Bradford Teaching Hospitals NHS
NHS Foundation Trust

Title: Drill for High Regional Block in Obstetrics

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Approved by: Anaesthetic Department March 16

Review date: 9.6.18
25/06/2018 reviewed by Debbie Horner - currently safe. Under review - extended for 6 months.
08.02.2019 reviewed by Debbie Horner.
Review date 01.02.2020

Version: 5

Flowchart

high regional (3).pptx

In the context of this guideline, the term high regional block applies to the management of clinical regional block well above the level required for surgical anaesthesia in the presence of significant sequelae (such as respiratory compromise or bradycardia).

Management is supportive and dependent on degree and height of block.

Recognise early - features include weakness and/or tingling of the upper arms and shoulders, difficulty breathing slurred speech and sedation, difficulty speaking or coughing, cranial nerve involvement, arm / hand dysaesthesia / paralysis, nausea and anxiety, as well as a demonstrably high level of insensitivity to cold, touch etc. Symptoms and signs usually occur within minutes however, delay of up to 30 minutes has been reported.

- **Call for help**
- **ABC management:**
- **Administer oxygen** if not already doing so
- If patient apnoeic or hypoxic then intubation by anaesthetist, or guedal / bag & mask until suitably trained personnel arrive
- Establish monitoring
- **Treat hypotension** with uterine displacement, vasoconstrictors (ephedrine, phenylephrine and adrenaline are all suitable in the face of severe maternal hypotension) and intravenous fluids. **Maternal blood pressure must be restored to prevent cardiac arrest**
- **Consider the patient's partner** - explain the situation and detail a team member to escort them out of the room as soon as possible. Also try to **explain and reassure the patient**. This can be a very frightening experience, and the incidence of awareness is high
- **Prepare for tracheal intubation.** Intubate if a rapidly ascending block reaches the shoulders, the patient loses consciousness or the breathing is affected
- **Use a rapid sequence induction with cricoid pressure**
- **Keep the patient anaesthetised and ventilate her lungs**. Ensure anaesthesia is provided as patient may be aware even if she appears unconscious.
- Assess the adequacy of spontaneous ventilation carefully before awakening and tracheal extubation. Remember that peripheral nerve stimulation will not indicate the degree of recession of the block
- If intubation is difficult or fails, do not wait for the return of spontaneous ventilation - it may not occur. Proceed with emergency airway management and intermittent positive pressure ventilation (see failed intubation drill)
- **Consider urgent delivery of the baby**. If there is no foetal compromise it may not be necessary to proceed to a LSCS. Discuss with a senior member of the anaesthetic and obstetric team
- Exclude other causes of unconsciousness, e.g. hypoglycaemia, epilepsy, intracranial lesion, opiates.