Their first embrace shaped by love, not pain.

C-Section Pain Management

Guideline-aligned anesthesia and analgesia support for the first precious moments after birth.

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SHARING EXPERTISE

C-section is common.
Pain can be overlooked.

For many mothers, recovery begins at the same time as bonding.

Cesarean delivery is among the most frequently performed surgical procedures worldwide. As global rates continue to rise, structured perioperative pain management becomes an essential part of quality care. The clinical task is not only to provide anesthesia for surgery, but to support recovery in the first hours after birth. [1-3]

Women identify pain control during and after C-section as a top priority. For clinicians, this makes pain management both a perioperative responsibility and a maternal wellbeing issue: pain can influence breathing, movement, rest and the ability to hold and care for the newborn. [3]

Key facts at a glance

approx
30%
births globally are by c-section [2]

ranked
9th
among 179 procedures for Day-1 pain [4]

approx
14.6%
develop chronic post surgical pain (CPSP) at 3 months [7]

[1] Betran et al. 2021; [2] Zaigham et al. 2024; [3] Sutton & Carvalho 2017; [4] Gerbershagen et al. 2013; [7] Espinós Ramírez et al. 2026.

Pain after C-section reaches beyond the incision.

Postoperative pain can affect recovery, function and early care.

Postoperative pain after C-section can be substantial and is frequently underestimated. Severe pain may affect ambulation, sleep, breathing and coughing, breastfeeding and length of stay. Higher post-C-section pain scores are also associated with lower rates of breastfeeding initiation and longer hospital stays.[5,6] For the mother, these outcomes can translate into everyday challenges: sitting up, walking, taking a deep breath, finding a comfortable breastfeeding position or holding the baby close. The message is deliberately human, but remains clinical: adequate pain management supports recovery moments that matter.

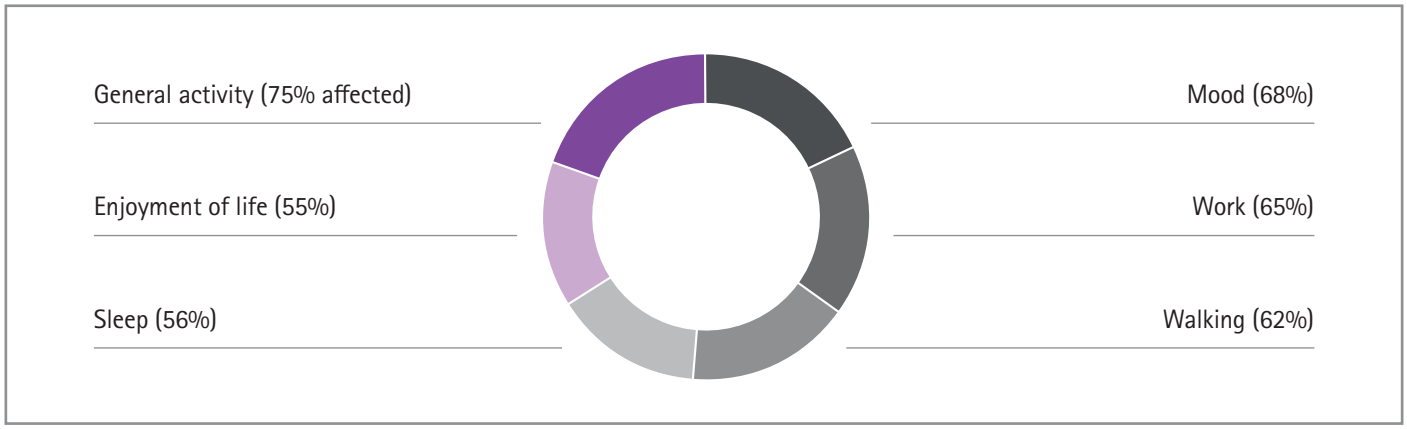
The first 24 hours are a critical window for pain Control and can shape the recovery pathway. Early pain control is more than a score: it is the ability to move, breathe, rest and care. Poor early pain management is described as a strong predictor of chronic pain at three months. The focus should therefore include pain at rest and during movement, not only a single pain score. [7]

Persistent pain is not rare.

Approx. 14.6% of women suffered from chronic postsurgical pain three months after C-section; 75.4% reported pain triggered by movement. [7]

In daily practice, incomplete blocks, neuraxial failures and variable guideline implementation can make consistent pain control challenging. A clear plan helps teams anticipate rescue strategies before pain escalates and supports transitions from OR to recovery, ward and early maternal care.

CPSP after C-section significantly impacts daily life: [7]



[5] Emrich et al. 2023; [6] Babazade et al. 2020; [7] Espinos Ramirez et al. 2026.

A structured pathway helps turn awareness into action.

Procedure-specific, multimodal pain management across the perioperative continuum.

Current recommendations emphasize a multimodal, procedure-specific approach extending across the perioperative continuum. This includes pre- and intraoperative measures, structured postoperative analgesia and appropriate rescue strategies. [8]

A pathway visual should make the clinical logic easy to understand without becoming a treatment algorithm: start with planning, consider a neuraxial approach when appropriate, add scheduled multimodal analgesia and define what happens when no neuraxial opioids are used.

1 **Plan continuum**
Pre-, intra- and postoperative measures

2 **Neuraxial approach**
Spinal ± intrathecal opioids;
CSE/epidural by context

3 **Scheduled multimodal analgesia**
Non-opioid analgesic peri-op;
NSAIDs post-op, per protocol

4 **If no neuraxial opioids**
Choose one additional local technique

5 **Additional technique**
TAP / QL / ESP / II-IH or wound infiltration

6 **Rescue and reassessment**
Pain at rest and movement; patient factors

Additional techniques

Complementary routes can be considered when no neuraxial opioids are used.

Regional techniques such as TAP, QL, ilioinguinal/iliohypogastric blocks or wound infiltration may be considered as part of multimodal analgesia, particularly when neuraxial opioids are not used. Technique selection should be individualized according to patient factors, protocol and clinical expertise.[8] Current evidence indicates no additional benefit from combining multiple block techniques or combining blocks with wound infiltration.

No neuraxial opioids used?
Choose one local technique.

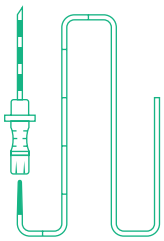
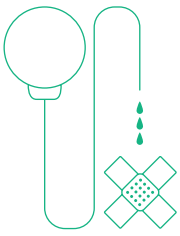
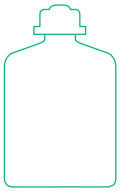
Fascial Plane Blocks
Stimuplex® Ultra 360

Wound infiltration
Cimpax C-CAT® + Easypump® II

[8] Roofthooft et al. 2021.

Products mapped to selected techniques.

B. Braun products can be integrated seamlessly within the clinical pathway.

	Clinical technique	Supporting product	Role in the pathway
	Spinal anesthesia	Pencan®	Atraumatic spinal needle for intrathecal drug administration
	Epidural / CSE	Perifix® / Espocan®	Epidural and combined spinal epidural anesthesia and continuous analgesia
	Abdominal wall blocks	Stimuplex® Ultra 360 Ultraplex® 360°	PNB needle for TAP / QL / ESP techniques
	Wound infiltration	Cimpax C-CAT® + Easypump® II	Catheter and elastomeric pump for continuous wound infiltration
	Systemic analgesia	NSAIDS and Non-opiod analgesic	Core part of scheduled multimodal analgesia

[8] Roofthooft et al. 2021; [9] Nath et al. 2018; [10] Xu et al. 2017.

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