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Four Treatments every Caesarian Section Patient needs

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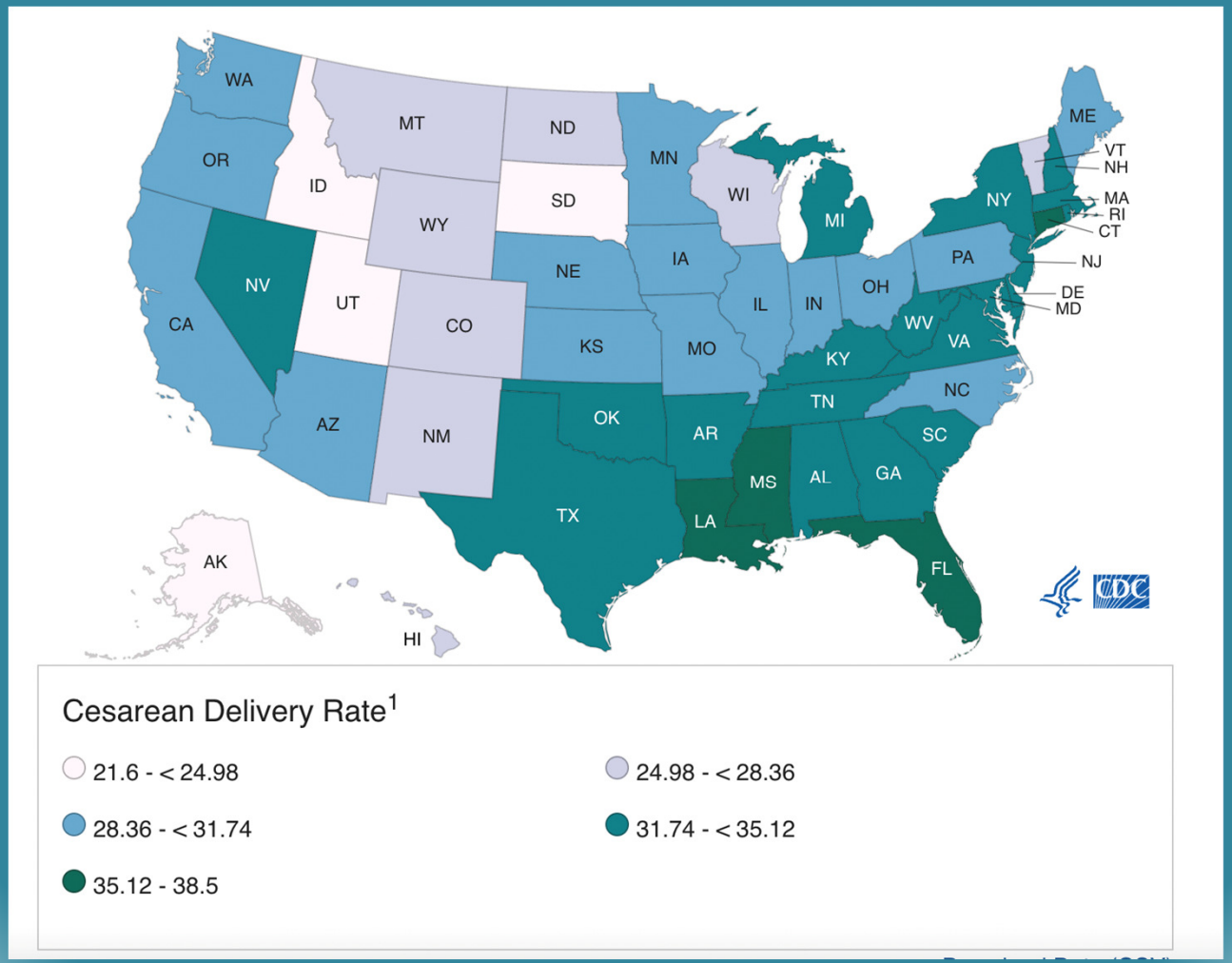
Learning Goals for This Lecture

- Four key treatment strategies for post Cesarean section patients, and their appropriate time windows
  - Distal needling to reinstate Qi flow
  - Moxa to disperse cold, promote immune response/healing
  - Scar therapy
  - Prelabor treatments in future pregnancies!

Overview

- What exactly happens in a Cesarean Section?
- What we can do about it and when:
  - ASAP – treat pain (aka restore channel flow)
  - As soon we're home – moxa the scar!
  - 6 weeks to 6 months (or whenever) – serious scar therapy
  - Next time she gets pregnant – labor prep (NOT 'acupuncture induction') starting 37 weeks

Cesarean rates across the US



https://www.cdc.gov/nchs/pressroom/sosmap/cesarean_births/cesareans.htm

Rates in Canada?

- Most recent/useful data on Canada I could find, see link below
  - A total of 286 201 women gave birth; among these, 83 262 (29.1%) had CDs.
  - Robson group 5 (term singleton previous CD) had a CD rate of 80.5% and was the largest contributing group to the overall number of CD (36.6%).
  - Women whose labour was induced (Robson group 2A) had a CD rate almost double the rate of women with spontaneous labour (Robson group 1): 33.5% versus 18.4%.
  - These latter two groups made the next largest contributions to overall CD (15.7% and 14.1%, respectively). There were substantial variations in CD rates across provinces and among hospital peer groups.
- Note the use of 'Robson Groups'
  - This can be a really effective way of selling an acupuncture program
  - https://www.sciencedirect.com/science/article/pii/S170121631930831X
- PS, here's Europe, it's 'all over the map'
  - https://obgyn.onlinelibrary.wiley.com/doi/pdf/10.1111/1471-0528.17670

Terminology

- 'Emergency' Cesarean section
  - A true emergency section usually takes place in under 6 minutes and may have worse scarring due to larger, less careful cuts
  - Most patients who didn't plan their CS will describe it as 'emergency'
- 'Unplanned' is the more accurate term in these cases
  - (Not to minimize their distress and pain, just to clarify)

Anesthesia

- Combined epidural/spinal is most common
- Spinal block
  - A needle is inserted into the dural tube at L2-L3 (!)
  - Delivers a bolus of fentanyl or other agent
  - Lasts ~2 hours
- Epidural analgesia
  - A catheter is threaded through a large-bore needle (see above) and left just outside the dural tube
  - Delivers a timed dose, usually through PCA (patient-controlled anesthesia) device with button
- General anesthesia
  - This is used mostly for true obstetric emergencies where the patient does not already have an epidural in place

What gets cut ('bikini line')

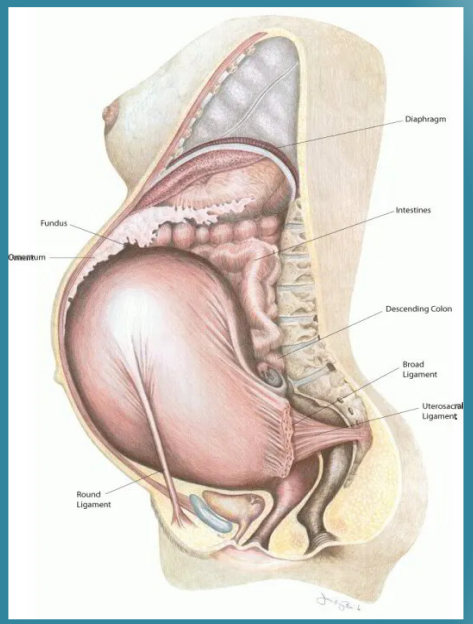
- Skin and subcutaneous fat
  - BMI is an issue in considering unplanned section (vs. waiting for possible emergency)
- Fascia
  - Increasingly identified with the acu channels – support and structures all the tissue and needs to be cut away from uterus, bladder, etc.
  - Fascia is torn away from the rectus abdominis, which is then separated (!!!) and pulled back
  - The peritoneum is then cut (care for intestines)
- Uterus
  - Structures to avoid cutting include bladder, amniotic sac, baby head
- Vertical incision may be made due to time or placenta previa

Baby and placenta out

- This may not be easy, especially after long labor
  - Head may be deep in the pelvis and molded
  - Contractions may have pulled vaginal canal up to level of baby's head so it's hard to cut!
- High dose Oxytocin is immediately administered to constrict & stop bleeding

Sewing up the uterus & incision

- Uterus is pulled out onto maternal abdomen for better visibility
  - This tugs on round ligaments, can cause fascial disruption as well as cold (!!!)
  - Important that it firms up before closure



- Incision is repaired in layers
  - Sewing fascia (e.g. perotineum) is not necessary – makes more adhesions!
  - Fat layer may need extra stitches if large
  - Bleeding is cauterized throughout the procedure

Complications

- Average blood loss ~1 liter
- Maternal morbidity/mortality is 2x vaginal birth*
- Infection
- Clotting (local or embolus to heart/brain/lungs)
- Surgical injury (cut bladder, bowel, etc.)
- Uterus doesn't contract well -> excess bleeding

Hospital aftercare

- If no epidural/spinal, will typically get morphine
  - Postoperative pain meds worsen constipation
- Typically discharged 2 days after surgery unless problems
  - Risk of wound infection 5-10%, double if chorioamnionitis (despite all getting prophylactic abx)
  - Constipation; UTI (from catheter)
  - Deep vein thrombosis
- Walking encouraged on first day
  - Dressing removed after 12-24 hours
  - Staples usually removed on discharge

Home aftercare – 6-8 weeks

- Avoid stairs, lifting (even baby if he's big!)
  - Hold abdomen when sneezing/coughing
  - Abdominal binder may be helpful (<6 weeks, <12hrs/day)
- Don't work out heavily but do walk!
- Watch for…
  - Pus, redness, swelling or pain of scar
  - Fever (more than mild)
  - Heavy bleeding or malodorous discharge
  - Leg pain/swelling, chest pain
  - Postpartum depression

So what's our role?

https://unsplash.com/photos/white-and-gray-yarn-on-white-background-oZyok-2sDag

Step 1 - asap - Reinstate Flow (1-2 therapeutic goals per treatment)

- Check for trauma, scattered spirits etc.
  - Ear needles, KD1/Du20, etc.
- Reinstate Chong & Ren – SP4/PC6, Lu7/KD6
- Address surgical pain distally at first
  - I like SP6/8, Liv8 plus ear needles (e.g. battlefield, or use sensor)
  - If pain is bad, try estim 2hz between sympathetic and tender point above point zero
- Address other channel/organ issues e.g. lactation, numb/tingling, dampness headache, fatigue/depletion, depression
- Reinstate LV, SP, KD, ST over 2-4 treatments
  - Start with points above/below, e.g. ST36/12, KD10/27
  - Move gradually closer to incision, e.g. Ren15/12, then ST25, ashi @ inner thigh

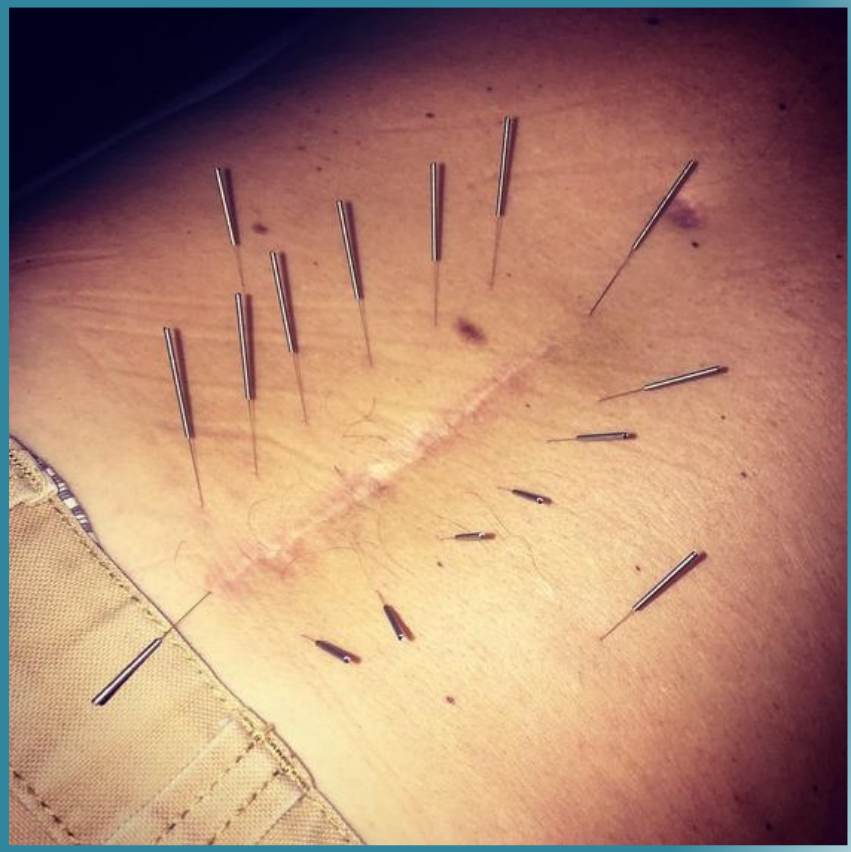
Step 2 – also asap! – Scar Moxa

This treatment is critically important asap, not only to reinstate channels but also to chase evil OR cold out of the uterus!

- Use pole moxa, smoky if possible. 20mins or more.
  - Use your fingers to check carefully for heat (hover over the skin, don't touch it)
  - Keep the pole moving in in transverse sweeps so that the heat penetrates slowly and deeply – she should feel it
  - WARN HER THERE MAY BE REDNESS OR PUS AFTER! This is not the moxa 'causing' heat, but prompting appropriate immunity!
- May be simultaneous with Step 1 (very useful for shock/scattered spirits)
  - Also combines great with Raven's Mother Roasting!!!
  - The two combine very well with Rebozo 'Shawl Massage'

Step 3 – 6 weeks to 6 months Scar Therapy

- Part 1: surround the dragon
- Above/below points (as before) on the 2-3 most affected channels, plus
- As shown, 1” needles inserted towards scar at ½” intervals



Scar Therapy (continued)

- One course is 5-8 treatments (depending how thick/hard the tissue)
- Start at 1” away and move in as inflammation subsides
  - This may mean needling into pubes at first, can also start closer, using Seirin ear needles the first time or two
  - If scar is old, no longer hot to touch, then you can start more like ½” away
  - As you go, parts of the scar will get nice and soft and others will stay hard and gnarly. Start going closer towards those, even needling into the hard stuff.

Scar Bodywork

- With clothes or draping, make your 8 fingers even with each other and settle in to the scar
  - Let gravity pull your fingers in as the tissue releases under you (not faster)
- You may find some fingers feeling like they want to twist into a tight place. Let them!
  - This will unwind tight/twisted fascia
  - Follow the feeling inwards, then just hold at what seems like the tightest part of the twist; the body will release itself in a new direction
- Usually 5-10 minutes is about good for this deep work
  - may do it before (as palpation where to put the needles) or after (to build on the acu treatment) or both

Step 4 – Labor Preparation!!!

- NOT 'ACUPUNCTURE LABOR INDUCTION'
- For the VBAC patient, contractions can tear the scar open!
  - Also, cervical ripening meds are not an option, so if she goes postdates they are likely to section
  - Patients with 2 CS do better if they deliver at 38 weeks; 3 CS do better at 37 weeks (will be induced)
- The optimum labor would be super ripe cervix before contractions really get going, ideally on the early side
  - These patients also really benefit from acupressure/puncture in labor to promote progress so oxytocin isn't needed
  - Relax them into labor, don't stimulate them there! (This is true for everyone but especially VBAC).

Questions???

Thank you!!!

- Lorne, Lorianne, Patricia and everyone else who keeps Healthy Seminars healthy!!!
- The patients, nurses, midwives and doctors at Lutheran Medical Center
- My forebears and beloved colleagues – Raven, Sharon, Sarah, Debra, Zena, Kate, Caroline, Marnae, Tzivya, Anna, Joanne, Jennifer

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