Time to Cut the Cord

Wendy C. Budin, PhD, RN-BC, FAAN

ABSTRACT

In this column, the editor of *The Journal of Perinatal Education* discusses the latest consensus on recommendation for timing of umbilical cord clamping. The editor also describes the contents of this issue, which offer a broad range of resources, research, and inspiration for childbirth educators in their efforts to promote, support, and protect natural, safe, and healthy birth.

Wendy Budin
Editor

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For a long time, obstetricians, midwives, and proponents of physiologic birth have been debating the best time to cut the umbilical cord. Before the mid-1950s, the term *early clamping* was defined as umbilical cord clamping within 1 minute of birth, and *late clamping* was defined as umbilical cord clamping more than 5 minutes after birth. Because of the lack of specific recommendations regarding the optimal time to cut the cord, the interval between birth and umbilical cord clamping began to be shortened, and it became common practice to clamp the umbilical cord shortly after birth, usually within 15–20 seconds. Back in the days when general anesthesia and narcotics for pain relief were prevalent, early cutting of the umbilical cord reduced the amount of anesthesia and sedation the baby received. Even today, in many U.S. hospital settings, the moment the baby is born, the obstetrician will immediately cut the cord and hand off the newborn to an attending health-care provider to be assessed under a radiant warmer.

Those who continue to argue for immediate cord cutting believe a delay in umbilical cord clamping

may jeopardize timely resuscitation efforts, if needed, especially in preterm infants. Some believe that delayed cord clamping is associated with an increase in maternal hemorrhage despite evidence to the contrary. Another concern is that a delay in umbilical cord clamping could increase the potential for excessive placental transfusion, and the increased hemoglobin may increase the risk of polycythemia or jaundice. Although this may be true, the slightly higher level of jaundice rarely meets criteria for phototherapy in term infants.

Those who support delayed cord cutting argue that for in term infants, the increased hemoglobin levels at birth improves iron stores in the first several months of life. This may have positive effects on developmental outcomes. In preterm infants, rates of intraventricular hemorrhage, and necrotizing enterocolitis are lower.

Midwives have for a long time supported the physiologic practice of waiting for the cord to cease pulsating before cutting the cord. It is the position of the American College of Nurse-Midwives (ACNM)

We invite readers to respond to the contents of this journal issue or share comments on other topics related to natural, safe, and healthy birth. Responses will be published as a letter to the editor. Please send comments to Wendy Budin, Editor-in-Chief (wendy.budin@rutgers.edu).

It is the position of the American College of Nurse-Midwives (ACNM) that delayed cord clamping should be the standard of care in all birth settings for term and preterm newborns (American College of Nurse-Midwives [ACNM], 2014).

To review the American College of Nurse-Midwives Position Statement on Delayed Umbilical Cord Clamping, see <http://www.midwife.org/ACNM/files/ACNMLibraryData/UPLOAD-FILENAME/00000000290/Delayed-Umbilical-Cord-Clamping-May-2014.pdf>

ACOG Committee Opinion on Delayed Umbilical Cord Clamping After Birth is available at <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Delayed-Umbilical-Cord-Clamping-After-Birth>

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that delayed cord clamping should be the standard of care in all birth settings for term and preterm newborns (American College of Nurse-Midwives [ACNM], 2014). In situations requiring resuscitation, umbilical cord milking may be of benefit when delayed cord clamping is not feasible, particularly for the preterm newborn.

Despite the differing opinions, it seems that there is finally some consensus guiding the decision on when to cut the cord. The growing body of strong evidence (McDonald, Middleton, Dowswell, & Morris, 2013) for delayed cord cutting has led several professional organizations in addition to the ACNM to endorse clear guidelines. The World Health Organization recommends that the umbilical cord not be clamped earlier than 1 minute after birth in term or preterm newborns. The Royal College of Obstetricians and Gynecologists also recommends deferring umbilical cord clamping for healthy term and preterm infants for at least 2 minutes after birth. And most recently, in January 2017, the American College of Obstetricians and Gynecologists' (ACOG) Committee on Obstetric Practice now recommends a delay in umbilical cord clamping in vigorous term and preterm infants for at least 30–60 seconds after birth. This ACOG guideline was also endorsed by The American Academy of Pediatrics. It was noted, however, that the ability to provide delayed umbilical cord clamping may vary among institutions and settings; decisions in those circumstances are best made by the team caring for the mother–infant dyad.

So what can pregnant women and their partners do? First, it is important for women and their partners to identify personal feelings about risks and benefits of immediate cord clamping. Childbirth educators and other health-care providers need to share up-to-date information with clients and encourage them to discuss issues that matter to them with their care providers. Sharing up-to-date evidence on the risks and benefits of a care practice is essential so that families can make truly informed decisions.

IN THIS ISSUE

In this issue's feature article, Elizabeth Armstrong shares a provocative commentary on how to make sense of advice about drinking during pregnancy. She asks readers, "Does evidence even matter?" For decades, women have been told not to drink during pregnancy. More recently, the Centers for Disease Control and Prevention (CDC) extended that advice to all women who were at risk for experiencing a pregnancy. This commentary puts the recent CDC guidelines in historical perspective and considers the unintended consequences of public health messages that extend beyond what is supported by evidence.

Continuing the tradition of sharing a birth story in the JPE, in this issue's Celebrate Birth column, Basha Mindell describes the beautiful birth of her fifth child, Miriam. Under the care of a midwife, she feels free, for the first time, to dream of a birth without interventions. She eloquently describes how during pregnancy she visualizes, over and over again, the kind of birth she wants. Her labor moves quickly, and she gives birth in her van on the way to the hospital. She encourages women to remember that their bodies know just what to do in labor.

Also in this issue, authors Timmerman, Walker, and Brown describe findings from their survey that examined obstetricians' perceived barriers and interventions for managing gestational weight gain. The most frequent recommendations were increase activity, aerobic activity, patient education about weight management, increase fiber intake, and use of guidelines for weight gain. Self-tracking weight gain charts were the least used. The greatest barriers to gestational weight gain (GWG) management were patients not interested in changing behavior, high relapse rates, lack of community resources, patients cannot afford referrals, and lack of time.

Mother's and care providers have identified both pros and cons to the practice of rooming-in in the hospital after birth. Although rooming-in has many benefits, a challenge that mothers face in the early postpartum period is balancing the needs of their newborns while getting adequate rest. To explore this further to create a better rooming-in experience, Theo and Drake conducted semistructured interviews with 25 postpartum mothers during their hospital stay. The results revealed how postpartum mothers perceived their sleep quality, rooming-in experience, and overall satisfaction. Most of the postpartum mothers in this study had a positive rooming-in experience.

To determine grand multiparous mothers' embodied experiences of natural and technological altered births, Fleming, Vandermause, Shaw, and Severtsen conducted in-depth interviews with 14 grand multiparas. A comprehensive secondary analysis of the lived experiences of natural birth and the high use of technology and oxytocin during birth, which was found in an original theme of a previous study, was explored. An overarching theme emerged of *Embodiment of Birthing in US Hospitals*. Two patterns: *Embodied Technological Altered Natural Births* and *Embodied Technologically Altered Induced Births* were uncovered. Childbirth educators, doulas, and nurses are an integral part of creating changes in hospital settings, which discourage nonmedically indicated inductions and encourages changes in hospitals.

To explore the effects of comfort education on maternal comfort and labor pain, Garlock, Arthurs, and Bass used a quasi-experimental pretest/posttest comparison group design. No significant difference was found in maternal comfort or pain between the intervention group that received comfort education and the control group. Comfort education did result in change for plans to maintain comfort during la-

bor, an increased use of comfort measures during labor, and an increased probability of continuation with original plans for pain control during labor. The authors suggest that providing education for maintaining comfort during labor can allow women to make informed choices during labor.

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WENDY C. BUDIN is the editor-in-chief of The Journal of Perinatal Education. She is also professor and associate dean for Entry to Baccalaureate Practice at Rutgers School of Nursing. She is a fellow in the American College of Childbirth Educators and member of the Lamaze International Certification Council.

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