CERVICAL SUTURE / CERCLAGE – REMOVAL GUIDELINE

1. OPTIMAL OUTCOMES
   • Removal of suture using an aseptic technique prior to established labour

2. PATIENT
   • Woman with Shirodkar or McDonald suture

3. STAFF
   • Medical Staff
   • Registered midwife

4. EQUIPMENT
   • Speculum
   • Long handled scissors
   • Rampley’s forceps
   • Spotlight

5. CLINICAL PRACTICE
   • Remove suture electively between 37 and 38 weeks gestation. With woman in lithotomy position:
     o insert duck-billed speculum
     o identify knot
     o grasp with Rampley’s forceps
     o cut suture next to cervix
     o ensure entirety is removed
   • Remove suture in an emergency in the event of pre-term labour or membrane rupture to avoid infection

6. HAZARDS/SUB-OPTIMAL OUTCOMES
   • Infection of the cervix
   • Chorioamnionitis
   • Injury to the cervix or bladder
   • Bleeding

7. DOCUMENTATION
   • Integrated clinical notes
   • Yellow card

8. EDUCATIONAL NOTES
   • Decision making with regard to insertion of a cervical suture is complex and controversial and made on a case by case basis
   • If a woman labours with her suture in, it may cause a severe cervical tear, cervical incompetence or rupture of her uterus\(^1\).
   • When McDonald cerclage is electively removed at 36-37 weeks only a small number of women (11%) spontaneously deliver within 48 hours, and mean interval from removal to spontaneous delivery is 14 days\(^2\).
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9. RELATED POLICIES/PROCEDURES/CLINICAL PRACTICE GUIDELINES
   • Cervical shortening
   • Obesity in pregnancy, labour and postpartum
   • Aseptic Technique

10. REFERENCES

REVISION & APPROVAL HISTORY
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