

## **CERVICAL SUTURE/CERCLAGE – REMOVAL**

*This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.*

### **1. AIMS**

- The safe removal of cervical suture/cerclage using an aseptic technique

### **2. PATIENT**

- Woman with a cervical suture/cerclage requiring removal

### **3. STAFF**

- Medical, midwifery and nursing staff

### **4. EQUIPMENT**

- Sterile speculum
- Long-handled scissors
- Sponge forceps
- Spotlight

### **5. CLINICAL PRACTICE**

- Plan removal of cervical suture/cerclage electively at 37 weeks gestation (unless clinical indication prior e.g. preterm prelabour rupture of membranes (PPROM), premature labour, or in consultation with obstetric consultant)
- Organise removal of suture in the most appropriate location – either antenatal ward procedure room, delivery suite (DS) or operating theatres (OT). This may depend on type of suture/cerclage or other patient factors (e.g. analgesia requirements). If uncertain, check with obstetric consultant or senior registrar
- Liaise with anaesthetic team and theatre staff if removal of suture is required in OT. Book on an elective caesarean section (CS) list or emergency list
- Ensure appropriate analgesia is in place
- Implement the following procedure for removal:
  - Position woman in lithotomy position
  - Insert bivalve speculum
  - Identify knot
  - Grasp knot with sponge forceps
  - Cut suture/cerclage next to knot and remove suture/cerclage
  - Ensure entirety of suture/cerclage is removed
  - Send to pathology for culture if symptoms/signs of sepsis/infection
- Document removal date in medical record and on antenatal card
- Remove suture/cerclage as a matter of urgency in the event of labour or rupture of membranes at any gestation to minimise risk of infection
- Remove suture in woman having a caesarean section if need for removal has been confirmed. Timing of the removal will need to be individualised depending on clinical circumstances and in consultation with obstetric consultant.

## CERVICAL SUTURE/CERCLAGE – REMOVAL

### 6. DOCUMENTATION

- Medical record
- Antenatal card

### 7. EDUCATIONAL NOTES

- Cervical suture/cerclage is usually placed in the context of:
  - cervical incompetence at non-viable gestation
  - significant cervical surgery
  - $\geq 2$  previous mid-trimester pregnancy loss
  - progressive cervical shortening despite progesterone therapy
  - a rescue cerclage in a dilated cervix at a non-viable gestation in the absence of contractions and evidence of infection
- Cervical suture/cerclage is usually placed < 24 weeks gestation, and can be placed as early as 10-14 weeks gestation if indicated
- Decision making with regard to insertion of a cervical suture/cerclage is complex and controversial and made on a case by case basis as to the indication and type of suture placed
- If a woman labours with her suture in, it may cause a severe cervical tear, cervical incompetence or rupture of her uterus
- Other risks associated with a cervical suture include:
  - chorioamnionitis
  - injury to the cervix or bladder
  - bleeding
  - cervical dystocia
  - PPROM
  - preterm labour
- When a McDonald (purse-string) 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<sup>1</sup>
- There is evidence that removal of the suture/cerclage followed by immediate artificial rupture of the membranes or spontaneous onset of labour is more likely to be associated with chorioamnionitis with coliforms than if this is delayed for 48 hours or longer. Antibiotic prophylaxis (e.g. benzylpenicillin) should be given for the duration of labour in this circumstance<sup>2</sup>
- Women who go into labour with the suture in-situ should have the suture removed as early as possible. If this cannot be achieved, remove the suture after birth.
- The onset of preterm labour unresponsive to tocolysis and/or a strong suspicion of sepsis are indications for the removal of the cerclage as an emergency

### 8. RELATED POLICIES/PROCEDURES/CLINICAL PRACTICE LOP

- Rupture of Membranes – Preterm pre-labour – Assessment and Management
- Sepsis in pregnancy and postpartum

## **CERVICAL SUTURE/CERCLAGE – REMOVAL cont'd**

### **9. RISK RATING**

- Low

### **10. NATIONAL STANDARD**

- Standard 5 – Comprehensive Care

### **11. REFERENCES**

1. Bisulli M, Suhag A, Arvan R, et al. Interval to spontaneous delivery after elective removal of cerclage. American Journal of Obstetrics and Gynaecology 2009 Aug: 201: 163.e 1-4.
2. SA Perinatal Practice Guidelines: Cervical Insufficiency and Cerclage, Endorsed by: South Australian Maternal, Neonatal & Gynaecology Community of Practice Last Revised: 14/11/17

### **REVISION & APPROVAL HISTORY**

Reviewed and endorsed Maternity Services LOPs group 18/6/19  
Approved Quality & Patient Safety Committee 20/6/13  
Reviewed June 2013  
Approved Quality & patient Safety Committee 15/10/09  
Endorsed Obstetrics Clinical Guidelines Group September 2009

**FOR REVIEW : JUNE 2024**