

The Cambridge Cerclage following Full Dilatation Caesarean Section and Excisional Cervical Surgery

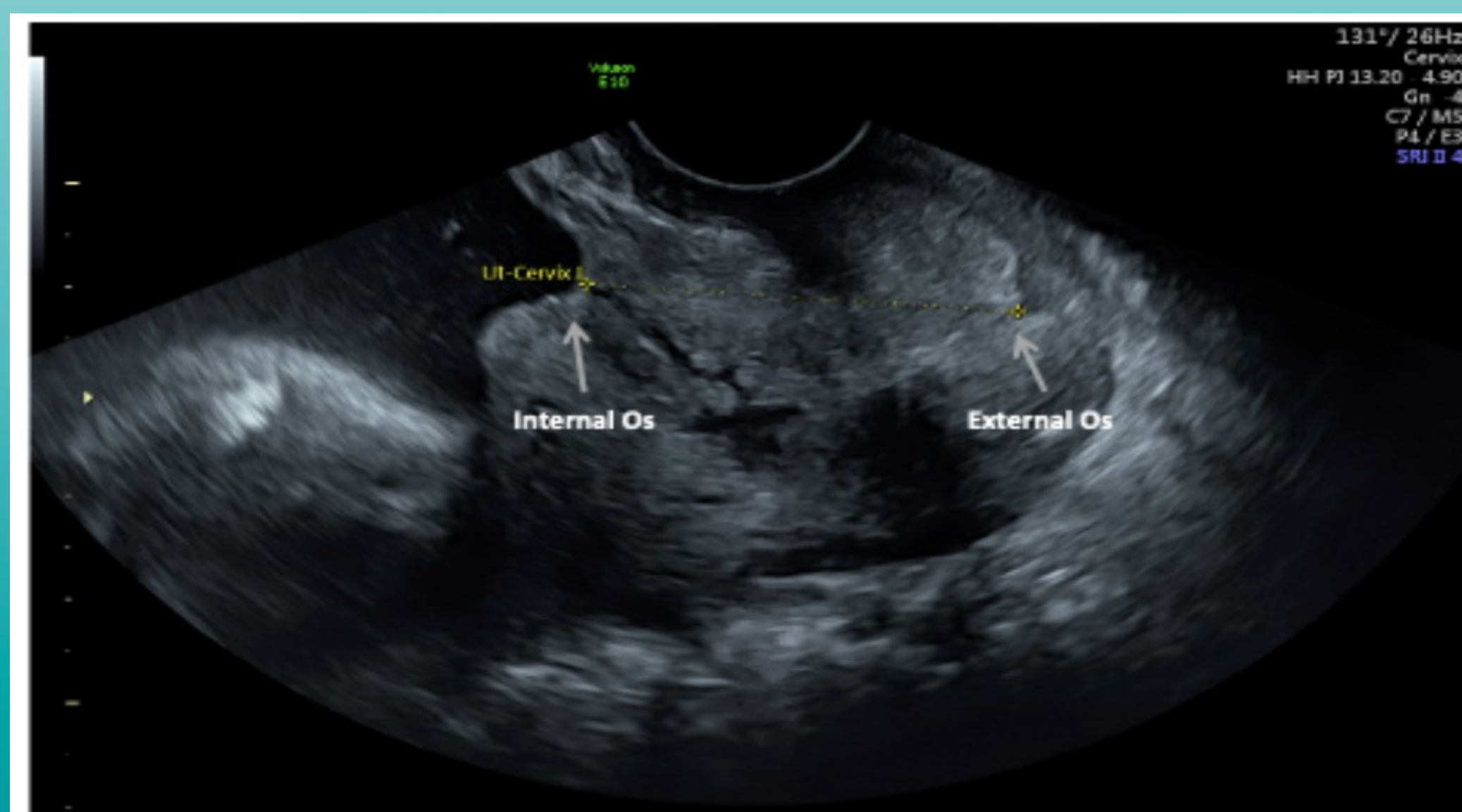
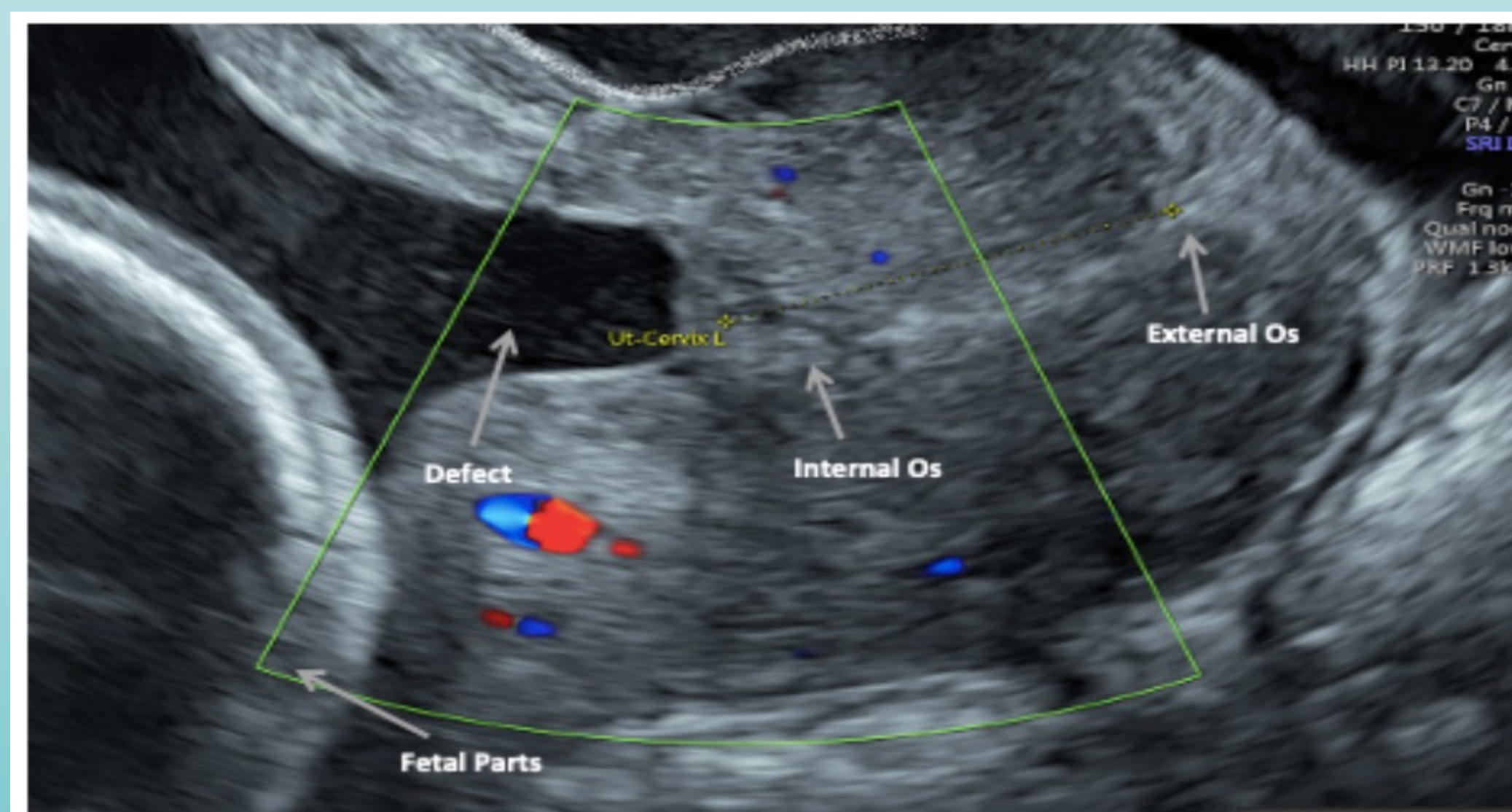
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ABSTRACT

Prematurity is the leading cause of neonatal morbidity and mortality worldwide. The global increase in Caesarean births, particularly at full dilatation (FDCS), coupled with excisional cervical treatments has increased the burden of the short cervix at a preterm gestation in a subsequent pregnancy. Accumulation of evidence now suggests that women with a short cervical length due to injuries from previous Caesarean Sections at full dilatation, or those with stenosed and fibrosed cervixes from multiple excisional treatments have a higher failure rate of cervical cerclage. We propose the Cambridge Cerclage; a collection of evidence-based ultrasound-proven modifications of known transvaginal cerclage techniques in such cases to mitigate this failure rate.

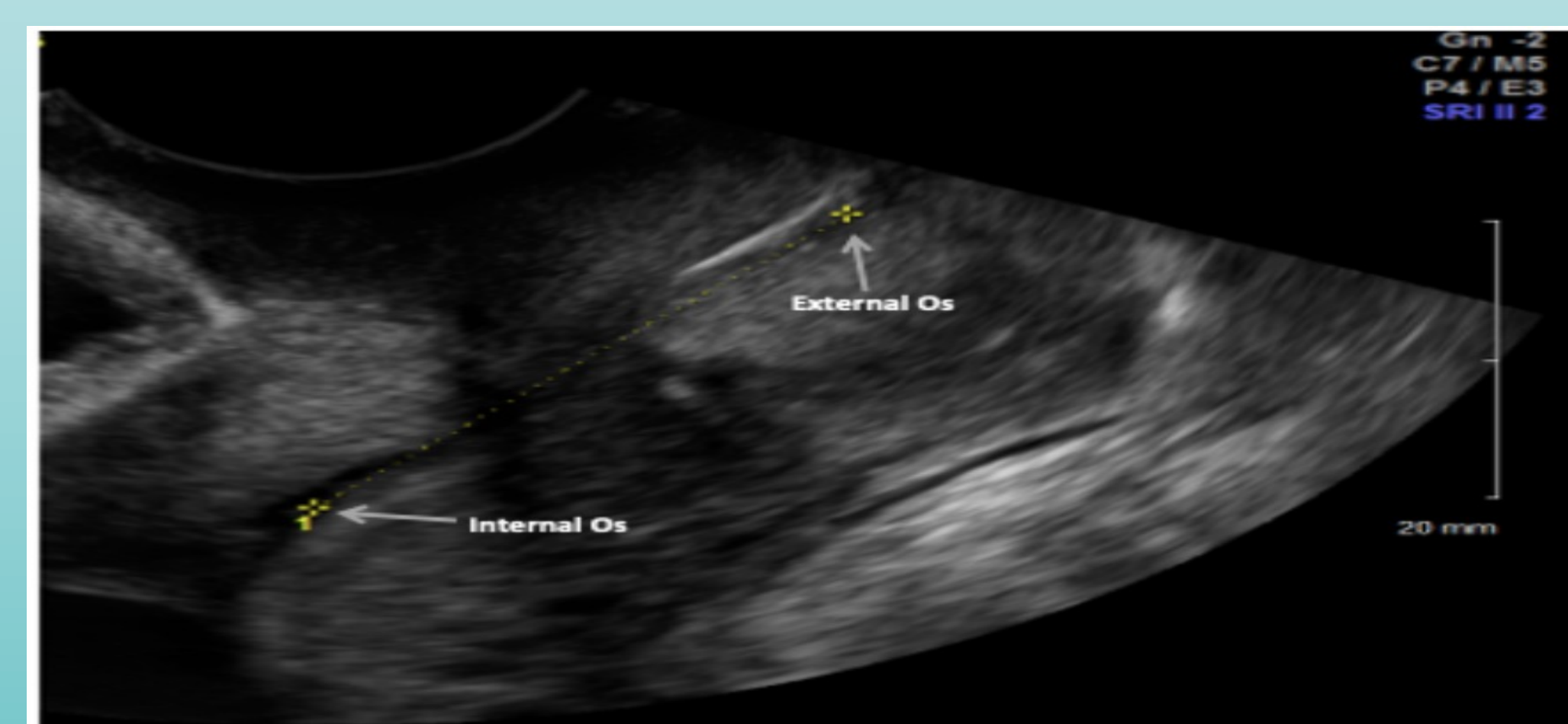
TUG OF WAR

In women with an incompetent cervix following FDCS, two purse string sutures are placed. The first purse string starts at the highest level posteriorly at the 5 – 6 o'clock position. This aims to bring the long intact posterior aspect of the cervix in contact with the defects seen mainly on the anterior lip of the cervix. The opposing anterior purse string is placed at the same level as high as possible or even higher.



TAUT

In women with excisional surgeries or with injured cervixes from forceful dilatations and multiple injuries, the two purse strings can be placed in the same direction starting either anteriorly or posteriorly. The purpose here is to provide rigidity and tightness.

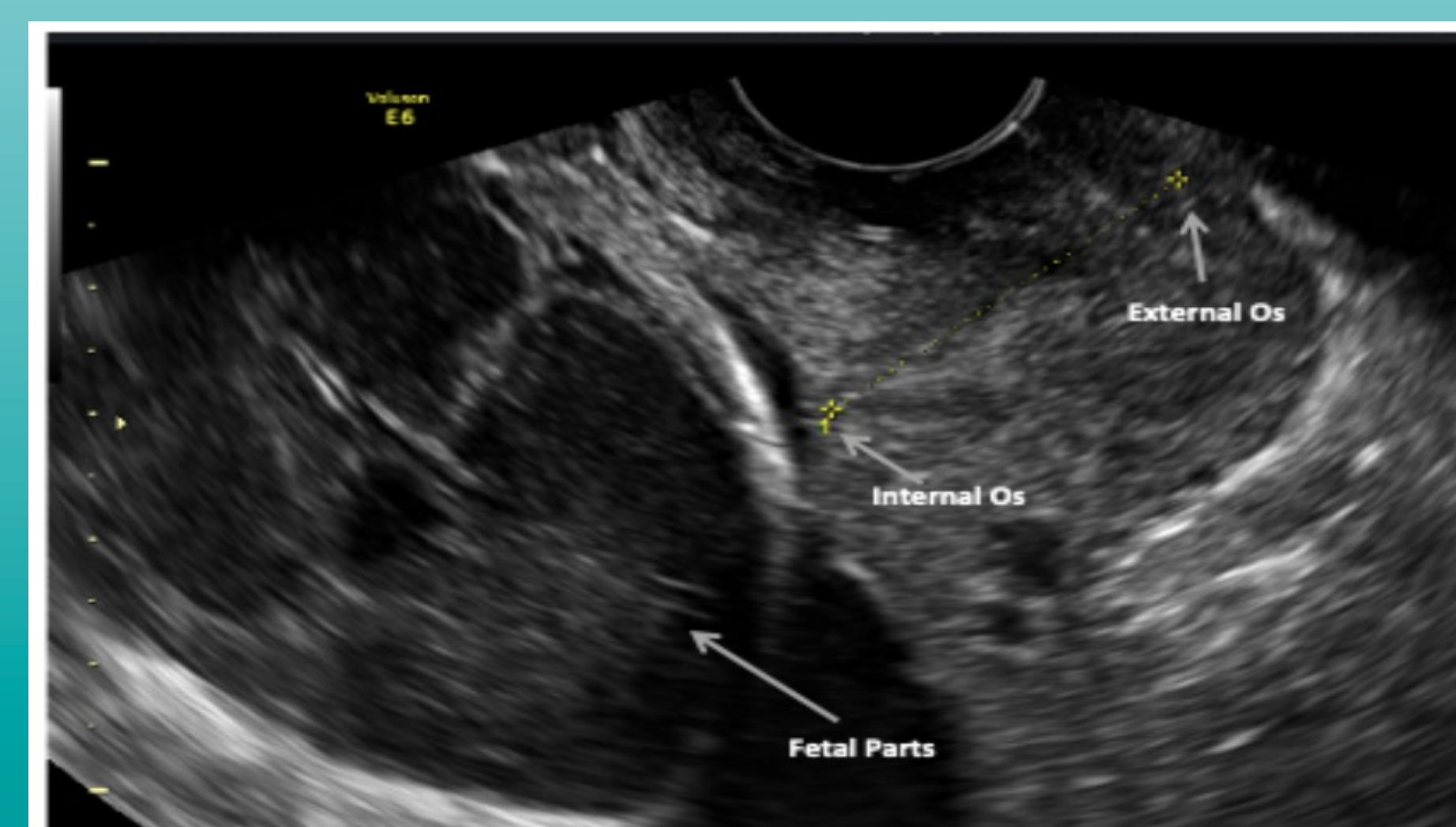
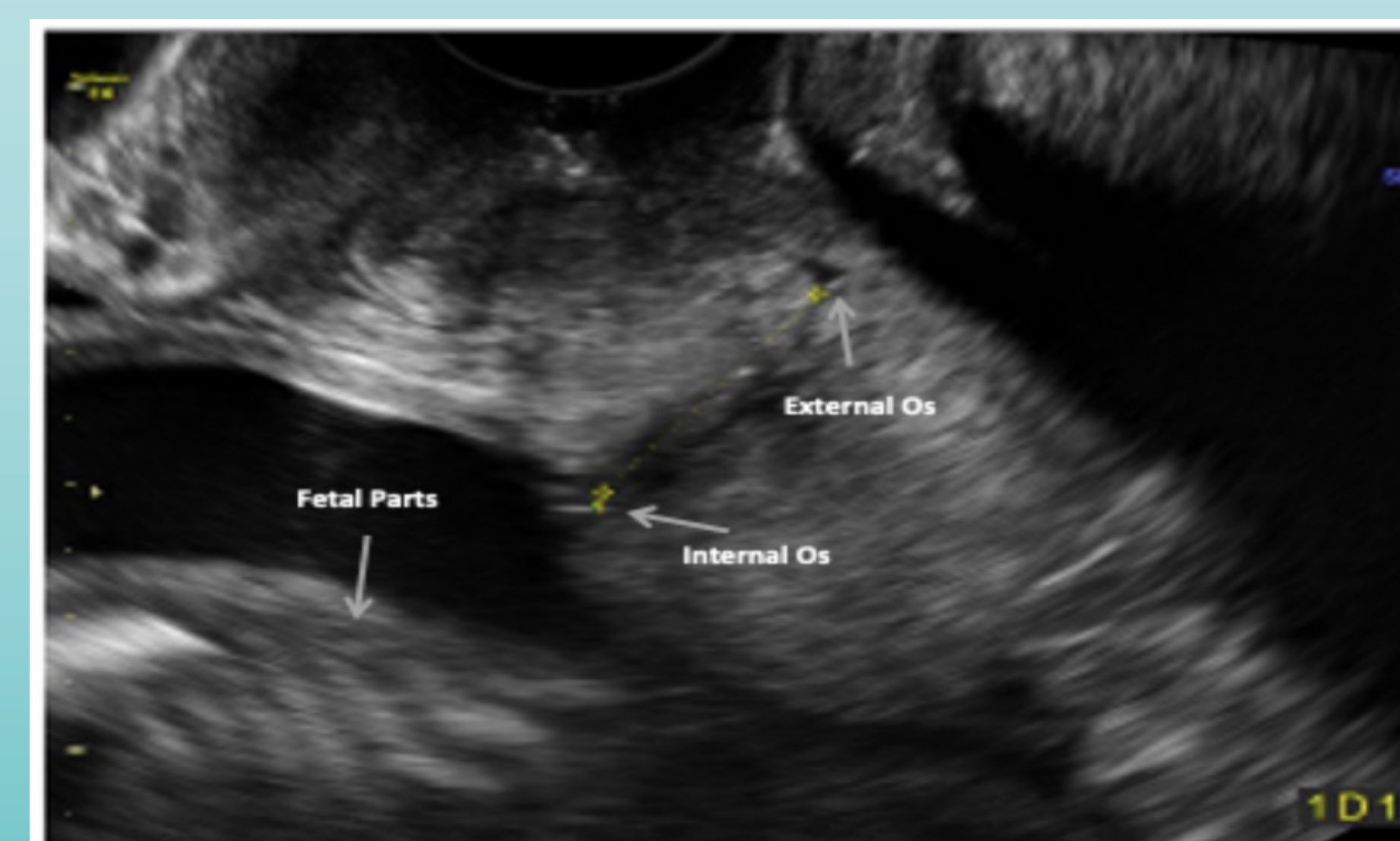


CONCLUSION

90% (54/60) of our patients delivered at term. The Cambridge Cerclage could be a mainstay in treatment of challenging cervical defects.

VERTICAL STRETCH

This technique is appropriate for women with an extremely effaced cervix and a raised BMI, where the cervix is seen as a flat sheet. Three purse strings are used with the initial cerclage placed around the external cervical os and a second one placed higher. Gently pulling on the first and second stitch may allow placing the third stitch much closer to the internal cervical os.



TOWING

This technique is most effective in the presence of inequalities of the cervix at the lower end especially in the previously torn and fibrosed cervix. After encircling the cervix with the suture, one end of the thread is taken around without the needle and tied to the loose end of the first knot. A second supporting purse string is taken higher than the first suture, starting either anteriorly or posteriorly.

