should be involved in decision making.
- Stay up to date with intrapartum fetal surveillance, PROMPT and GAP & GROW training programs

4. ii) No influence on the likelihood of caesarean birth

Inform women that the following interventions during intrapartum care have not been shown to influence the likelihood of caesarean birth, although they can affect other outcomes:

- Walking in labour
- Non-supine position during the second stage of labour
- Immersion in water during labour
- Epidural analgesia during labour
- The use of raspberry leaves

Inform women that the effects on the likelihood of caesarean birth of complementary therapies used during labour (such as acupuncture, aromatherapy, hypnosis, herbal products, nutritional supplements, homeopathic medicines, and Chinese medicines) are uncertain.

Slow progression in labour and caesarean birth

- Do not offer the following as they do not influence the likelihood of caesarean birth for slow progression in labour. Although they can affect other outcomes:
- Active management of labour (comprising a strict definition of established labour, early routine amniotomy, routine 2-hourly vaginal examination, oxytocin if labour becomes slow)
- Early amniotomy

5. Procedural aspects of Elective Caesarean birth

Describe the nature and procedure of caesarean birth. All procedures and risks must be discussed and explained and recorded on the consent form (Appendix 1).

N.B. If any other procedures are anticipated, these must be discussed and a separate consent obtained. A decision for sterilisation should not be made while the woman is in labour or immediately prior to the procedure. An additional specific consent form should be used for sterilisation at caesarean birth (RCOG 2009).

Timing of planned caesarean birth

Do not routinely carry out planned caesarean birth before 39 weeks, as this can increase the risk of respiratory morbidity in babies.

5.1 Classification of urgency for caesarean birth

- Document the urgency of a caesarean birth and aid clear communication between healthcare professionals:

Category 1	Immediate threat to the life of the woman or fetus (for example, suspected uterine rupture, major placental abruption, cord prolapse, fetal hypoxia or persistent fetal bradycardia)
Category 2	Maternal or fetal compromise that is not immediately life threatening
Category 3	No maternal or fetal compromise but needs early birth
Category 4	Birth timed to suit woman or healthcare provider

- Perform category 1 as soon as possible, and in most situations within 30 minutes of making the decision.
- Perform category 2 as soon as possible and in most situations within 75 minutes of making the decision.

Take into account the condition of the woman and the unborn baby when making decisions about rapid birth. Be aware that rapid birth can be harmful in certain circumstances. Remember that rapid birth may be harmful in certain circumstances.

5.2 Booking and consent

- Elective CB should be carried out after 39 weeks' gestation to decrease the risk of respiratory morbidity unless clinically indicated otherwise.
- The procedure must be booked with approval of registrar **and** consultant after discussion of risks/benefits with the woman (Appendix

1). If an interpreter is needed do not use a family member, use the language assistance approved by the health board.
- The indications need to be recorded clearly in the notes.
- The date of the elective CB has to be arranged through the pathway approved by the maternity multidisciplinary team. The number of elective caesarean births on the same day, as well as the surgeon performing them, will be decided based on the modified complexity scoring system designed for that purpose (Appendix 2).
- Details of the CB list must be made available to Labour Ward, SCBU, Antenatal Ward and anaesthetic team.
- Only staff members able to do the procedure or trained in obtaining consent should complete the consent form.
- Inform women booked for CB for malpresentation alone, that a presentation scan will be done on the day of surgery. If cephalic presentation is confirmed then a discussion will take place with the woman and the CB may be cancelled and their birth options re-discussed.

Lists: Elective CB lists in PCH and POW will be set by the local multidisciplinary teams and may change according to the needs of the local units respectively
Pre-op: Routine pre-op with midwives to be booked in Maternity Day Assessment unit on both sites when booking the CS.

5.3 Pre-operative assessment:

Before caesarean birth, carry out a full blood count to identify anaemia, antibody screening, and blood grouping with saving of serum.

Do not routinely carry out the following tests before caesarean birth:
- cross-matching of blood
- A clotting screen
- Pre operative ultrasound for localization of the placenta
- Prescribe omeprazole 20mg to be taken on the night before and morning of surgery

Carry out caesarean birth for pregnant women with antepartum haemorrhage, abruption or placenta praevia at a maternity unit with on-site blood transfusion services, as they are at increased risk of blood loss of more than 1,000ml

Give women having caesarean birth with regional anaesthesia an indwelling urinary catheter to prevent over-distension of the bladder.

Anaesthesia for caesarean birth

- Provide pregnant women having a caesarean birth with information on the different types of post-caesarean birth analgesia, so that they can make an informed choice
- Offer women who are having a caesarean birth regional anaesthesia in preference to general anaesthesia, including women who have a diagnosis of placenta praevia.
- Ensure anaesthetists are aware of and/or have reviewed all high-risk cases.
- Apply a left lateral tilt of up to 15 degrees or appropriate uterine displacement once the woman is in a supine position on the operating table to reduce maternal hypotension.
- Ensure Cell Saver is available if needed with a trained ODP available on the date of surgery.
- Ensure each maternity unit has a set of procedures for failed intubation during obstetric anaesthesia
- For diabetic patients ensure pre-op, intra-op and post-op insulin regimes are present in the case notes. If not available, contact the consultant endocrinologist responsible or the diabetic team via switchboard for a plan.

5.4 Preparation of CS (on day of surgery)

- The first elective case is usually admitted to labour ward at 08:00 hours on the day of the surgery.
- Pre-admission checks, bloods and consent should have already been performed.
- If antibodies are present, the obstetrician should discuss with the on-call anaesthetist the possible need for cross match prior to surgery as electronic issue may not be available.
- The anaesthetist to discuss choice of anaesthetic (may have already been done at pre-admission).
- If any possible delays in CS, ensure the Labour Ward co-ordinator and the woman are informed as soon as possible.
- Consider fluids and/or food if a significant delay is anticipated after discussion with team.
- Ensure paediatricians and neonatal unit have been informed with adequate notice if it is a preterm CS or if there are concerns about the fetus.
- It is the responsibility of the surgeon to:
    - Review and introduce themselves to the woman prior to theatre.
    - Confirm woman’s identity.
    - Confirm/obtain woman’s written consent.

- Check that the indication for the procedure is still valid, e.g. confirming breech presentation by ultrasound if this is the indication for the CS.
- Inform the anaesthetist if the case may take longer than expected so that regional anesthetic can be tailored to the expected duration of surgery.
- Crossmatch blood if Hb <8 g/dl, platelets <100 x 109/l or placenta praevia.
- Check that an indwelling catheter has been inserted prior to the CB, to remain in-situ for the duration of the procedure and for at least until the patient is mobilizing or up to 12-24hrs post procedure (refer to bladder care guidelines).
- Ensure that high-risk cases are not delegated to juniors without adequate senior supervision.
- Clear and comprehensive documentation of procedure using the CS proforma.
- Clear documentation of post-op instructions that deviate from routine.
- If increased risk of Post-Partum Haemorrhage or the measured blood loss requires ongoing uterotonic support after the Caesarean birth, prescribe a bag of oxytocin 40 IU in 500mL of Sodium chloride 0.9% infusion (125mls/hr) and follow the wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/postpartum-haemorrhage-all-wales-pph-guideline/.

5.5 Steroid Replacement in Women with adrenal insufficiency or taking long-term oral steroids

For women having a planned or emergency caesarean birth who have adrenal insufficiency or who are taking long-term oral steroids (equivalent to 5 mg or more prednisolone daily for more than 3 weeks):

Continue their regular oral steroids, and…

Give intravenous hydrocortisone when starting anaesthesia; the dose will depend on whether the woman has received hydrocortisone in labour, for example:

Consider giving 50 mg if she has had hydrocortisone in labour

Consider giving 100 mg if she has not had hydrocortisone in labour

Give a further dose of hydrocortisone 6 hours after the baby is born.

Do not offer supplemental hydrocortisone in the intrapartum period to women taking inhaled or topical steroids.

5.6 Antibiotics

- Offer women prophylactic antibiotics prior to skin incision at caesarean birth. The risk of maternal infection is increased when the antibiotics are given after skin incision. No effect on the baby has been demonstrated.
- Choose antibiotics effective against endometritis, urinary tract and wound infections, which occur in about 8% of women who have had a CS.
- **Do not** use co-amoxiclav as antimicrobial prophylaxis (RCOG). See Table 1 for antimicrobial choice.

Table 1: Antibiotic regimen for caesarean births

1st line No Penicillin allergy	Cefuroxime 1.5g IV *plus* Metronidazole 500mg IV (To be given 60 mins prior to skin incision)
2nd line Penicillin allergy	Clindamycin 600mg IV *plus* Gentamicin 3mg/kg (max 160mg)

5.7 WHO checklist

- Complete the WHO surgical safety checklist before and at the end of every case.
- A swab, needle and instrument count must be undertaken and documented for all procedures where swabs, instruments and sharps could be retained. ‘A retained foreign body is a ‘never event’.’

5.8 Prevention and management of hypothermia and shivering

- Warm IV fluids (500ml or more) and blood products used during caesarean birth to 37 degrees Celsius using a fluid warming device
- Warm all irrigation fluids used during caesarean birth to 38 to 40 degrees Celsius in a thermostatically controlled cabinet

5.9 Surgical techniques

Methods to reduce infectious morbidity

- Use alcohol- based chlorhexidine skin preparation before caesarean birth to reduce the risk of wound infection
- Use aqueous povidene-iodene vaginal preparation before caesarean birth in women with ruptured membranes to reduce the risk of

endometritis. If aqueous povidene-iodene vaginal preparation is not available or is contraindicated, aqueous chlorhexidiene vaginal preparation can be used.

Methods to prevent HIV transmission in theatre

- ✓ Wear double gloves when performing or assisting a caesarean birth for women who have tested positive for HIV, to reduce the risk of HIV infection of staff.
- ✓ Follow general recommendations for safe surgical practice during caesarean birth to reduce the risk of HIV infection of staff.

Abdominal wall incision

Perform caesarean birth using a low, transverse, straight skin incision with subsequent tissue layers opened bluntly and, if necessary, extended using sharp dissection. This may need to be modified with a higher incision for women and pregnant women with class 3 obesity (BMI 40kg/m2 or more) A vertical midline incision may be required for some clinical indications.

Instruments for skin incision

Do not use separate surgical knives to incise the skin and the deeper tissues in caesarean birth, as it does not increase wound infection.

Extension of the uterine incision

When there is a well-formed lower uterine segment, use blunt rather than sharp extension of the uterine incision to reduce blood loss, incidences of postpartum haemorrhage and the need for transfusion during caesarean birth.

Use of forceps

Only use forceps in caesarean birth if there is difficulty delivering the baby's head. The effect on neonatal morbidity of the routine use of forceps at caesarean birth remains uncertain.

Delay cord clamping where clinically possible for at least 1 minute

Use of uterotonics

Use oxytocin 5 international units by slow intravenous injection in caesarean birth to encourage contraction of the uterus and decrease blood loss.

Method of placental removal

Remove the placenta in caesarean birth by using controlled cord traction and not manual removal to reduce the risk of endometritis.

Exteriorisation of the uterus

Perform intraperitoneal repair of the uterus for caesarean birth. Routine exteriorisation of the uterus is not recommended because it is associated with more pain and does not improve operative outcomes such as haemorrhage and infection.

Closure of the uterus

Use single layer or double layer uterine closure in caesarean birth, depending on the clinical circumstances. Note that single layer closure does not increase the risk of postoperative bleeding or uterine rupture in a subsequent pregnancy.

Checking fallopian tubes and ovaries

Ensure tubes and ovaries are checked and findings documented on operation sheet.

Consider planned removal of ovarian cysts if indicated.

If ovarian cyst noted but not removed please ensure follow up scan and follow up clinic appointment is arranged.

Closure of peritoneum

Do not suture the visceral or the parietal peritoneum in caesarean birth to reduce operating time and the need for postoperative analgesia, and improve maternal satisfaction.

Closure of the abdominal wall

If a midline abdominal incision is used in caesarean birth, use mass closure with slowly absorbable continuous sutures as this results in fewer incisional hernias and less dehiscence than layered closure.

Closure of subcutaneous tissue

Do not routinely close the subcutaneous tissue space in caesarean birth unless the woman has more than 2cm subcutaneous fat, as it does not reduce the incidence of wound infection.

Use of superficial wound drains

Do not routinely use superficial wound drains in caesarean birth as they do not decrease the incidence of wound infection or wound haematoma.

Closure of the skin

Consider using sutures rather than staples to close the skin after caesarean birth to reduce the risk of superficial wound dehiscence.

Umbilical artery PH measurement

Perform paired umbilical artery and vein measurements of cord blood gases after caesarean birth for suspected fetal compromise, to allow for assessment of fetal wellbeing and guide ongoing care of the baby.

Women's preferences during caesarean birth

Accommodate a woman's preferences for her caesarean birth whenever possible, such as music playing in theatre, lowering the screen to see the baby born, or silence so that the mothers voice is the first the baby hears.

6. Emergency Caesarean Birth

- On-call consultant obstetrician must **always** be consulted prior to any emergency CB being performed
- In the event of Category 1 CB for fetal distress due to cord prolapse, placental abruption or any other life threatening event to the woman or fetus, the on-call consultant should be informed
- If the consultant cannot be informed by the registrar on-call, it is then the responsibility of the labour ward coordinator to inform the Consultant on-call about acute/urgent/life threatening situations even if the consultant would not be there in person in time for the CB
- Once the decision for an emergency CB is made:
  - Document the grade, time and indication for CB in the woman's labour notes. This should be done at the time decision is made by the appropriate person making the decision.
  - If labour has been augmented, stop the oxytocin infusion and document the time it was stopped.
  - Check that an up-to-date full blood count and group and save have been requested.
  - The surgeon will communicate with the anaesthetist on-call (and remain on labour ward) and midwifery team to inform the theatre staff including ODP with specific instructions on the degree of urgency and time by which birth must be achieved. **All members of the multidisciplinary team must be informed of the need (or likely need) for caesarean birth as early as possible.**
  - Continue CTG monitoring until ready to commence the CB
  - Apart from exceptional circumstances ensure written consent is obtained. Verbal consent is acceptable in cases of extreme fetal or maternal compromise however this must be documented clearly in the notes.
- Any reasons for delay in performing a CB as expected for the relevant category must be documented in the case notes. An assessment must be made by the obstetrician for the possible need to open a second theatre (this will include all cases which would be classified as Category 1).
- Any significant delay must be reported and a datix report completed by the team caring for the woman.
- Aim for birth of baby within 30 minutes of the decision for a category 1 CB. Remember that too hurried a process can also potentially cause harm.

- A decision-to-birth interval of <30 minutes is the ideal but is not itself crucial, except in situations of maternal ± fetal compromise. The 30-minute target has been accepted as an audit standard for response to emergencies in maternity services.
- If decision for Emergency CB being made for 'Fetal Distress', if the fetal heart rate recovers in theatre, the decision for emergency CB as well as the degree of urgency can be reviewed and downgraded or stood down based on the clinical circumstances.
- Inform the paediatric team including degree of urgency as well as other relevant factors such as fetal blood pH, meconium, gestational age etc.
- Written consent should be obtained.
- Antibiotic prophylaxis: see above in section 5.6
- Corticosteroid replacement: see above in section 5.5
- Catheterise with an indwelling catheter prior to surgery. This may be done in the labour room but must not cause delay in moving the woman to theatre.
    - In cases where regional block has been used leave the catheter in-situ for at least until the patient is mobilising or up to 12 hours (For epidural - 12 hours following the last "top-up") and/or If there has been any bladder trauma, the catheter needs to remain in-situ for up to 10 – 14 days after the operation (refer to bladder care guidelines) wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/postnatal-bladder-care/
- At any CB, the incidence of bladder or ureteric injury can be reduced by attention to the following recommendations:
    - The lower uterine incision should be pointing upwards at each end.
    - While attempting to secure haemostasis, use compression on the bleeding area rather than blind haemostatic sutures.
    - Careful dissection and separation of the bladder from the lower segment.
    - Deliver the placenta by controlled cord traction, not by manual removal.
    - In cases of difficulty in visualising the angle(s), the uterus can be exteriorised to give better exposure.
    - Take care to warn the Anaesthetist and patient about the procedure, if regional block analgesia is being used.
    - Routine exteriorisation of the uterus in uncomplicated CS is not recommended.
    - Involve the Urologist if there is any suspicion of ureteric injury.

- **The umbilical cord pH (from artery and vein) must be checked in ALL Emergency CB, irrespective of the indication.** These results should be documented in the neonatal record and stapled onto the operative delivery record sheet, and also recorded on the CB proforma. These results should also be entered onto the electronic records of the woman and baby by the Midwife.

- **The Obstetrician must ensure that the woman is debriefed and provide information regarding future births including suitability for vaginal birth after CB. This discussion must be documented in the woman's records prior to discharge and a copy of the CB counselling letter should be given to the woman.**
- All women will require routine postnatal thromboprophylaxis as per CTM UHB guideline.
- Category 1 C/B would trigger completion of a Datix.

7. Thromboprophylaxis

A Venous thromboembolic (VTE) risk assessment of all women undergoing elective or emergency will be undertaken following birth. Thromboprophylaxis will be offered to all women and prescribed as appropriate. For local VTE risk assessment, prophylaxis and treatment see CTM UHB guidance link below.

wisdom.nhs.wales/health-board-guidelines/cwm-taf-maternity-file/venous-thromboembolism-vte-risk-assessment-prophylaxis-and-treatment-in-pregnancy-and-puerperium/

Thrombo-prophylactic doses for antenatal and postnatal LMWH: Table 3

Prescribe according to booking weight unless there has been a significant weight gain (>12 kg) during pregnancy. Lower doses of LMWH should be employed if the creatinine clearance is less than 30 ml/minute with enoxaparin or less than 20 ml/minute with tinzaparin.

Table 3: Suggested prophylactic doses of LMWH in pregnancy

WEIGHT (KG)	ENOXAPARIN	TINZAPARIN
< 50	20 mg daily	3500 units daily
50 - 90	40 mg daily	4500 units daily
91 - 130	60 mg daily*	7000 units daily*
131 - 170	80 mg daily*	9000 units daily*
>170	0.6 mg/kg/day*	75 units/kg/day*
HIGH PROPHYLACTIC DOSE FOR WOMEN WEIGHING 50 – 90 KG	40 mg 12 hourly	4500 units 12 hourly

* Can be prescribed in divided dose twice a day

* Single daily dose advised in women with needle-phobia, and/or if administered by community midwife.

Venous Thromboembolism during Pregnancy and the Puerperium Green-top Guideline No. 37a April 2015)

8. References

- Caesarean Section. NICE guidelines (NG192); updated January 2024
- NICE [NG89] 2018 Venous thromboembolism in over 16's: reducing risk of hospital-acquired deep vein thrombosis or pulmonary embolism
- Royal College of Obstetricians and Gynaecologists. Birth after Previous Caesarean Birth. Green-top Guideline No. 45 October 2015.
- Royal College of Obstetricians and Gynaecologists. Reducing the Risk of Venous Thromboembolism during Pregnancy and the Puerperium Green-top Guideline No. 37a April 2015
- Royal College of Obstetricians and Gynaecologists Consent Advice No. 14 November 24.
- Intrapartum care for women with existing medical conditions or obstetric complications and their babies. NICE guidelines (NG121); Published 6th March 2019.

9. Auditable standards

1. Post caesarean birth wound infection
2. Caesarean birth decision-to-delivery interval
3. WHO checklist

10. Appendix 1

Elective Caesarean Birth Consent Form

Name of proposed procedure: PLANNED CAESAREAN BIRTH Birth of baby/babies through a cut in your abdomen (tummy) and uterus (womb).
Anaesthetic: This procedure will require an anaesthetic (to ensure that you do not feel any pain). An anaesthetist will discuss this with you before the procedure.

Statement of healthcare professional

(to be filled in by healthcare professional with appropriate knowledge of caesarean birth)

I have explained the procedure to the woman, specifically, I have explained:

- ☐ This procedure involves birth of baby/babies through a cut in the abdomen and uterus
- ☐ Numbers quoted below are estimates only based on the data currently available

Summary estimates

Summary estimates of risks of planned caesarean birth compared to planned vaginal birth to inform discussions. Precise numerical estimates of risks cannot be given and will vary for individual women.

		Planned caesarean birth	**Planned vaginal birth**
Risks For The Woman	Perineal tears (third- or fourth-degree)	0 per 100 000	560 per 100 000 vaginal births (about 1 in 179) – risk is higher for assisted vaginal birth than for unassisted vaginal birth
	Urinary incontinence occurring more than 1 year after birth	7300–19 600 per 100 000 (about 1 in 5–14)	19 800 per 100 000 (about 1 in 5) for assisted vaginal birth 48 700 per 100 000 (about 1 in 2) for unassisted vaginal birth
	Faecal incontinence occurring more than 1 year after birth	7800 per 100 000 (about 1 in 13)	15 100 per 100 000 for assisted vaginal birth (about 1 in 7) No difference for unassisted vaginal birth
	Urinary tract injury	About 1 per 1000*	No data available
	Wound infection, which may require readmission to hospital for treatment	2–7 per 100 (about 1 in 14–50)	Infection rates of perineal tears or episiotomy is variable ranging from less than 1 per 100 to 13 per 100, but there is less likelihood of readmission being required
	Hospital stay	About 4 days on average	About 2 and a half days on average

Risks For The Woman	Uterine rupture in future pregnancy or birth	200 per 100 000 (1 in 500)* Risk is higher after multiple caesarean births and after emergency caesarean than after planned caesarean births	7 per 100 000 (about 1 in 14 000) Risk is higher for planned vaginal birth in women who have had multiple previous caesarean births
	Emergency hysterectomy: removal of your uterus	200 per 100 000 (about 1 in 500)	100 per 100 000 (1 in 1000)
	Placenta accreta spectrum (abnormally adherent or invasive afterbirth) in future pregnancy	100 per 100 000 (1 in 1000)* Risk is higher after multiple caesarean births and after emergency caesarean than after planned caesarean births	34 per 100 000 (about 1 in 2900)
	Maternal death (death within 6 weeks of childbirth)	25 per 100 000 (1 in 4000)	4 per 100 000 (1 in 25 000)
	Perineal/abdominal pain	Typical pain scores† of 1 (during birth) and 4.5 (3 days after birth)	Typical pain scores† of 7.3 (during birth) and 5.2 (3 days after birth)
	Risks associated with anaesthesia	As discussed with the anaesthetist	
Risks For The Baby	Skin lacerations/cuts	1–2 per 100	Up to 10 per 100 with assisted vaginal birth Unlikely with unassisted vaginal birth
	Childhood obesity	Evidence to compare this outcome is limited/conflicting	
	Asthma	1809 per 100 000 (about 1 in 55)	1500 per 100 000 (about 1 in 67)
	Higher neonatal mortality (death of babies within 28 days of birth)	58 per 100 000 (about 1 in 1700)	30 per 100 000 (about 1 in 3300)

* Figures based on planned and unplanned caesarean births.

† Using a scale where 1 is no pain through to 10 which is most severe pain.

Note: Studies including pregnant women with breech presentations, multiple pregnancies, preterm births, babies who are small-for-gestational-age, placenta praevia, and maternal infections were excluded.

☐ **I have discussed the risks that this woman considers are relevant to her, taking into account her individual circumstances, risk factors and plans for future pregnancies (specify details):**

I have discussed the risks of alternative modes of childbirth, including:

☐ Planned vaginal birth: unassisted or assisted

☐ Emergency caesarean birth

I have discussed the procedures that may become necessary during the caesarean birth (tick as appropriate from following list if agreed by the woman):

☐ Blood transfusion

☐ Repair of any damage to bowel, bladder or blood vessels

☐ Emergency hysterectomy (when necessary, as a life-saving procedure)

The following resources have been provided (specify details):

☐ Caesarean birth leaflet

☐ Enhanced recovery leaflet

☐ Additional resources: ____________________

I confirm ____Name of Pregnant Person____ has been offered time and opportunity to seek clarification on the information provided.

Healthcare professional

Signed ______________________________ Date _________________________

Name (PRINT) ________________________ GMC number __________________

Job title____

Contact details ____

Woman or service-user

I ___Enter Full Name___, _Enter do or do not agree to the procedure, examination or treatment described above, including the procedures, treatments or examinations which may become necessary.

I Enter do or do not agree that students may be present during the procedure.

I Enter do or do not agree that students may examine me during the procedure.

Signed ______________________________ Date _________________________

Name (PRINT) ____

Statement of interpreter (where appropriate)

I have interpreted the information above to the woman to the best of my ability and in a way in which I believe they can understand.

Signed ______________________________ Date _________________________

Name (PRINT) ____

Contact details ____

Confirmation of consent on the day of the procedure

(to be completed by a healthcare professional and the woman or service-user)

Healthcare professional

Signed ______________________________ Date ________________________

Name (PRINT) ________________________ GMC number _________________

Job title ____

Woman or service-user (tick the appropriate decision)

☐ I Confirm That I Still Want The Procedure/Treatment To Go Ahead.

Signed ______________________________ Date ________________________

Name (PRINT) ____

OR

☐ I Confirm I Have Withdrawn My Consent For The Procedure/Treatment.

Signed ______________________________ Date ________________________

Name (PRINT) ____

11. Appendix 2
Modified Risk Stratification for Elective Caesarean Birth

6	Placenta accreta
5	Placenta praevia 4 or more previous CS BMI >50
4	Previous Midline Laparotomy / high risk of adhesions Multiple pregnancy BMI >45 3 x previous CS
3	2 x previous CS BMI >35 Tubal ligation / Salpingectomy / Cystectomy Unstable or transverse lie Fibroids General Anaesthetic Required
2	Prematurity 32 to 33+6 weeks 1 x previous CS Cell Salvage needed Type 1 or 2 Diabetes Previous spinal surgery
1	Breech presentation Maternal Request Previous Traumatic Delivery Previous 3rd/4th degree tear Gestational Diabetes Baby >34 weeks

Score each Caesarean birth

Consider all factors, but use highest single risk factor to give score for individual caesarean

Add up the maximum scores for each Caesarean birth on the list.

Maximum total score of 6 for the list with maximum of 3 Caesarean Births