Cervical Cerclage Anesthetic Considerations

Performed for incompetent cervix

Timing:

- Can be done as **Interval Type** (before pregnancy): increased risk of infertility or difficulty evacuating miscarriage or
- During pregnancy: 12-18 wks gestation with confirmed viable fetus.

Contraindications: preterm labor, vaginal bleeding, fetal anomalies, fetal death, ROM, placental abruption, chorioamnionitis

Types:

- Elective (typically more effective with fetal survival from 78-87% compared to 42-68% with emergent). vs emergent
- Transvaginal vs Transabdominal (laparoscopic and targets internal os better, but requires 2 procedures)

Risks: ROM, preterm labor, hemorrhage, infection, chorioamnionitis, uterine rupture

Anesthetic considerations: uterine relaxation with volatile agent (isoflurane), terbutaline or ritodrine (tocolysis), T-burg

Technique:

- Epidural/spinal if cervix NOT dilated or uterine relaxation is NOT needed.
- GA for dilated cervix or if uterine relaxation is needed. Avoid anything that increases intraabdominal pressures (ie bucking on ETT, coughing, etc).

McDonald (pursestring technique) vs Shirodkar (embedded within the wall of the cervix). Important from anesthesia viewpoint since its removal may require an anesthetic.