DELAYED CORD CLAMPING

- Delayed cord clamping (not earlier than 30 seconds to 1 minute after birth) is recommended for improved maternal and infant health and nutrition outcomes.
- This should apply to both vaginal and Caesarean births
- Recommended in settings where anaemia is common
- Considered in developing countries where iron deficiency is common in the first six months of life.
- In newly born term or preterm babies who do not require positive-pressure ventilation, the cord should not be clamped earlier than 1 minute.
- Newly born babies who do not breathe spontaneously after thorough drying should be stimulated by rubbing the back 2-3 times before clamping the cord and initiating positive – pressure ventilation.
- When newly born term or preterm babies require immediate positive-pressure ventilation, the cord should be clamped and cut to allow effective ventilation to be performed.
- Early umbilical cord clamping (less than 1 min after birth) is recommended when the neonate is asphyxiated and needs to be moved immediately for resuscitation.
- It increases early HB concentration in the neonate and reduces need for transfusion.
- It increases iron stores in the infant and may affect neurodevelopment of the new born.
- The benefits outweigh the small risk of neonatal jaundice.
- It does not interfere with stem cell collection
- For preterm babies – 30 to 60 seconds delay in cord clamping, increases blood volume and iron stores by as much as 30%.
- Monitor both mother and new born during this time for any signs of distress.
- Halt procedure if there are any urgent issues
- Individualise your patients according to clinical indications and benefit
- Do not delay clamping if it is a growth restricted baby
- Reduces risk of PPH
- The risk for transmission of HIV in HIV positive mothers is negligibly small and the benefits outweigh the risk.

Authorship

These guidelines were drafted by a clinical team from Mediclinic and were reviewed by a panel of experts from SASOG and the BetterObs clinical team. All attempts were made to ensure that the guidance provided is clinically safe, locally relevant and in line with current global and South African best practise. Succinctness was considered more important than comprehensiveness.

All guidelines must be used in conjunction with clinical evaluation and judgement; care must be individualised when appropriate. The writing team, reviewers and SASOG do not accept accountability for any untoward clinical, financial or other outcome related to the use of these documents. Comments are welcome and will be used at the time of next review.

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