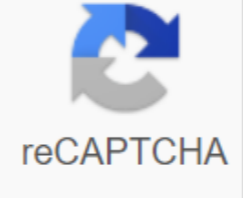




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## Caesarean section guidelines pdf

C-section is defined as the delivery of the fetus through surgical incisions made through the abdominal wall (laparotomy) and the wall of the uterus (histerotomium). In 2014, 32.2% of women who gave birth in the United States did so by caesarean section. The rapid increase in caesarean section rates in 1996-2014, without clear evidence of concomitant reductions in maternal or neonatal morbidity or mortality, raises serious concerns that caesarean section is excessive. The most common signs of primary caesarean section include labor dystocia, abnormal or uncertain fetal heart rate tracking, fetal malformations, multiple pregnancies and suspected fetal macrosomy. A safe reduction in the primary rate of caesarean section will require different approaches for these readings as well as others. It has also been shown that increasing women's access to non-medical interventions during childbirth reduces caesarean section. The external head version for the presentation of the shutter and the labor test for women with double pregnancies when the first twin is in a cephalic presentation are examples of activities that can help safely reduce the primary rate of caesarean section. The American College of Obstetricians and Gynecologists (ACOG) recommends that all women eligible for a squealing in the near term be offered an external head version (ECV) to reduce the overall caesarean section. [3, 4] ACOG/SMFM Guidelines for the Prevention of Primary Caesarean Section american College of Obstetricians and Gynecologists (ACOG) and Society of Maternal and Fetal Medicine (SMFM) have issued joint guidelines for the safe prevention of primary caesarean section. These include the following No. 5, 6 : The long hidden (early) phase of childbirth should be allowed to begin the active phase of childbirth can be defined as an extension of the cervix 6 cm, not 4 cm in the active phase, more time should be allowed for childbirth for the progress of Multiparous women should be able to click on 2 or more hours and primiparous women within 3 or more hours; pressing may be allowed to continue for even longer periods in some cases, As when epidural anesthesia is introduced methods to assist vaginal delivery, such as the use of pinching, should be used Patients should be encouraged to avoid excessive weight gain during pregnancy Access to non-medical interventions during childbirth, such as continuous support during childbirth and childbirth, should be increased External cephalic option should be performed for a brief representation of women with a double pregnancy test should, if the first twin is in the cessel, were originally performed to separate the mother and fetus in an attempt to save them later evolved to address maternal or fetal complications without delivery, either for mechanical limitations or for temporary birth for maternal or fetal benefit. Leading caesarean section rates (85%) are previous caesareans, shutter presentations, dystocia, and fetal distress. Maternal indications for caesarean section include: Obstructive lesions in the lower genital tract, including malignancies, large vulvovaginal warts, obstructive vaginal septus, and lower uterine leiomyomas that prevent the fetus from participating in pelvic abnormalities that exclude participation or interfere with the descent of the fetus in the work of some heart diseases, which exclude normal valsals made by patients during vaginal birth: Situations in which neonatal morbidity and mortality can be reduced by preventing injury Malpresentations (e.g. premature shutter presentations, non-frank shutter term fetuses Some congenital malformations or skeletal disorders Indications for caesarean section that benefit the mother and fetus include following congenital malformations or skeletal disorders Indications for caesarean section that benefit the mother and fetus include the following : Abnormal placentation (e.g. placenta previa, placenta accreta) abnormal labor due to cephaloic pelvic disproportions Situations in which labor is contraindicated there are several contraindications to performing a caesarean section. In some cases, caesarean section should be avoided, for example: when maternal status may be compromised (e.g. a mother has severe lung disease), if the fetus is known for a karyotypic abnormality or a known congenital abnormality that can lead to death (anencephaly), there is a debate about electable caesarean section at the mother's request (CDMR). The 2006 Committee on Obstetric Practices of the American College of Obstetricians and Gynecologists (ACOG) and the 2006 National Institutes of Health (NIH) Consensus Committee determined that the evidence supporting this concept was not conclusive and that more research was needed. Both committees submitted the following recommendations regarding CDMR No.9, 10: If there are no maternal or fetal indications for caesarean section, vaginal delivery should be recommended CDMR should not be performed before 39 weeks of pregnancy without checking the maturity of the foetal lung (due to the potential risk of respiratory diseases for the baby) CDMR is not recommended for women, who want more children (due to the increased risk for placenta previa/accreta and engrave-shaped hysterectomy with each caesarean section) The inaccessibility of effective analgesia should not be the determining factor for CDMR Group NIH Consensus NiH on CDMR also noted the following: CDMR has the potential to reduce the risk of hemorrhage mother and reducing the risk of childbirth CDMR requires individual counseling of the practitioner of the potential risks and benefits of both and caesarean section guidelines recommend a minimum preoperative fasting time of at least 2 hours of clean liquids, 6 hours of light meals and 8 hours of regular meals. However, patients are usually asked not to eat anything for 12 hours before the procedure. The following are also included in the preoperative control: Placement of intravenous (IV) line Of infusion of IV liquids (e.g., lacquered Ringer solution or saline solution with 5% dextrose) Placement of Foley's catheter (for bladder draining and urine flow control) Placement of external fetal monitor and monitors for the patient's blood pressure, pulse, and oxygen saturation Preoperative antibiotic prophylaxis (reduces the risk of endometritis after an elective caesarean section by 76%, regardless of the type of caesarean section (emerging or electable)) Assessment by surgeon and anesthesiologist of laboratory testing The following laboratory tests can be obtained prior to caesarean section: blood type and screen, cross-match screening tests on human immunodeficiency virus Hepatitis B, studies of syphilis clotting (e.g. prothrombin and activated partial thromboplasty times, fibrinogen level) Imaging studies in the field of childbirth and childbirth, documenting the position of the fetus and the intended weight of the fetus. Although ultrasonography is commonly used to assess fetal weight, a prospective study reported the sensitivity of clinical and ultrasonic macrosomy prediction, respectively, of both 68% and 58%. The caesarean section technique includes: laparotomy through middle-line infraumbilic, vertical or transverse (e.g. Pfannenstiel, Mayland, Joel Cohen) incision hissterotomy via transverse (Monroe-Ker) or vertical (e.g. Kronig, DeLee) incision Closing If the patient has been consulted and agreed prior to the procedure, IUDs may be placed prior to repair of hysterotomy or left-fire subdermal implant can be placed in the patient's arm at this time .15 See the list below: Regular postoperative assessment of vital signs If necessary, it has been shown that early feeding reduces hospital stay (IV or intramuscular (IM) analgesia if the patient has not received a long-term analgesic or has general anesthesia; analgesia, Generally not required if the patient has received regional anesthesia, with/without long-term pain relief on postoperative day 1: in advance, as tolerated If the patient plans to breastfeed, initiate within a few hours after delivery; if the patient plans to feed the bottle, she may use a tight bra or binder breast in the postoperative discharge period on the postoperative day 2 to 4, if no complications (17) from intercourse during the 4-6 weeks postpartum period if the patient had LARC placed during the procedure Approximately 2-fold increase in maternal mortality and caesarean section morbidity in relation to vaginal delivery : Partly related to the procedure itself, and are partly related to conditions that may have led to the need to perform a caesarean section of infection (e.g. postpartum endomyometritis, fascial dechication, wound, urinary tract) thromboembolic diseases (e.g. deep venous thrombosis, septic thrombophlebitis pelvis) Surgical trauma (e.g., lacerations of the uterus; The delayed return of bowel function Graph below depicts caesarean section in the U.S. (1991-2007). C-section delivery rates, USA. C-section is defined as the delivery of the fetus through surgical incisions made through the abdominal wall (laparotomy) and the wall of the uterus (histerotomium). Since the words C-section and section are derived from the verbs that mean cut, the phrase C-section is a tautology. Therefore, the terms caesarean delivery and cesarean birth are preferable. Initially, a caesarean section of the mother and fetus was carried out in an attempt to save the fetus of the dying patient. Subsequently, this operation became a surgical procedure to resolve maternal or fetal complications, not maleable for vaginal delivery, or for mechanical limitations, or to complicate childbirth for maternal or fetal use. C-section has evolved from a futile attempt to save the fetus to an attempt in which the doctor and the patient participate in the decision-making process, seeking to achieve the greatest benefit to the patient and her unborn child. Currently, caesarean sections are performed on various indications of the fetus and the mother (see indications). The readings have expanded to reflect the patient's wishes and preferences. Controversy surrounds the current rate of caesarean section in developed countries and its use for indications other than medical necessity. Go to Perimortem caesarean section and vaginal delivery after caesarean section for full information on these topics. In 1910-1928, caesarean section rates at Chicago Hospital increased from 0.6% to 3%. In 1965, the caesarean section rate in the United States was 4.5%. According to the National Hospital Discharge Survey, caesarean section rates rose from 5.5 per cent in 1970 to 24.1 per cent in 1986. Less than 10% of mothers had vaginal birth after a pre-caesarean section, and women spent an average of 5 days in hospital for caesarean section and only 2.6 days for vaginal delivery. It was predicted that if the age-related caesarean section continued with the steady upward trend observed since 1970, 40 per cent of births would occur by caesarean section in 2000. These predictions did not come true, but not by much. The National Centre for Health Statistics reported that the percentage of caesareans in the United States 20.7% in 1996 to 32.2% in 2014. Caesarean section rates have increased for women of all ages, races/ethnicities and gestational ages and in all states (see image below). Both primary and repeated caesarean sections have increased. C-section delivery rates, USA. The increase in the number of primary caesarean sections without any specific indications is faster than in the general population, and appears to be the result of changes in obstetric practices rather than changes in the medical risk profile or an increase in maternal request. This occurred despite several studies that noted an increased risk of neonatal and maternal mortality for all caesarean sections, as well as for medical optional caesarean sections compared to vaginal births. The decrease in the total number and re-caesarean section observed between 1990 and 2000 was due to a temporary increase in the number of vaginal births following caesarean section. The rate of caesarean section has also increased worldwide, but the rates in some parts of the world are still significantly lower than in the United States. The caesarean section rate is approximately 21.1% for the most developed regions of the world, 14.3% for less developed regions and 2% for the least developed regions. In a 2006 publication, in a survey of caesarean section in South America, the average rate was 33%, with rates ranging from 28% to 75% depending on the public service compared to the private provider. The authors conclude that higher caesarean section rates do not necessarily indicate an improvement in perinatal care and may be associated with harm. Why the rate of caesarean section has increased so dramatically in the United States is not entirely clear. Some causes that may explain the increase in repeated caesarean section, delayed delivery and reduced parity, reduced rate of vaginal births after caesarean section have been present since the 1960s, by 1987 less than 10% of women with pre-caesarean delivery had attempted to give birth vaginally. In 2003, a second C-section for all women was 89.4 per cent; for women at low risk, the figure was 88.7 per cent. Today, low-risk women who give birth for the first time after a caesarean section are more likely to have a follow-up C-section. Over the past decade, despite a decrease in their relative size among the population, the proportion of births among women aged 30-50 has declined. C-section at the age of 40-54 in 2007 was more than doubled mothers under the age of 20 (48% and 23% respectively). The risk of caesarean section is higher in zero-age patients, and with increasing maternal age, the risk of caesarean section increases secondary to medical complications such as diabetes and pre-eclampsia. By 1985, almost 85% of all shutter presentations (3% of the fetus' term) were delivered by caesarean section. In 2001, a multicenter and multi-national perspective study determined that the safest way to deliver a shutter presentation was by caesarean section. The study has been criticized for differences in care standards among training centres, which makes it impossible to obtain a standard recommendation. The most recent recommendation of the American College of Obstetricians and Gynecologists (ACOG) on childbirth within a few years is that planned vaginal births may be reasonable in accordance with protocol guidelines for specific hospitals, both for law and for labour management. This may lead to a slight decrease in shutter delivery rates, but the vast majority of cases are likely to continue to be delivered by elective caesarean section. Cluster-randomized controlled study Chaillet et al reported a significant but small decrease in caesarean rate. The advantage was due to the effect of intervention in low-risk pregnancies. There are many signs for caesarean section. In those women who have a planned procedure (e.g., optional or specified repetition, or malpresentation or placental abnormalities), it has already been decided that the alternative to medical therapy, i.e. vaginal delivery, is the least optimal. For other patients hospitalized for childbirth and childbirth, waiting for vaginal delivery. Each patient hospitalized in this case is hospitalized with the thought of a successful vaginal birth. However, if the patient's situation needs to change, a C-section is performed because it is believed that the result may be better for the fetus, the mother, or both. C-section is performed for maternal testimony, fetal readings, or both. Leading indications for caesarean section are previous caesarean sections, shutters, dystocia, and fetal distress. These figures are responsible for 85% of all caesarean sections. Maternal indications for caesarean section include: Obstructive lesions in the lower genital tract, including malignancies, large vulvovaginal warts, obstructive vaginal septum and lower uterine leiomyomas that interfere with the involvement of pelvic fetal abnormalities, which prevent or interfere with the descent of the fetus during the birth of the fetus. pressure generated by Valsalva's manoeuvres can lead to complications for the mother. These Are These left heart stenosis, enlarged aortic valve root, some cerebral arteriovenous malformations (AVMs), and recent retinal detachment. Women who have previously undergone vaginal or perineal reparative surgery (such as colporrhaphy or repair major involvement from inflammatory bowel disease) also benefit from a caesarean section to avoid damaging previous surgical repairs. There is no clear evidence to support planned caesarean sections for extreme maternal obesity. A prospective cohort study conducted in the United Kingdom included women with a body mass index of 50 kg/m2 or more and noted a possible increase in shoulder dystocia (3% vs. 0%), but found no significant differences in anesthesia, postpartum or neonatal complications between women who underwent a planned vaginal birth and those who underwent a planned C-section. However, recent studies show that women who are obese and obese have an increased diet of 2.05 and 2.89 compared to normal weight of women. Distocia in labor (labour dystocia) is very often cited indication of a C-section, but it is not specific. Dystocia is classified as a protracted disorder or as an arrest disorder. These may be primary or secondary disorders. Most dystocias are caused by power abnormalities (uterine contractions), passage (mother's pelvis), or passenger (fetus). When diagnosing dystocia in childbirth, the indication must be detailed in accordance with the previous classification (i.e., primary or secondary disorder, arrest or protracted disorder, or combination above). For more information, see recently there has been controversy over the possibility of elective caesarean sections at the mother's request (CDMR). Evidence suggests that it is prudent to inform a pregnant woman by requesting a caesarean section about the risks and benefits of the current and any subsequent pregnancies. The role of the doctor should be to ensure that the best advice from a woman is based on evidence and that she is independent and that decisions can be made when considering the route of delivery. In 2006, the National Institutes of Health (NIH) convened a consensus conference to review CDMR. They decided that the evidence to support the concept was not conclusive. Their recommendations included: CDMR should be avoided by women wishing to have multiple children. CDMR should not be performed until the 39th week of pregnancy or without checking the maturity of the fetus's lungs. CDMR has the potential benefit of reducing the risk of hemorrhage for the mother and reducing the risk of childbirth. CDMR has a potential risk of respiratory diseases for the child, associated with longer hospital stays of the mother and increased risk of placenta previa and placenta accretion with each successive caesarean section. (38) (38) further noted that the procedure required individual counseling by the practitioner about the potential risks and benefits of both vaginal and caesarean section, and it should not be motivated by a lack of effective pain management. CDMR detractors argue that the premise of a caesarean section on request applies to a very small proportion of the population and that it should not be offered regularly for ethical reasons. The emerging consensus is that a randomized prospective study is needed to address this problem. Fetal indications for caesarean section include the following: Situations in which neonatal morbidity and mortality can be reduced by preventing injuries Some congenital malformations or skeletal fetal disorder in the representation of nonvertex is at increased risk of injury, cord prolapse and head grip. Malpresentation includes premature shutter presentations and a non-frank shutter term for fetuses. The decision to proceed with a caesarean section for the term outspoken shutter singleton fetus has been challenged. While most practitioners will always perform a C-section in this situation, ACOG has left open the opportunity to consider shutter delivery under appropriate circumstances, including a practitioner experienced in assessing and managing labor and qualified in the delivery of a fetal shutter. Some government agencies to help mothers even implement tools to reduce the number of caesarean sections in the event of a shutter presentation, with guidelines recommending the formation of a team in a hospital that is trained and convenient with disruption and prompt supplies. If a patient is diagnosed with a fetal malformation (such as a shutter or transverse lie) after 36 weeks, a variant of the external cephalic version is offered to try to convert the fetus into a top lie, allowing the attempt of vaginal delivery. The outer cephalic version is usually tried for 36-38 weeks with research underway to establish the use of performing the outer head version at 34 weeks gestational age. Ultrasonography is performed to confirm the shutter presentation. If the fetus is still in nonvertex performance, the intravenous (IV) line is developed, and the baby is controlled with an external fetal heart rate monitor before the procedure to confirm well-being. With reassuring fetal heart rate tracking, the version tries. The outer cephalic version involves an attempt to externally manipulate the fruit in the presentation of the top. This is achieved by using ultrasonographic instructions to establish the lies of the fetus. Attempt to manipulate the fruit either through a forward roll or a backward roll. The overall chances of success are about 60%. Some practitioners inject the patient with an epidural dose of subcutaneous terbutalin (beta-mimetics used for tocolysis) shortly before the attempt. Factors influencing the success of the attempted version include multiparity, the posterior placenta, and normal amniotic fluid with a normally grown fetus. In addition, to be a candidate, the patient must be entitled to attempt vaginal delivery. Contradictions to the external cephalic version of include oligohydramnios, intrauterine growth restriction with abnormal dopler or fetal heart tracking, major uterine abnormalities, prenatal hemorrhage, abnormal fetal heart tracking, multiplelipsis and memembran rupture. Relative contraindications include low fetal growth or the presence of congenital abnormalities. Risks of the external cephalic version include rupture of membranes, childbirth, fetal injury, and the need for an emerging caesarean section due to placental cutting. A recent survey reported a severe complication rate of 0.24% and a C-section rate of secondary complications of 0.34%. If the version is successful, the patient is placed on the fetal monitor in the immediate vicinity of the separation of childbirth and childbirth or in the department of childbirth and childbirth. If fetal heart rate testing is encouraging, the patient is discharged while waiting for spontaneous delivery, or it can be caused if the fetus is of appropriate gestational age or the patient has a favorable cervix. The first twin in the nonvertex presentation is a sign of a caesarean section, as are multiples of higher order (triplets or more). A large amount of literature supports both direct caesarean section as well as spontaneous shutter delivery or extraction of the second twin. The decision is made jointly with the patient after appropriate consultation on the risks and benefits, as well as under the supervision of a doctor experienced in the management of the birth and childbirth of the restrictive fetus. Evidence suggests that the rate of severe complications of the twin's second shutter does not depend on the method of delivery. Several congenital abnormalities are controversial signs of caesarean section; These include defects in the fetal neural tube (to avoid tearing the sac), especially defects that are larger than 5-6 cm in diameter. One study found no difference in long-term motor or neurological outcomes. Some authors noted no link between the mode of delivery and infant outcomes, while others advocated for a C-section of all infants with a neural tube defect. C-section is indicated in some cases of hydrocephalus with increased biparietic diameter, and some skeletal dysplasia such as type III osteogenesis is imperfect. The question of whether a direct caesarean section should be performed in the face of a foetal abdominal wall defect (e.g. gastroschisis or omphalocele) remains a questionable one. Most reviewers agree that C-section is not beneficial if squeezed liver, which is a very rare event. The total frequency of caesarean section in this group of patients is probably due to an increase in the incidence of intrauterine growth delay and fetal distress before or in childbirth. In an unfeasible and unsequential model of distance from childbirth, caesarean section is recommended to prevent mixed or metabolic acid, which can potentially cause significant morbidity and mortality. Electronic fetal monitoring was used in 85% of births in the United States in 2002. Its use increased the rate of caesarean section to 40%. This happened without a reduction in cerebral palsy or perinatal mortality. ACOG recommended that any obstetric care agency be able to perform a C-section within 30 minutes of the decision. Despite this recommendation, the decision on delivery time of more than 30 minutes is not necessarily associated with a negative neonatal outcome. Among patients with genital herpes infection in the first episode, the risk of transmission of the mother's fetus is 33 times higher than in recurrent outbreaks. The largest population-based study reported that for primary infection, the risk of transmission to a newborn was 35%, compared with a 2% risk of recurrent infection. Among patients with culturally-positive herpes, the rate of transmission with vaginal birth is 7 times that of caesarean section. Currently, all patients with an active or symptomatic herpes infection are candidates for a C-section. Neonatal herpes infection can lead to significant morbidity and mortality, especially in the primary outbreak. In periodic outbreaks, the risk to newborns is reduced by the presence of maternal antibodies. Unfortunately, not all women with active viral shedding can be detected when they give birth and childbirth. The treatment of women with HIV has undergone tremendous changes over the past few years. Women with a viral number above 1000 should be offered a C-section within 38 weeks (or earlier if they are in childbirth). In women who are treated with high active antiretroviral therapy (HAART), caesarean section (before or without long-term membrane rupture) appears to further reduce the risk of neonatal transmission, especially among women with viral numbers above 1,000. Among patients with low or undetectable viral numbers, the evidence to support the benefit is not so clear; however, the patient should be able to have a caesarean section. Indications for caesarean section, which benefit both the mother and the fetus, include the following: Abnormal birth due to cephaloic pelvic disproportions Situations in which childbirth is contraindicated In the presence of placenta previum (i.e., placenta covering the inner cervical axen), attempt of vaginal delivery both the mother and the fetus risk developing hemorrhagic complications. This complication actually increased as a result of an increase in the frequency of repeated caesarean section, which is a risk factor for placenta previa and placenta accretion. Both placenta previa and placenta accreta carry an increased morbidity associated with hemorrhage and the need for a hysterectomy. [58, 59, 38] Cephalop pelvic imbalances can be suspected based on possible macrosomy or arrest of labor, despite the increase. Many cases diagnosed as pelvic cephalosis disproportion are the result of primary or secondary arrest of dilation or arrest of origin. Predicting a true primary or secondary arrest of descent due to pelvic cephaloic disproportion is best assessed by overlapping sagittal seam, but not overlapping the seam of lambdoid, especially where progress is poor in the labor test. Continuing to attempt vaginal delivery in this environment increases the risk of infectious complications for both the mother and the fetus from long-term membrane rupture. Less frequently maternal hemorrhagic and fetal metabolic effects occur as a result of uterine rupture, especially among patients with previous caesarean section. Vaginal delivery can also increase the risk of maternal injury and fetal injury (e.g. Erb-Duchenne or Klampke paralysis and metabolic acidosis) from shoulder dystocia. Among women who have a scar on the uterine eyes (before a transmural myomectomy or caesarean section at a high vertical incision), a caesarean section must be performed before the birth to prevent the risk of uterine rupture, which is approximately 4-10%. There are several contraindications to the caesarean section. If the fetus is alive and of a viable gestational age, then a C-section can be performed in the appropriate setting. In some cases, caesarean section should be avoided. Rarely can maternal status be compromised (e.g. with severe lung disease) to the point where surgery can jeopardize the mother's survival. In such difficult situations, a care plan should be developed outlining when and when to intervene in family affairs in setting up an interdisciplinary meeting. C-section may not be recommended if the fetus has known karyotypic abnormalities or known congenital abnormalities that can lead to death (anencephaly). However, the doctor and the patient should actively discuss all options before making this decision. Solution. caesarean section guidelines rocg. caesarean section guidelines pdf. caesarean section guidelines australia. category 1 caesarean section guidelines. emergency caesarean section guidelines. nice caesarean section guidelines. nhs caesarean section guidelines. ranczog caesarean section guidelines

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