Obstetric Anesthesia

Problem Based Learning Discussion

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How many people do obstetric anesthesia

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Do you wait for labs before placing a labor epidural?

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Practice Guidelines for Obstetric Anesthesia

*An Updated Report by the American Society of Anesthesiologists Task Force on Obstetric Anesthesia and the Society for Obstetric Anesthesia and Perinatology**

Intrapartum Platelet Count

- The anesthesiologist's decision to order or require a platelet count should be individualized and based on a patient's history (*e.g.*, preeclampsia with severe features), physical examination, and clinical signs. ‖ ‖ ‖
    - A routine platelet count is not necessary in the healthy parturient.

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What Platelet count is your cutoff for placing an epidural?

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The Society for Obstetric Anesthesia and Perinatology Interdisciplinary Consensus Statement on Neuraxial Procedures in Obstetric Patients With Thrombocytopenia

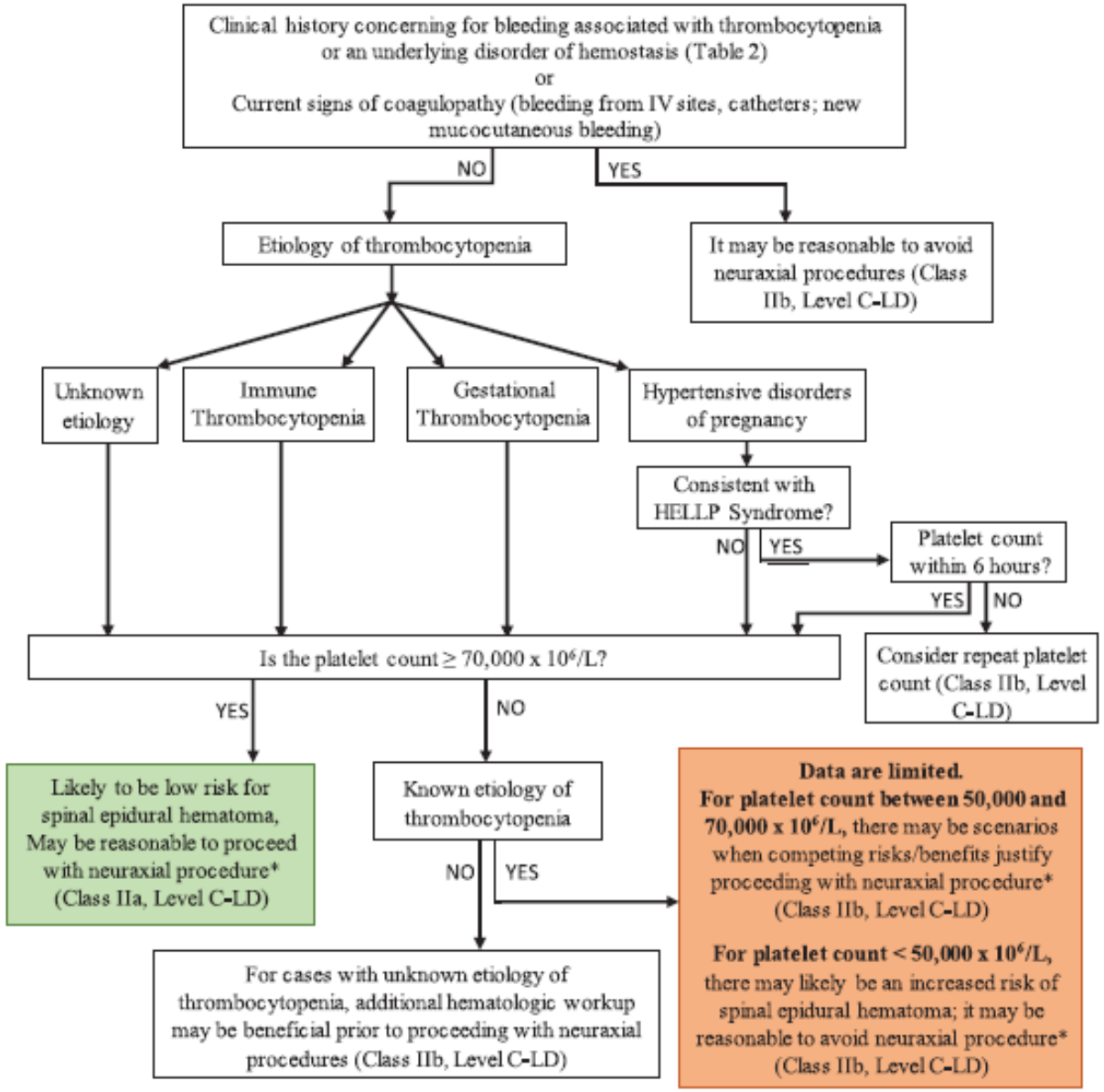
Data are limited.

For platelet count between 50,000 and 70,000 x 10^6/L, there may be scenarios when competing risks/benefits justify proceeding with neuraxial procedure* (Class IIb, Level C-LD)

For platelet count < 50,000 x 10^6/L, there may likely be an increased risk of spinal epidural hematoma; it may be reasonable to avoid neuraxial procedure* (Class IIb, Level C-LD)

SPECIAL ARTICLE

Decision Pathway for Platelets in OB



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What is your epidural technique of choice?

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Dural Puncture Epidural Technique Improves Labor Analgesia Quality With Fewer Side Effects Compared With Epidural and Combined Spinal Epidural Techniques: A Randomized Clinical Trial

	CLE	DPE	CSE
Onset	+	++	+++
Sacral Spread	+	++	+++
Bilateral Spread	+	++	+++
Detect False LOR	-	+	+
Tested Catheter	+	+	-

Epidural catheter replacement rates with dural puncture epidural labor analgesia compared with epidural analgesia without dural puncture: a retrospective cohort study

A.A. Berger, J. Jordan, Y. Li, J.J. Kowalczyk †, P.E. Hess †

Highlights

- Up to 13% of labor epidural catheters fail and require replacement.
- Retrospective study of 19 123 labor neuraxial analgesia procedures.
- Dural puncture epidural (DPE) was compared with lumbar epidural analgesia (LEA).
- DPE was associated with fewer failures than LEA.
- DPE catheters failed significantly later than those placed for LEA.

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"Your patient needs a top-off dose" What do you assess

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What is your normal top off dose?

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Your patient has failed to progress. What is do you use for C/S.

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What adjuncts do you like to use?

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When selecting which medicine to administer neuraxially: do you consider whether it's FDA approved and whether that would increase your liability in a lawsuit?

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If you have an inadequate block after bolusing an epidural for C/S, what is your next step?

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Which benefits of regional anesthesia do you consider when deciding between regional anesthesia and general anesthesia?

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Perioperative Medicine | June 2019

Adverse Events and Factors Associated with Potentially Avoidable Use of General Anesthesia in Cesarean Deliveries

What This Article Tells Us That Is New

- In New York State, 5.7% of cesarean sections without a clinical indication for general anesthesia are performed with general anesthesia
- The use of potentially avoidable general anesthesia in these patients is associated with an increased risk of anesthesia-related complications, surgical site infection, and venous thromboembolism, but not death or cardiac arrest

Practice Guidelines for Obstetric Anesthesia

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- Consider selecting neuraxial techniques in preference to GA for most cesarean deliveries.
- If spinal anesthesia is chosen, use pencil-point spinal needles instead of cutting-bevel spinal needles.
- For urgent cesarean delivery, an indwelling epidural catheter may be used as an alternative to initiation of spinal or GA.
- GA may be the most appropriate choice in some circumstances (*e.g.*, profound fetal bradycardia, ruptured uterus, severe hemorrhage, and severe placental abruption).

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You have a routine, scheduled C/S and your spinal fails. What's your next step.

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What is your preferred method for managing post-operative pain in cases done under spinal/epidural?

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What is your preferred method for managing post-operative pain in cases done under general anesthesia?

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41 yo, G6P5, BMI 45, 1 previous C/S, Ruptured membranes at home 36 hours ago, fever, hx gestational htn. What's your biggest concern?

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ADMISSION AND LABOR RISK FACTORS		
Low	**Medium**	**High**
MONITOR FOR HEMORRHAGE *Routine obstetric care*	**NOTIFY CARE TEAM** *Personnel that could be involved in response are made aware of patient status and risk factors*	**NOTIFY CARE TEAM** **MOBILIZE RESOURCES** *Consider anesthesia attendance at delivery*
Specimen on hold in blood bank	*Type and screen*	*Type and cross, 2 units on hold*
No previous uterine incision	Prior cesarean(s) or uterine surgery	Placenta previa, low lying placenta
Singleton pregnancy	Multiple gestation	Suspected/known placenta accreta spectrum
≤ 4 vaginal births	> 4 vaginal births	Abruption or active bleeding (> than show)
No known bleeding disorder	Chorioamnionitis	Known coagulopathy
No history of PPH	History of previous postpartum hemorrhage	History of > 1 postpartum hemorrhage
	Large uterine fibroids	HELLP Syndrome
	Platelets 50,000 - 100,000	Platelets < 50,000
	Hematocrit < 30% (Hgb < 10)	Hematocrit < 24% (Hgb < 8)
	Polyhydramnios	Fetal demise
	Gestational age < 37 weeks or > 41 weeks	2 or more medium risk factors
	Preeclampsia	
	Prolonged labor/Induction (> 24 hrs)	

ADDITIONAL BIRTH AND ONGOING POSTPARTUM RISK FACTORS*		
ROUTINE CARE	INCREASED SURVEILLANCE POSTPARTUM CARE TEAM ASSESSES RESPONSE READINESS	
	Cesarean during this admission – *especially if urgent emergent/2nd stage*	Active bleeding soaking > 1 pad per hour or passing a ≥ 6 cm clot
	Operative vaginal birth	Retained placenta
	Genital tract trauma including 3rd and 4th degree lacerations	Non-lower transverse uterine incision for cesarean
	Quantitative cumulative blood loss 500-1000 mL with a vaginal birth	Quantitative cumulative blood loss ≥ 1000 mL or treated for hemorrhage
		Received general anesthesia
		Uterine rupture

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What's your anesthetic of choice?

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What's do you need to be adequately prepared prior to going to the OR.

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What's your medication plan to manage hemorrhage?

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Case Studies

I. Airway
II. Embolism
III. Residents first save
IV. Fatal Hemorrhage
V. Hemorrhage save

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Questions or comments?

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