

WoSOA

West of Scotland Obstetric Anaesthesia

Advanced Problem Based Learning Scenarios for Obstetric Anaesthesia

Scenario A- Tick box when completed

A 32 year old p0+0 not in labour at 32/40 gestation is in the High Dependency unit with a diagnosis of pregnancy induced Hypertension (PIH) and the obstetricians have suggested you refer her

How would you define PIH. How would the obstetricians initially be managing this patient. What aspects are we particularly interested in from the anaesthetic point of view.

Her BP is consistently +40/+00 with proteinuria +++ and she has had an episode of headache prior to admission - the obstetricians have prescribed steroids or fetal lung maturation and are discussing with their senior regarding therapy

How is the disease process likely to be affecting this lady's physiology at this stage.

- the obstetricians consider steroid therapy

Why Mg? What are the anaesthetic implications of this drug? How is it administered and monitored? What is the only curative treatment for PIH?

+/- hours later the obstetricians decide on the balance of risks to deliver this lady by CS

What are our anaesthetic options and what are the pros and cons of each?

After discussion with the senior anaesthetist and excluding a coagulopathy you elect to do a CS.

How does your intra-operative management differ from a normal elective section?

If she had a clotting problem, and you had elected a GA,

How would you conduct this differently from a standard GA?

Intra-op she has no problems but post-op is (virtually anuric with rising urea, creatinine and urates and a platelet count of 54/c) + +0 pre-op and remains oedematous

What is your management

How institute monitoring

How do you interpret CVP readings here? Is renal failure a real possibility? When is the danger period for pulmonary oedema. What other problems may develop.

- transfer to skilled interdisciplinary team, manage this lady in, proceed (over 45hrs with no residual problems)

Scenario * - tick box when completed

You are paged by the medical obstetric clinic to provide an anaesthetic assessment for a couple of antenatal patients. Patient 1 is a 37-year-old primigravida with a history of DVT and gestational diabetes, who has stopped her initial treatment for diabetes because she is pregnant. She is now at 25/40 gestation and has been prescribed enoxaparin 40 mg bd and aspirin 81 mg daily.

What other details of her management plan do you need to know?
What are the main anaesthetic problems here?

The obstetricians think an induction of labour at 35/40 is appropriate.

Why have they decided this? What will you discuss with the patient?

You will be in a high risk situation, manage the patient (or,)

What do you consider a suitable plan to be for this lady?

Patient 2 is a 19-year-old girl with a diagnosis of von Willebrand's disease.

What are the features of this disease? How common is it in the obstetric population? How is it likely to have been diagnosed in this girl? What sources of information can we access for unusual conditions?

The girl is under combined care with the haematologists.

How will they have been assessing the severity of the disease?

The girl says she thinks she will want an epidural in labour.

How do you advise her?

You will be in a high risk situation, manage the patient

What do you consider a suitable plan for this patient to be?

Scenario 1 - tick box when completed

You are the senior anaesthetist covering the labour suite) - the trainee who is with you has asked to see a 10, 60min Spinal Epidural if there is a suitable patient)

In obstetrics, which patients may be suitable for this technique?

You should see the trainee the 153 01 in this hospital)

What other types of CSE kit are available? How could you perform a CSE without a specialised CSE kit?

- the trainee asks you what the advantages and disadvantages of this technique are)

How would you respond?

Later in the day the obstetricians inform you that they have a 32 year old lady at 36+/40 gestation who has booked for a section at 35/40 because previous cervical surgery would make a conventional delivery impossible) - this lady has gone into premature labour and they would like her to be sectioned) You think this might be a good case for a 153)

Why might the CSE have a benefit here? What would be your alternative anaesthetic type, and what advantages might this offer?

- the lady is brought to theatre and you begin)

Describe your technique. What are the potential difficulties and pitfalls of the CSE? What spinal drug/dose would you give? What epidural drug/dose would you give and at what point?

Your initial spinal dose gets to 10 at 9 mins)

What would you do?

Your anaesthetic is excellent and uncomplicated)

When would you remove the epidural, and what might you use it for before removal?

- the trainee is impressed and asks you about the 153 in other obstetric patients)

What drugs would you give for this? In other units CSE is the standard technique for elective section- why might this be, and why do we not use it routinely?

Scenario D ? tick box when completed

Accidental Dural Puncture (ADP) and Post Dural Puncture Headache (PDPH)

You are called to labour ! and because the anaesthetic SHO believes they may have accidentally punctured the dura during insertion of an epidural)

What information do you wish from the SHO? What options are available to you now for analgesia in labour? What patient variables may influence your decision on future management?

- the patient is a 35yo primigravida (induction of labour)
She is 2-3cm dilated. You decide to re-site the epidural)

How will you manage the epidural now? Have you any anxieties about complications during labour. What will you tell the mother?

- the woman has an uncomplicated labour until she is 4cm dilated ! then she experiences severe sacral pressure)

How will you manage sacral pressure?

So, eventually she is fully dilated)

Have you any comments about management of second stage?

What will you tell the woman and post natal ward about postnatal care?

She develops a headache on the first postpartum day)

How will you assess her headache? What specific questions will you ask? What might you look for on clinical examination? What treatment options are available? How will you decide on your management plan?

You decide to proceed with an epidural blood patch)

What will you tell the mother about EBP? What proportion of women are 'cured' with an EBP?

What advice would you give the mother to follow post EBP?

Although the headache gets better immediately ! then you relieve her the next day she again complains of headache)

What history would you take? What options are available?

You repeat the EBP and the headache is relieved)

If the headache again recurs what would be your thoughts?

When the patient is discharged home, what advice will you give her?

What is the outcome for untreated PDPH?

