PIPADOR REVISION

MRCOG Part 1 Revision Notes

Caesarean Section

CLINICAL MANAGEMENT • LECTURE 481

VISUAL EXAMINATION REVISION NOTES

2026 Edition

481

MRCOG PART 1 REVISION NOTES | CLINICAL MANAGEMENT

Caesarean Section

Definitions, categories, indications, perioperative care, risks and VBAC (NICE NG192, RCOG GTG 45)

≈ 40%	Cat 1	39 weeks	VBAC ≈ 75%
England births by CS	Within 30 min	Planned CS	Success

■ KEY FACTS: Learning objectives

- Define the categories of caesarean section (CS) and planned vs emergency CS.
- Describe indications, consent, perioperative care and techniques (NICE NG192).
- Describe risks, maternal request CS, and birth after previous CS (RCOG GTG 45).

481.1 Key definitions

Term	Definition
Caesarean section (CS)	Surgical birth through an abdominal and uterine incision
Planned (elective) CS	Scheduled before labour (category 4)
Emergency CS	Categories 1–3, decided during pregnancy or labour
Lower segment CS (LSCS)	Transverse incision in the lower uterine segment — standard
Classical CS	Vertical upper-segment incision (very preterm, transverse lie with back down, fibroids) — high rupture risk in future labour
VBAC / ERCS	Vaginal birth after caesarean / elective repeat caesarean section
Decision-to-birth interval	Time from decision to birth — targets 30 min (cat 1), 75 min (cat 2)

■ IN PLAIN ENGLISH: Caesarean section

CS is common and generally safe, but it is major surgery with risks for this and future pregnancies. Good care means the **right decision, at the right urgency, with informed consent and evidence-based techniques** to reduce infection, VTE and bleeding.

481.2 Categories and indications

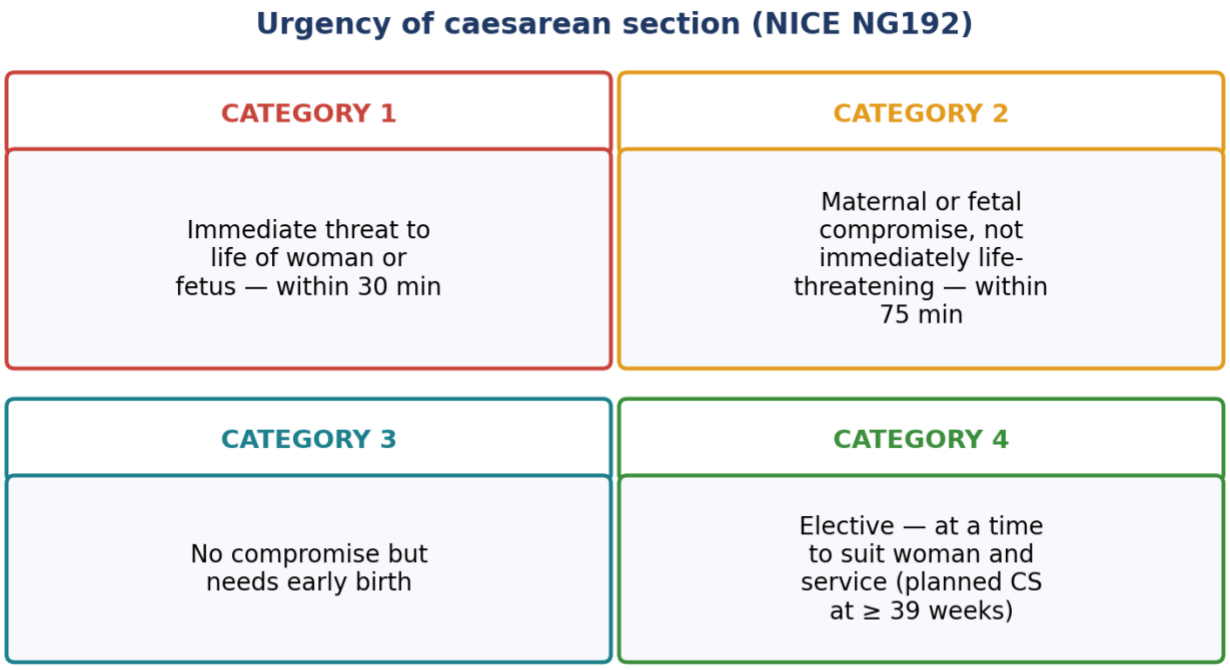


Figure 481.1 — Urgency of CS (NICE NG192)

- Common indications: previous CS
  - Failure to progress
  - Suspected fetal compromise, breech
  - Placenta praevia/accreta
  - Multiple pregnancy (complicated)
  - Maternal medical conditions
  - HIV with detectable viral load
  - Primary genital herpes in 3rd trimester, maternal request.
- **Maternal request**: explore reasons, discuss risks/benefits, offer perinatal mental health support (e.g. fear of childbirth)
  - If after discussion she still requests CS, **offer a planned CS** (or refer to a colleague who will).

481.3 Perioperative care (NICE NG192)

Element	Recommendation
Timing	Planned CS at or after 39+0 weeks (↓ neonatal respiratory morbidity)
Antacids	H_2-receptor antagonist (or PPI) and antacids before CS; antiemetics
Anaesthesia	• Regional anaesthesia preferred • GA for category 1 if regional not possible
Antibiotics	Prophylactic antibiotics BEFORE skin incision
VTE	Risk assessment; LMWH ± stockings per RCOG GTG 37a
Skin preparation	• Chlorhexidine-alcohol • Vaginal cleansing (povidone-iodine/chlorhexidine) may reduce endometritis
Technique	• Transverse (Joel-Cohen) skin incision • Blunt extension of uterine incision • Oxytocin 5 IU slow IV (or carbetocin) at birth

Element	Recommendation
	• Placenta removed by controlled cord traction • Uterine closure (two layers outside research per many units) • Do not close peritoneum routinely • Subcutaneous suture only if fat > 2 cm
Neonate	Delayed cord clamping if possible; skin-to-skin; early breastfeeding
Postoperative	• Early eating/drinking, mobilisation • Catheter removal once mobile (≥ 12 h after last top-up) • Analgesia (oral opioids + paracetamol + NSAID), wound care • Discharge after 24 h if well

481.4 Risks

Maternal	Baby / future pregnancy
• Haemorrhage, infection (wound, endometritis, UTI), VTE • Bladder/bowel/ureteric injury, hysterectomy • Anaesthetic complications, longer recovery, readmission	• Neonatal respiratory morbidity (↓ after 39 weeks), fetal laceration (≈ 1–2%) • Future: uterine rupture, placenta praevia/accreta, stillbirth (small ↑), repeat CS, adhesions

481.5 Birth after previous CS (RCOG GTG 45)

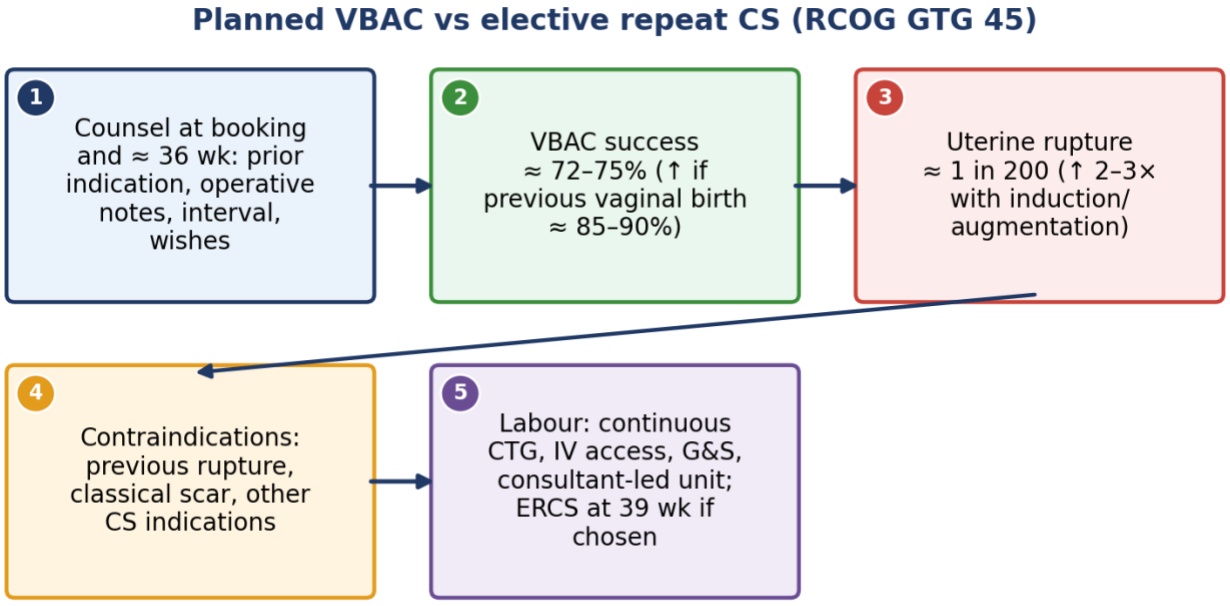


Figure 481.2 — Planned VBAC vs elective repeat CS

- VBAC is appropriate for most women with one previous lower-segment CS; consider carefully after ≥ 2 previous CS.
- Contraindications: previous uterine rupture, classical CS, other contraindications to vaginal birth.
- Uterine rupture signs: abnormal CTG (most common), severe pain, vaginal bleeding, haematuria, loss of station, maternal tachycardia/shock → category 1 CS.
- Induction/augmentation increases rupture risk — mechanical methods preferred; consultant involvement.

■ COMMON PITFALLS

Giving antibiotics after cord clamping rather than before incision.

Planned CS before 39 weeks without indication.

Not discussing future-pregnancy implications.

481.6 Must-know summary

■ EXAM TIP

- Categories: 1 (threat to life — 30 min), 2 (compromise — 75 min), 3 (early birth), 4 (elective).
- Planned CS ≥ 39+0 wk; antibiotics before incision; antacids; VTE prophylaxis; regional anaesthesia.
- Maternal request: explore, support, offer planned CS if still requested.
- VBAC success ≈ 72–75%; rupture ≈ 1 in 200 (↑ with IOL); contraindications: previous rupture, classical scar.

■ MNEMONIC / MEMORY AID

CS categories — '1 = Immediately (30 min), 2 = Urgent (75 min), 3 = Soon, 4 = Scheduled'.