Quick reference guide for obstetric anaesthesia 2018

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1. LSCS - under regional anaesthesia

Achieve a sensory block height cold to T4, light touch to T6. Abx prophylaxis prior to skin incision

a) Spinal – standard

- 14g or 16G IV cannula - IV fluids connected & running
- 2.2-2.5ml 0.5% heavy bupivacaine + 300mcg diamorphine
- Phenylephrine infusion (100mcg/ml) Start at 20ml/hr as soon as spinal in and titrate to target <10% drop in syst BP from baseline

b) CSE - consider in patients with complex medical conditions or when prolonged surgery anticipated

- Needle-through-needle or separate spaces
- Reduce spinal dose in cardiac disease, short stature and morbid obesity
- Phenylephrine as above
- Tegaderm dressing + mefix strip

c) Epidural top up - only if working appropriately. If not → spinal

- 0.5% plain L-bupivacaine 15-20ml given as increments of 5ml
  Or
  2% lidocaine with 1:200 000 adrenaline 15-20ml
  And
- 50-100mcg fentanyl (epidural)
- 3mg diamorphine diluted in saline given down epidural at end for post op analgesia
- Remove epidural at end of LSCS unless contra-indicated (e.g. coagulopathy) or high index of suspicion of need to return to theatre

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2. LSCS - under GA

Usually category 1 emergencies to facilitate rapid delivery of fetus (immediate threat to life of mother or fetus) or when neuraxial anaesthesia contra-indicated/refused.

- Ranitidine 150mg oral pre-theatre. If not, 50mg IV prior to induction
- Oral Sodium citrate 0.3M 30ml
- Pre-oxygenation during catherisation and surgical preparation. HFNO if available.
- Abx as per trust policy
- Optimise position – Oxford or *HELP* pillow + left lateral tilt.
- Refer to DAS Obstetric guidelines
- RSI with cricoid.
  - Propofol or Thiopentone
  - Suxamethonium or Rocuronium
  - Alfentanil up to 1mg for hypertensive mothers Alert neonatal team
- Consider video laryngoscope –size 7 COETT.
- Volatile agent immediately after intubation in 50% N_2O at high flows of 6-8L/min.
- Opioid analgesia following delivery (10-20mg IV Morphine + PCA) +/- US guided TAP blocks at the end (20ml 0.25% bupivacaine each side)

Analgesia during LSCS

At the end of surgery give: Unless contra-indicated/already administered

- Paracetamol 1g IV or PR
- Diclofenac 100mg PR

Post op analgesia prescription:

- Paracetamol 1g PO QDS
- Ibuprofen 400mg TDS-QDS
- Dihydrocodeine 30mg QDS PRN
- Oramorph 10-20mg 2hrly PRN

Post op anti-emetics

- Ondansetron 4mg TDS PRN
- Cyclizine 50mg IM TDS PRN

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3. Trial of Forceps

- Anaesthetic as for LSCS – i.e. block to T4, as potential for conversion to LSCS
- No prophylactic Abx (d/w surgeon)

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4. Manual Removal of Placenta

Assess haemodynamic stability prior to decision for type of anaesthesia – If unstable → GA. If stable → neuraxial anaesthesia (T6 block). Abx.

- Spinal
  - 2ml 0.5% heavy bupivacaine +/- 15-25mcg fentanyl
- Epidural top up
  - 0.5% L-bupivacaine 10-15ml
  - 2% lidocaine + 1:200,000 adrenaline (10-15ml)

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5. Perineal tear repair

Sacral block required. Abx.

- Epidural top up – 2% lidocaine + 1:200,000 adrenaline, or 0.5% L-bupivacaine (10ml)
- Spinal
  - 0.5% heavy bupivacaine 1.5-2ml +/- fentanyl 10-25mcg
  - keep sitting for approx. 3mins to enhance sacral block
- Paracetamol, diclofenac 100mg PR at end
- Post op: paracetamol + ibuprofen.
- Opioids not usually required

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6. Labour Analgesia

a) Epidural

- L2/3, L3/4 or L4/5
- 16G Touhy needle. LOR to saline
- Leave 4-5cm catheter in the space
- Test dose
  - 10ml +/-10ml bag mix (0.1% L-bupivacaine + 2mcg/ml fentanyl)
- Maintenance – follow Trust Policy for pumps
  - PCEA vs. continuous infusion
  - e.g. 8ml bolus with 20 min lockout and set max hourly volume

b) CSE

- Useful for rapid analgesia in advanced labour or severe maternal distress
- L3/4
- Intrathecal dose
  - 3ml 0.1% L-bupivacaine + 2mcg/ml fentanyl

    Or
  - 1ml 0.25% Bupivacaine + 25mcg fentanyl
- Reassess epidural after 45mins

c) Remifentanil PCA

- Only if uninterrupted 1:1 midwifery care can be provided. Check your unit policy.
- When regional analgesia is contra-indicated.
- See Trust guidelines for dosing.
- Dedicated IV cannula
- Respiratory rate and SpO_2 must be monitored every 15mins.

Contraindications to epidural analgesia

- Maternal refusal
- Sepsis
- ↑ICP
- Thrombocytopenia
  - $75\text{-}100 \times 10^9$ – OK to proceed if normal clotting studies
  - $<75 \times 10^9$ – epidural contra-indicated

Anticoagulation

- Therapeutic LMWH - wait 24hrs prior to epidural
- Prophylactic LMWH - wait 12hrs prior to epidural

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7. PPH

Causes - Tone, Trauma, Thrombin, Tissue

Initial treatment

- High flow O_2
- 2 x wide bore IV access
- IV (warmed) fluid bolus
- Confirm immediate availability of red cells or O-ve blood
- Massive Obs haemorrhage if >1.5L – Activate Major Haemorrhage Protocol
- Tranexamic acid 1g (slow IV bolus over 10min) after 500ml loss (SVD) or 1L loss (LSCS)
- Keep patient warm. Correct Ca^{2+}

Uterotonic Drugs

- **Syntocinon** 5 IU(slow IV bolus) + 10IU/hr infusion (repeat 5IU bolus if required)
- **Ergometrine** 500mcg IM (Not in PET/↑BP). Give with antiemetic.
- **Carboprost** (haemabate) 250mcg IM every 15 mins (max 2mg) (Not in Asthma)
- **Misoprostol** 0.4-1mg PR

Further guidelines and information can be found at:

- www.oaa-anaes.ac.uk
- www.aagbi.org
- www.das.uk.com
- Your local policy/guidelines

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