

INSTRUCTIONS FOR USE
TechniqueGEBRAUCHSANWEISUNG
TechnikMODE D'EMPLOI
TechniqueISTRUZIONI PER L'USO
ProceduraGEbruIKSAANWIJZING
ProcedureBRUKSANVISNING
TeknikBRUKSANVISNING
AnvendelseKÄYTTÖOHJEET
TekniikkaBRUKSANVISNING
TeknikkINSTRUCCIONES DE USO
TécnicaMANUAL DE INSTRUÇÕES
TécnicaΟΔΗΓΙΕΣ ΧΡΗΣΗΣ
ΤεχνικήNAVOD K POUŽITÍ
TechnikaINSTRUKCJA OBSŁUGI
Technika

TECHNIQUE

VORSICHTSMASSENNAHMEN
Technik

CAUTION: Federal US law restricts this device to sales by or on the order of a health professional.

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Important note
Product delivery procedures and techniques are the responsibility of the medical practitioner. Each physician must evaluate the appropriateness of the procedure based on his or her medical training and experience.

Indications

- Failure to deliver spontaneously following an appropriate second stage
- Fetal distress in the second stage
- Need to avoid voluntary expulsive efforts
- Inadequate maternal expulsive effort
- Shortening of the second stage

Conditions

- Gestational age > 36 weeks
- Vertex presentation, with the head well down
- Ruptured membranes
- Cervix fully dilated
- Head fully engaged
- Empty maternal bladder

Contraindications (Fig. 1 and 2)

Non-vertex presentation

- Head presentation
- Bleeding from a fetal blood sampling site
- Suspected Cephalopelvic Disproportion (CPD)
- Complete cervical dilation
- Gestational age less than 36 weeks
- Estimated fetal weight less than 2,500 grams
- Previous failed fetal head extraction
- Previous or disengagement of cup twice
- Fetal scalp damage
- Prior failed vacuum or forceps extraction
- Fetal bone de-mineralization condition
- Known fetal coagulopathies
- Suspected macrosomia or risk of shoulder dystocia
- Fetal IV positive status

Precautions

Conditions that require close observation:

- Fetal scalp damage
- Delivery requiring unusual amounts of traction
- Progressive descent of the fetal head should result with each effort at traction
- If this progress does not occur, the attempt at vacuum delivery should be discontinued

These recommendations are intended only as general guidelines. Practitioners must refer to current obstetric and medical recognized guidelines that address suction cup delivery procedures.

Technique

1. The position of the fetal head and posterior fontanelle must be clearly assessed.
2. On vaginal examination the head should be palpated and the cervix checked.
3. Vaginal examination will indicate the type and size of cup that should be used. In general, the biggest cup size should be used.
4. If there is excessive caput, the Silic Cup should not be used; a Bird or Malmstrom Cup should be used instead.

Procedure

- Single Use Bird Cup / Stainless Steel Suction Cups / CaesAid Cup

Cesarean Delivery – Procedure

The following procedure is not recommended with low vaginal or classical uterine incision.

Caution: An attempt to deliver the fetus through a cesarean section is dangerous.

1. Proceed according to vaginal Delivery

2. Once the head is engaged, place the extractor cup 30 mm in front of the posterior fontanelle.

3. If the head is high and readily available beneath the uterine incision, place the extractor cup 30 mm in front of the posterior fontanelle.

4. If the head is high and not easily accessible, place the gloved fingers under the head and flex upward bringing the scalp into the uterine incision.

5. Connect the sterile suction tubing with the cup and the vacuum pump (Fig. 3). Check the integrity of the device with respect to seal level according to instructions of the manufacturer.

6. Make sure the patient's bladder is empty. Verbal informed consent should be taken prior to the vacuum aided delivery process.

7. Make sure the skin is clean as possible. Carefully examine fetal presenting part prior to positioning and position the cup over the flexion point.

8. An effort should be made to place the cup 30 mm in front of the posterior fontanelle (Fig. 8).

9. Make sure that neither the cervix nor the vagina is included in the cup by gently moving a finger around the rim of the cup.

10. With the cup placed at the flexion point, raise the vacuum level approximately to -20 kPa (-150 mmHg).

11. Now palpate the rim of the cup with one finger and move the cup until it is seated under the cup (Fig. 9 and 10).

12. With the onset of contraction, rapidly raise the vacuum to -60 to -80 kPa (-450 to -600 mmHg) and do not exceed -80 kPa (-600 mmHg) vacuum.

The vacuum should be increased in one step; gradual increase is not recommended. Adhesion will be satisfactory as soon as the cup is seated.

13. Traction can then be applied synchronously with the contractions.

Traction can be applied with one hand. One hand grasps the handle and pulls gently while the index finger of the other hand is held against the fetal head and edge of the cup at the same time in order to check if the head follows when traction is applied. It is not the cup itself that causes the traction.

14. With each successive traction, draw the patient's head down towards the midline.

If the fetal head does not follow when traction is applied, check that the traction is along the axis of the birth canal (Fig. 12).

15. Between contractions, discontinue the traction and reduce the vacuum to approximately -20 kPa (-150 mmHg) while awaiting the next contraction.

Indications

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- Need to avoid voluntary expulsive efforts
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- Shortening of the second stage

Conditions

- Gestational age > 36 weeks
- Vertex presentation, with the head well down
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Contraindications (Fig. 1 and 2)

Non-vertex presentation

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Technique

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2. On vaginal examination the head should be palpated and the cervix checked.

3. Vaginal examination will indicate the type and size of cup that should be used. In general, the biggest cup size should be used.

4. If the head is high and readily available beneath the uterine incision, place the extractor cup 30 mm in front of the posterior fontanelle.

5. If the head is high and not easily accessible, place the gloved fingers under the head and flex upward bringing the scalp into the uterine incision.

6. Connect the sterile suction tubing with the cup and the vacuum pump (Fig. 3).

7. Check the integrity of the device with respect to seal level according to instructions of the manufacturer.

8. Document the use of the vacuum extractor and notify the nursery staff per hospital protocol.

9. Place the patient in the lithotomy position. Delivery can also be undertaken in dorsal, lateral or knee-chest positions.

10. The need for padded blockade or local anaesthesia is determined as it is spontaneous delivery and in accordance with local clinical guidelines.

11. Ensure the patient's bladder is empty.

12. Verbal informed consent should be taken prior to the vacuum aided delivery process.

13. Make sure the skin is clean as possible.

14. Carefully examine fetal presenting part prior to positioning and position the cup over the flexion point.

15. The traction force introduced by advancing the cup towards the fetal head (Fig. 4-6), squeeze it together and advance towards the fetal head.

16. Lubricate the cup by means of suitable obstetric antiseptic gel may be preferred.

17. Now palpate the rim of the cup with one finger and move the cup until it is seated under the cup (Fig. 9 and 10).

18. With the onset of contraction, rapidly raise the vacuum to -60 to -80 kPa (-450 to -600 mmHg) and do not exceed -80 kPa (-600 mmHg) vacuum.

The vacuum should be increased in one step; gradual increase is not recommended. Adhesion will be satisfactory as soon as the cup is seated.

19. Traction can then be applied synchronously with the contractions.

Traction can be applied with one hand.

One hand grasps the handle and pulls gently while the index finger of the other hand is held against the fetal head and edge of the cup at the same time in order to check if the head follows when traction is applied. It is not the cup itself that causes the traction.

20. Wählen die Saugglocke sanft auf den Kopf des Kindes gedrückt wird. Wenn Sie ein Vakuum von -20 kPa (-150 mmHg) an.

21. Nun palpiert die Ränder des Kopfes und zieht die Saugglocke so weit wie möglich nach unten, bis sie unter dem Kopf des Kindes sitzt (Fig. 9 und 10).

22. Bei jedem Auftreten einer Kontraktion, reduziert die Saugglocke die Vakuumstärke auf ca. -20 kPa (-150 mmHg).

23. Zwischen den Kontraktionen kann die Saugglocke abgezogen werden.

24. Der Vakuumdruck sollte in einem Schritt erhöht werden.

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