

## **Elective Caesarean Section Information guide**

Caesarean section operations can be either planned (elective) or unplanned (an emergency). This is information that we think a pregnant women needs to consent to a caesarean section.

### **Caesarean section** (and what to expect!)

If your caesarean section is planned you will be given a date for the operation. A few days before your operation you will see a midwife who will give you two ranitidine tablets to take home with you. These tablets reduce the acidity of your stomach contents and make it safer for you to have an anaesthetic. One ranitidine tablet should be taken at 10pm the night before the caesarean section and the other at 7.30am on the morning of the caesarean section (you can take this tablet with a small amount of water). You should have nothing to eat or drink from midnight on the evening before the operation. Usually, at the same appointment, you will have a blood test, to check your iron levels and to provide a sample for the blood transfusion department.

### **On admission to hospital**

You should arrive on the ward at the agreed time.. Your partner is encouraged to come with you and stay with you throughout the operation. If it becomes necessary to give you a general anaesthetic your partner will be asked to wait outside the operating theatre during the delivery.

Your operation will probably take place in the morning. You will meet the anaesthetist on the ward and he/she will discuss the planned anaesthesia with you. The vast majority of caesarean sections are performed with an epidural or a spinal anaesthetic; this means you will be awake during the operation, though you should feel no pain. You will be given elasticated stockings to wear, which will reduce the risk of blood clots developing in your legs. You may be given a small shave along the bikini line and your partner will be given theatre clothing to change into.

A drip (a small tube) will be put into your arm before the epidural is carried out. A urinary catheter (a flexible tube) will be inserted into your bladder to keep it empty during surgery. Just before the operation starts you may be given a dose of a mixture of sodium citrate to drink, to further reduce the acidity in your stomach.

### **The operation**

In theatre there will be the surgeon (your obstetrician), the assistant surgeon, the anaesthetist, the operating department assistant (ODA), a scrub nurse to help with the operation, another midwife to help with the baby and, very soon, your baby.

First your tummy will be cleaned and covered by sterile sheets. The sheets will form a sterile screen between you and the surgeon. The screen will stop you seeing what is being done but it may be lowered if you wish to see the baby being delivered. As soon as the team are confident that you will not be able to feel any pain, the operation will start. You may feel sensations such as pushing and pulling.

A cut along the bikini line will be made in the lower part of your tummy. Within a few minutes your baby will be delivered. The baby will be dried and quickly examined before being given to you. The surgeon will then close the cut that they have made, layer by layer. Usually the whole operation takes about one hour. At the end of the operation your vagina will be cleaned of any

collected blood and you may be given a pain-relieving drug called Diclofenac (or Voltarol), as a suppository, which is placed in the back passage. After the operation you may be moved to the recovery area for a few hours of close observation, before being taken to the ward. Both your partner and baby can remain with you throughout.

### **After the birth**

After the spinal/epidural has worn off you will be offered a combination of pain relieving drugs. If you get up and about soon after the operation you are less likely to develop a clot in your leg, which is one of the complications of surgery. Tell the midwife if you are in pain so that she can give you the most suitable combination of painkillers.

You will be given help to feed and change your baby, until you are able to manage this by yourself.

After 24 hours you can expect to be drinking normally, taking a light diet and walking to the toilet.

The dressing is removed from the wound the day after surgery, and the stitch (or staples) is usually removed after 5 days. The physiotherapist or midwife will give you advice on postnatal exercises and getting back to normal.

### **Going home**

You can usually go home on the third day following delivery. A midwife will visit you at home until the baby is 10 days old. The health visitor will then call.

You will be given pain-killing tablets and any other medicines that you require to take home with you. It is important to have help at home for the first few days. You can resume your normal life gradually as you feel stronger, but avoid driving and heavy lifting until you feel completely better.

You will have an appointment to be seen six weeks later. This is a good opportunity to discuss contraception, and check that you have fully recovered from the birth. It is important to remember you can become pregnant very soon after having a baby.

### **Your right to consent**

You have an absolute right to accept or refuse any medical treatment provided you are over the age of eighteen. Before a caesarean section can be carried out you have to give your consent ("yes, I will allow this operation to go ahead"). Before an elective caesarean section you will be asked to sign a consent form. For your consent to mean anything (to be valid) you must:

1. "Be competent". This means that you must be capable of making a decision. If you are under the influence of drugs, for instance, you might not be capable of making a decision.
2. Be able to make the decision voluntarily. In other words you should not feel that you are being forced into a decision by anyone.
3. Have sufficient information to make an informed choice. Except in the most exceptional circumstances, you should be given information about what is going to happen to you along with any serious risks, even if they are unusual. You should also be told of less serious risks if they are common.

## Risks of an elective caesarean section

All operations carry risks. Elective caesarean sections are relatively safe operations and are usually performed during the 39<sup>th</sup> weeks of your pregnancy.

The majority of the risks of an elective caesarean section can be divided into

- The risks of an anaesthetic, which should be discussed by the anaesthetist.
- Specific risks of the operation itself which include:
  1. Haemorrhage. This means bleeding heavily. Following a Caesarean section about 10% of mothers will be anaemic because of blood loss and about 3-5% will need a blood transfusion. Very rarely bleeding may continue despite normal obstetric management. Sometimes the only way to stop the bleeding is to perform a hysterectomy (which is fortunately very rare).
  2. Damage to other parts of the body. There is a small chance that your bladder, ureters (the tubes that carry urine from your kidneys to your bladder) or bowel might be damaged during the operation. The risk of this is thought to be around 1 in 200 and is more likely if you have had a previous operation on your tummy.
- The risk of problems after the operation, which include:
  1. Respiratory complications. A respiratory complication is one that affects your breathing, like a chest infection or pneumonia. They are more likely following general anaesthesia and in women who smoke or already have a problem with their breathing.
  2. Bowel complications, the most common of these is an ileus. An ileus is when your bowel stops working normally, it can make you feel bloated and sick. It gets better quickly, with very simple treatment.
  3. Infection. Infection is fairly common, affecting about 5% of women who have had a caesarean section. It usually affects your wound, your womb or your urinary tract. With the use of antibiotics during surgery the risk of serious complications is very low.
  4. Thromboembolism. A thrombosis is when a blood clot develops in a blood vessel. Usually these clots are small and develop in vessels in the leg; very occasionally they can be larger and affect blood vessels in the lungs. This is called a pulmonary embolism. To prevent a clot developing you will wear special stockings and receive injections of a medicine called heparin, which makes you less likely to form a blood clot. With these preventative measures the risk of thromboembolism is small.
  5. The risks to future pregnancy. The risk of a placenta praevia (a placenta that covers the opening to the womb) after 2 caesarean sections is approximately 2%. The risk of the placenta being stuck to the uterus (and therefore difficult to remove) is approximately 1% after two caesarean sections. These figures will be of concern to those considering a large family.

The most serious complication of any operation is death but fortunately this is extremely unlikely following an elective caesarean section (less than 1 in 10,000). Routine elective CS under epidural anaesthetic with adequate thromboprophylaxis (treatment to stop blood clots forming) and antibiotic cover is a very safe type of operation and is probably no more dangerous than planning to have a vaginal delivery.