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Royal College of Obstetricians & Gynaecologists

Information for you

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Cervical suture

About this information

This information is for you if you want to know about cervical suture. You may find it helpful if in the past you have had a baby born prematurely or have had late miscarriages. You may also find it helpful if you are a partner, relative or friend of someone who has been in this situation.

What is a cervical suture?

A cervical suture is an operation where a suture (stitch) is placed around the cervix (neck of the womb). It is also sometimes known as cervical cerclage. It is usually done at between 12 and 24 weeks of pregnancy.

Why is it done?

A cervical suture is sometimes recommended for women who are thought to have a high chance of a late miscarriage or of going into premature labour.

The purpose of the suture is to reduce the risk of your baby being born early. Premature babies have an increased risk of short- and long-term health problems. You can find out more about this from the RCOG patient information *Premature labour: information for you*, which is available at: www.rcog.org.uk/womens-health/clinical-guidance/premature-labour-0.

The exact cause of premature labour or late miscarriages is not clear, but they may be caused by changes in the cervix such as shortening and opening. A cervical suture helps to keep the cervix long and closed, thereby reducing the risk of premature birth or late miscarriage.

When might a cervical suture be advised?

Having a premature birth or late miscarriage can be devastating for parents and you are likely to be worried about a future pregnancy. If this has happened to you, you can be referred to a specialist who will talk to you about plans for a future pregnancy. Depending on your situation, a cervical suture may be recommended for your next pregnancy.

You may be in one of the following situations:

- If you have had one or two late miscarriages or premature births (before 34 weeks), you may be offered ultrasound scans between 14 and 24 weeks of pregnancy to measure the length of your cervix. If the scans show that it has shortened to less than 25 mm, you may be advised to have a cervical suture.
- If you have suffered three or more late miscarriages or three or more premature births you may be advised to have a cervical suture inserted at about 12–14 weeks of pregnancy.

During pregnancy it is sometimes noticed during a vaginal examination or a routine scan that the cervix has started to open up. Depending on your circumstances, you may be offered a suture called a **rescue suture**. If you are in this situation, a senior obstetrician will discuss with you the risks and benefits of having a rescue suture.

Are there situations when a cervical suture would not be advised?

Sometimes a cervical suture is not advised. It would not normally improve the outcome for your baby/babies and may carry risks to you in the following circumstances:

- you are more than 24 weeks pregnant
- you are carrying twins or triplets
- your womb is an abnormal shape
- an ultrasound scan done for another reason happens to show that you have a short cervix
- you have had treatment to the cervix for an abnormal smear.

If a suture is not the right option for you, you will still be closely monitored. This may include regular vaginal ultrasound scans to measure the length of your cervix until 24 weeks of pregnancy. If the cervix is shortened, you may be offered corticosteroid injections after 23 weeks to increase the chance of your baby surviving if born early. You can find out more about this from the RCOG patient information *Corticosteroids in pregnancy to reduce complications from being born prematurely: information for you*, which is available at: www.rcog.org.uk/womens-health/clinical-guidance/corticosteroids.

Are there situations when a cervical suture would not be put in?

Yes. A cervical suture would not be put in if:

- you are already in labour or your waters have broken
- you have signs of infection in your womb
- you have vaginal bleeding
- there are concerns about your baby's wellbeing.

How will the cervical suture be put in?

Insertion of the suture takes place in an operating theatre. You may have a spinal anaesthetic where you will stay awake but will be numb from the waist down or you may be given a general anaesthetic where you will be asleep. Your team will advise which would be the best option for you.

You will be advised not to eat or drink for 4–6 hours before the operation. In the operating theatre, your legs will be put in supports and sterile covers will be used to keep the operating area clean. The doctor will then insert a speculum (a plastic or metal instrument used to separate the walls of the vagina to show or reach the cervix) into the vagina and put the suture around the cervix. The operation should take less than 30 minutes.

Afterwards, you may be given antibiotics to help prevent infection and you will be offered medication to ease any discomfort. You may also have a tube (catheter) inserted into your bladder that will be removed once the anaesthetic has worn off.

You are likely to be able to go home the same day although you may be advised to stay in hospital longer.

Are there any risks?

There is a small risk that your bladder or cervix may be damaged at the time of the operation. Rarely, your membranes may be ruptured. The risk of complications is higher if you have a rescue suture and this will be discussed with you before the operation.

A planned cervical suture does not increase your risk of infection, miscarriage, or premature labour. It does not increase your risk of having to be started off in labour (be induced) or needing a caesarean section.

What might I expect afterwards?

After the operation, you will usually have some bleeding from the vagina, which should change to brown in colour after a day or two. You may have a rise in temperature that should settle without treatment.

Once you recover from the operation, you can carry on as normal for the rest of your pregnancy. Resting in bed is not normally recommended. Sexual intercourse may be continued when you feel comfortable to do so. Your doctor can advise you about the activities you can do and those best avoided during the first few days after the procedure.

Is there anything I should look out for?

If you experience any of the following symptoms, you should contact your maternity unit:

- contractions or cramping
- vaginal bleeding
- your waters breaking
- smelly vaginal discharge.

How and when will the suture be taken out?

Your suture will be taken out at the hospital. This will normally happen at around 36–37 weeks of pregnancy, unless you go into labour before then.

You will not normally need an anaesthetic. A speculum is inserted into your vagina and the suture is cut and removed. It usually takes just a few minutes.

You may have a small amount of bleeding afterwards. Any red bleeding should settle within 24 hours but you may have a brown discharge for longer. If you have any concerns, tell your midwife or doctor.

If you go into labour with the cervical suture in place, it is very important to have it removed promptly to prevent damage to your cervix. If you think you are in labour, contact your maternity unit straight away.

If your waters break early but you are not in labour, the stitch will usually be removed because of the increased risk of infection. The timing of this will be decided by the team looking after you.

Are cervical sutures sometimes inserted through the abdomen?

Yes, if a vaginal cervical suture has not worked in the past or it is not possible to insert a vaginal suture. This would involve an operation through your abdomen and is called a ‘transabdominal cerclage’. It is done

either before you become pregnant again or in early pregnancy. Such a suture is not removed and your baby would be born by caesarean section.

What to do if I have concerns or further questions

Talk to your doctor who should be able to help. You can also ask to be referred to a specialist if you have further questions or concerns.

Further information aimed at healthcare professionals is also available in the RCOG Green-top Guideline No. 60, *Cervical Cerclage*, which is available at: www.rcog.org.uk/womens-health/clinical-guidance/cervical-cerclage-green-top-60.

Making a choice

Shared Decision Making

If you are asked to make a choice, you may have lots of questions that you want to ask. You may also want to talk over your options with your family or friends. It can help to write a list of the questions you want answered and take it to your appointment.

Ask 3 Questions

To begin with, try to make sure you get the answers to three key questions if you are asked to make a choice about your healthcare.

1. What are my options?
2. What are the pros and cons of each option for me?
3. How do I get support to help me make a decision that is right for me?

These resources have been adapted with kind permission from the MAGIC Programme, supported by the Health Foundation

* Ask 3 Questions is based on Shepherd HL, et al. Three questions that patients can ask to improve the quality of information physicians give about treatment options: A cross-over trial. Patient Education and Counselling, 2011;84: 379-85

http://www.advancingqualityalliance.nhs.uk/SDM/

Sources and acknowledgements

This information has been developed by the RCOG Patient Information Committee. It is based on the RCOG Green-top Guideline No. 60, *Cervical Cerclage*, which is available at: www.rcog.org.uk/womens-health/clinical-guidance/cervical-cerclage-green-top-60.

The RCOG produces guidelines as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant health professionals. This means that RCOG guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management.

This leaflet was reviewed before publication by women attending clinics in Liverpool, London and Newcastle.

A glossary of all medical terms is available on the RCOG website at: www.rcog.org.uk/womens-health/patient-information/medical-terms-explained.

A final note

The Royal College of Obstetricians and Gynaecologists produces patient information for the public. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of the clinical data presented and the diagnostic and treatment options available. Departure from the local prescriptive protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.

All RCOG guidelines are subject to review and both minor and major amendments on an ongoing basis. Please always visit www.rcog.org.uk for the most up-to-date version of this guideline.

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