Bradford Teaching Hospitals NHS
NHS Foundation Trust

Title: Obstetric General Anaesthesia

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PRE-OPERATIVELY

Explain advantages and disadvantages of regional versus G.A., highlighting regional anaesthesia as our method of choice, providing that there are no contraindications.
Ask about previous GA problems, medical conditions, current drug therapy, allergies, and dentition. Make

intubation assessment.

Elective Premedication

1. Ranitidine 150 mg orally night before. Ranitidine 150 mg + metoclopramide 10 mg orally 2 hours pre-op.
2. 1/3 Molar sodium citrate 20-30 mls orally immediately pre-induction

Emergency Premedication

1. Ranitidine 50 mg IV slowly (over one minute).
2. Metoclopramide 10mg IV slowly (over one minute).
3. 1/3 Molar sodium citrate 20-30 mls orally immediately pre-induction.

INDUCTION

1. Ensure adequate assistance i.e. a trained anaesthetic assistant and one other.
2. Lateral tilt of pelvis using wedge on right side or table tilt 15° and lateral support.
3. Full monitoring ECG, oximetry, NIBP reading x 1 and $ETCO_2$ attached to circuit.
4. IV infusion with 16G or larger cannula.
5. Pre-oxygenation for 3 minutes, or 6 vital capacity breaths (keep mask on face until intubation), aim for end tidal FiO2 around 0.9
6. Position laryngoscopes (short handled, long blade and McCoy); COETT size 6.0, 7.0, with and without stylets; inflation syringe (clip); tube tape and bougies.
7. Suction on and under the pillow.
8. Rapid sequence induction. Thiopentone 5 mg/kg , suxamethonium 100 mg (have atropine 0.6 mg available), cricoid pressure as induction commences, COETT 7.0 mm.
9. Consider agents to prevent hypertensive response to intubation in preeclampsia.

MAINTAINANCE

Pre-delivery

1. IPPV 50% O_2 in N_2O. Set FGF at 8 L/min.
2. Adjust to keep $ETCO_2$ at normocarbia for pregnant patient i.e. 4.5% (4.0-4.5 KPa).
3. Supplement with sevoflurane and ensure MAC of at least 1.0. For elective LSCS and CVS stable emergencies, set inspired concentration to 1.5% for the first 3 mins post induction.
4. Maintain relaxation with atracurium or rocuronium.
5. Antibiotics: Cefuroxime 750mg and metronidazole 500 mg IV. Clindamycin and gentamicin for penicillin allergic patients.

Post-delivery

1. Change to 33% O_2 in N_2O. Reduce vapour concentration e.g. 0.5% sevoflurane.
2. Analgesic supplement: Morphine 10-20 mg, or Fentanyl 200 mcg IV.
3. Syntocinon 5 units IV as bolus and Syntocinon 40 units in 500mls as infusion if requested.
4. For emergency LSCS under GA, the patient's stomach should be emptied with a large bore stomach tube. If the pH of the aspirate is less than 3.5, 30 mls sodium citrate should be instilled down the stomach tube before its removal.
5. Diclofenac 100mg PR (omit if contraindication especially low platelet count, pre-eclampsia or massive haemorrhage).
6. All emergency LSCS should receive Tinzaparin sc (dose appropriate to weight) .
7. Consider performing TAP blocks

CONCLUSION

1. Standard reversing agents. Inspect and aspirate pharynx.
2. The patient should be extubated sitting up when there are active signs of tube rejection or eye opening.
3. Ensure that the sides of the bed are up and that ODP or anaesthetist do not leave patient until fully alert.
4. Postoperative analgesia: Morphine iv titrated in recovery .Oramorph 10-20mg prn po 2 hourly , paracetamol 1g 6 hourly, ibuprofen 400mg 8 hourly (unless contraindicated). See post op analgesia guideline.
5. Postoperative antiemetics: ondansetron 4mg IV/IM 8 hrly.
6. Postoperative oxygen, guided by SpO2.

NB

All women who have undergone Caesarean Section must remain fully supervised in the recovery area for a period of at least 30 minutes or until discharge criteria have been met (see below). The anaesthetist should be immediately available during this period and should not leave the unit. Please be aware that many midwifes are not experienced in recovering patients who have had a general anaesthetic. The anaesthetist should therefore remain with the patient until she is fully awake and maintaining her airway. The midwife should not have additional responsibility over caring for the mother. Another midwife or member of the team should look after the baby

ANAESTHETIC DRUGS TO BE KEPT IN REFRIDGERATOR

The following supply of drugs should be drawn up in labelled syringes and kept in the fridge, in order to be immediately available.

- Thiopentone 500 mg x 1
- Suxamethonium 100 mg x 2
- Atropine 0.6 mg x 1