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Abdominal cerclage

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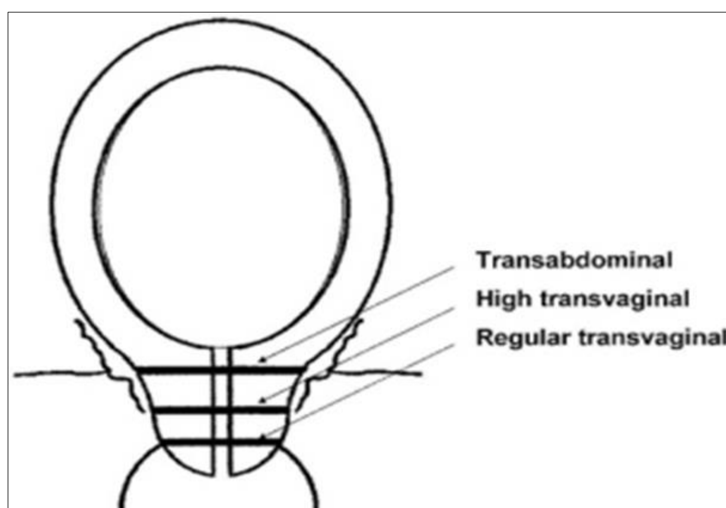
Abstract
Most cerclage operations for cervical insufficiency are performed transvaginally. The transabdominal route is beneficial in treating patients with cervices that are extremely short, congenitally deformed, deeply lacerated, or markedly scarred because of previously failed transvaginal cerclage procedures. The average gestational age at surgery was 11.5 weeks and the operation was performed after early ultrasonographic verification of fetal viability. Patients with advanced cervical effacement or dilatation in the second trimester were excluded. A 5 mm wide Mersilene band was applied in a vascular space above the junction of the cervix and the uterine isthmus without dissection or tunneling among broad ligament vessels. This simplified surgical approach resulted in little operative blood loss (mean, 75 ml; range, 50 to 200 ml). A survey of specialists in maternal-fetal medicine indicated an increasing interest and familiarity with transabdominal cervicoisthmic cerclage since its introduction more than two decades ago although this procedure is still not widely applied in obstetric practice.

Keywords: abdominal cerclage, transvaginally, ultrasonographic

Introduction
Definition
Transabdominal placement of a cerclage at the cervicoisthmic junction appears to be a safe and effective procedure for reducing the incidence of spontaneous pregnancy loss in selected patients with cervical incompetence.



Indications
1. Recurrent pregnancy loss due to cervical incompetence
2. Short cervix
3. Scarred cervix
4. Congenital deformed cervix
5. Failed vaginal cerclage

Contraindications
1. Intrauterine infection
2. Ruptured membranes
3. Vaginal bleeding
4. Severe uterine irritability
5. Cervical dilation >4cm.

Timing
Transabdominal cerclage placement is usually performed either prior to conception or during early pregnancy (at 11 to 14 weeks).

Procedure
Before procedure
1. Avoid sexual intercourse for 24 hours before the procedure.
2. If instructed, do not eat or drink anything (including water) after the midnight
3. Intravenous (IV) line is placed in your hand or arm. It delivers fluids and medication into the body.
4. Spinal anesthesia is given

The surgery may be done using either open surgery or laparoscopy.
For open surgery, one larger incision is made in the abdomen.
For laparoscopy, makes 2 to 4 small incisions in the abdomen. A thin lighted tube called a laparoscope is then used. The scope is put through one of the incisions. Surgical tools are placed through the other small incisions. The abdomen is filled with carbon dioxide.

Technique
1. Surgical tools are used to cut the tissue that connects the bladder and the lower part of the uterus, including the cervix. This gives access to the cervix.
2. 5 mm wide Mersilene band was applied in a vascular space above the junction of the cervix and the uterine isthmus without dissection or tunneling among broad ligament vessels. The tape is tied in a knot.
3. The incision is closed with stitches (sutures) or staples. A tube may be placed in the incision to drain fluids, and then be removed.

How Abdominal Cerclage Works
The goal of cerclage is to hold the cervix closed. This allows the baby to fully develop before leaving the womb. It helps to prevent recurrent pregnancy loss and premature birth.

After Procedure
1. Take the mother in to her room once she is recovered from anesthesia.
2. Watch the signs of premature labor.
3. Give a tocolytic agent that helps to prevent premature labor.
4. Monitor baby's heart rate
5. Mother will have some light bleeding and cramping. This is normal.
6. If the mother is having pain. Give pain medication.
7. Mother may be able to go home later that day (or) she may stay overnight in a hospital room to be sure the mother do not go into premature labor.
8. Take adequate bed rest for 3-4 days after the procedure.
9. If she can get out of bed, do light activities
10. Avoid sexual intercourse until 2weeks to 6weeks after the procedure
11. nearby organs
12. Risks of anesthesia

When to Call the Doctor
1. A fever of 100.4°F (38 °C) or higher
2. Pain that does not go away even after taking pain medication
3. Contractions or abdominal cramping
4. Unexpected vaginal spotting or bleeding
5. Fluid leaking from the vagina
6. Bleeding from the vagina
7. Foul-smelling drainage from the vagina
8. Back or abdominal pain
9. Signs of infection at the incision site or sites, such as redness or swelling, warmth, worsening pain, or foul-smelling drainage.

Advantages
1. More proximal placement of the stitch (at the level of the internal os)
2. Decreased risk of suture migration.
3. Ability to leave the suture in place for future pregnancies

Complications
1. Less Bleeding (75ml)
2. Infection
3. Premature contractions
4. Premature labor or delivery
5. Premature rupture of membranes
6. Pregnancy loss
7. Tearing or rupture of the cervix
8. Injury to bladder or other

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