Patient Information

University Hospitals Coventry and Warwickshire NHS Trust

Maternity

Anaesthesia for urgent obstetric operations

This is a summary for women who are in labour or may need urgent surgery in the maternity unit.

Please discuss anything that is not clear with your anaesthetist.

This information sheet covers anaesthesia for the following operations in maternity care:

- urgent caesarean birth
- delivery in operating theatre by forceps.
- perineal tear repair (stitches in the birth canal)
- manual removal of placenta (if needed after vaginal delivery)
- examination under anaesthesia (to find where bleeding is coming from)

Your anaesthesia options are:

- **spinal anaesthesia -** a single injection given in theatre that produces reliable anaesthesia for operations while you are awake
- **epidural top-up -** if you already have an epidural in place and working, this is likely to produce the same anaesthesia as a spinal injection, just a bit more slowly
- **GA (general anaesthesia) -** your anaesthetist uses this to put you into a state of controlled unconsciousness, where you are asleep and feel nothing – having a GA increases the chance of coronavirus

transmission, so we usually need to use more coronavirus protective equipment, and it will often take longer to protect the staff looking after you and maintain safety

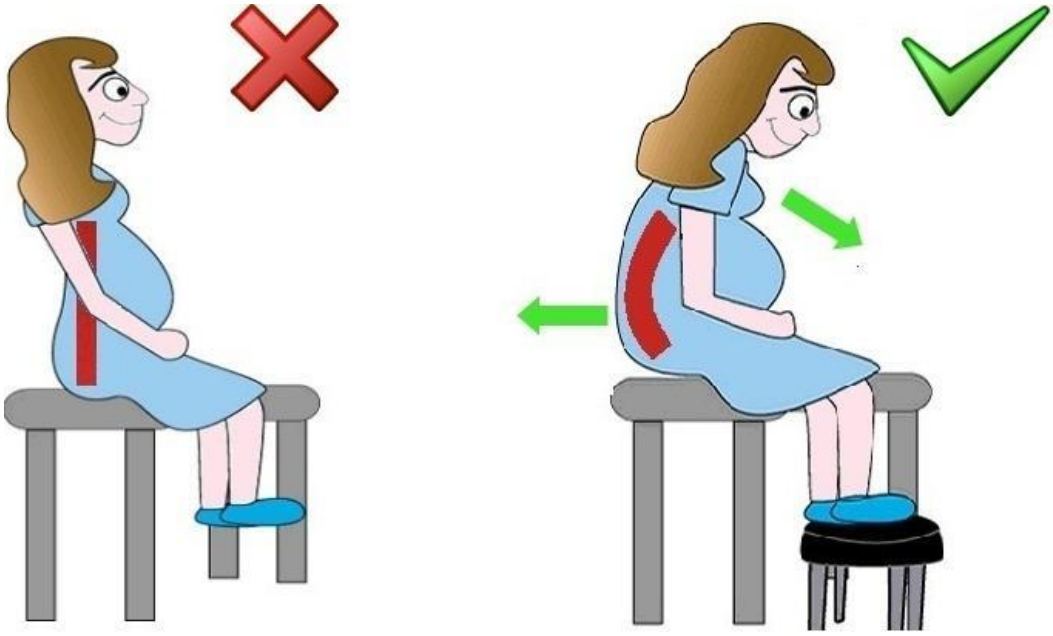
The rest of this leaflet describes the different types of anaesthetic and what they involve. Your anaesthetist will suggest to you the most appropriate form of anaesthesia in your circumstances and ask you what you think.

We ask you to read the information here as it will help you to understand how we will be helping and caring for you at a time when you may feel that things are happening quickly and can be difficult to follow.

Spinal anaesthesia

This involves injection of a local anaesthetic solution around your spinal cord with the help of a needle when you arrive in the operating theatre. We should be able to bring your partner into the operating theatre with you if you both are not in coronavirus isolation and do not have any symptoms or signs of COVID-19.

We ask that you help us by getting in a good position for spinal anaesthesia, with your heels together, your knees apart and curled forward over a pillow.



You will need to keep very still and maintain the position while you receive the injection. Your operation will start when you and your anaesthetist are sure that your body is properly numb below your chest. This is so that you cannot feel pain, cold or sharp sensations.

- you will remain awake and aware of your surroundings
- you will not feel sharp or cutting pain - if you are having a baby under spinal anaesthesia, you will probably feel some rummaging around, or pushing and pulling, when the baby is delivered - some women say it is like a heavy pressure on them for a few seconds
- you will not be able to feel or move your legs until the spinal anaesthetic wears off about three hours after the operation
- the operation will start after a final safety check of your details
- if you are having a caesarean birth, your baby will be born quite early in the operation. Your anaesthetist will be giving medicines to control bleeding in your uterus (womb) after the delivery, and the surgical team will close and dress the wound

Risks and side effects of spinal anaesthesia

These details are taken from the LabourPains web site. Accurate figures are not available for all these risks and side effects.

The figures are estimates and may vary from hospital to hospital. If you have any questions, you should discuss these with your anaesthetist.

Possible problem	**How common the problem is**
Itching	Common – about **1 in 3 to 10** people, depending on the drug and dose
Significant drop in blood pressure	Common – about **1 in 5**
Anaesthetic not working well enough, and more drugs are needed to help with pain during the operation	Occasional – about **1 in 20**
Regional anaesthetic not working well enough for the operation and general anaesthetic is needed	Occasional – about **1 in 50**

Possible problem	How common the problem is
Severe headache	Uncommon – about **1 in 500**
Nerve damage (for example, numb patch on a leg or foot, weakness of a leg)	Effects lasting less than six months: Quite rare – about **1 in 1,000 to 2,000** Effects lasting more than six months: Rare – about 1 in 24,000
Meningitis	Very rare – about **1 in 100,000**
Abscess (infection) in the spine at the site of the spinal or epidural	Very rare – about **1 in 50,000**
Haematoma (blood clot) in the spine at the site of the spinal or epidural	Very rare – about **1 in 168,000**
Abscess or haematoma causing severe injury, including paralysis (paraplegia)	Very rare – about **1 in 100,000**

Spinal anaesthesia is not a cause of low back ache (other than tenderness for a day or two at the point of injection).

Epidural top-up

If you already have an epidural for pain relief during labour and it is working well, we should be able to top it up for your operation in theatre. We should be able to bring your partner into the operating theatre with you if you both are not in coronavirus isolation and do not have any symptoms or signs of COVID-19.

In theatre, we will give larger doses of stronger anaesthetic down the epidural tube (catheter). This will anaesthetise the lower part of your body for a few hours. Your legs will be quite heavy and numb as well. You will remain awake and aware of your surroundings. You will not feel sharp or cutting pain. You will probably feel some pushing and pulling when the baby is delivered.

Risks and side effects of epidural top-up

As the epidural tube (catheter) has already been inserted, the risks are those of the large dose of drugs injected into the epidural. We do this carefully, but about 1 woman in 50 to 100 will be affected by a high block – it may be more difficult to take a deep breath, and your hands might be tingly or weak. Very rarely, your anaesthetist may need to help your breathing or anaesthetise you.

Very rarely, you may have a bad reaction to the drugs used and need urgent treatment on an intensive care unit.

Epidural top-ups are a bit slower than spinals, so your blood pressure is less likely to be affected.

If the epidural is not working well (the risk is about 1 in 10) or does not top up successfully (the risk is about 1 in 20), you will need to have another type of anaesthesia, probably general or spinal anaesthesia. We will check the block carefully and discuss your choices with you if it is not working well.

GA (general anaesthesia)

GA was often used when we needed to move swiftly to deliver your baby. However, we now must use more personal protective equipment to prevent coronavirus transmission. It will take time to prepare, and we cannot move so swiftly. Rarely, we may need to use general anaesthesia if you are bleeding or if you have a blood clotting problem.

We may be able to bring your partner into the operating theatre when you have general anaesthesia, but if we do, they will have to leave just before you are anaesthetised.

You will be given an antacid to drink (to reduce the acid in your stomach) and a midwife may insert a tube (catheter) into your bladder before the general anaesthesia is started.

Your anaesthetist will give you oxygen to breathe through a tight-fitting face mask which they put on your face for a few minutes. They will then

inject the anaesthetic I.V. (in your drip) to send you to sleep. Just as you go off to sleep, the anaesthetist's assistant will press lightly on your neck. This is to prevent stomach fluids getting into your lungs. The anaesthetic works very quickly.

When you are asleep, your anaesthetist will place a tube into your windpipe to allow a machine to breathe for you and to prevent fluid from your stomach from entering your lungs.

Your anaesthetist will continue the anaesthetic to keep you asleep and allow the obstetrician to deliver your baby safely. But you won't know anything about any of this.

At the end of the operation, your anaesthetist or obstetrician will put some local anaesthetic around the operation site on your tummy which will help reduce the pain afterwards.

Risks and side effects of general anaesthetic

These details are taken from the LabourPains web site. Accurate figures are not available for all these risks and side effects. Figures are estimates and may vary from hospital to hospital. If you have any questions, you should discuss these with your anaesthetist.

Possible problem	**How common the problem is**
Shivering	Common – about **1 in 3**
Sore throat	Common – about **1 in 2**
Feeling sick	Common – about **1 in 10**
Muscle pain	Common – about **1 in 3**
Cuts or bruises to lips and tongue	Occasional – about **1 in 20**
Damage to teeth	Quite rare – about **1 in 4,500**
The anaesthetist failing to insert a breathing tube when you are asleep	Uncommon - about **1 in 250**

Possible problem	How common the problem is
Chest infection	Common – about **1 in 100** – but most infections are not severe
Acid from your stomach going into your lungs	Quite rare – about **1 in 1,000**
Awareness (being able to recall part of the time during your anaesthetic)	Uncommon – about **1 in 250**
Severe allergic reaction	Rare – about **1 in 10,000**
Death	Very rare – fewer than **1 in 100,000 (1 or 2 a year in the UK)**
Brain damage	Very rare – exact figures are not known.

Bleeding during and after the operation

Many women do not bleed heavily, but some do, and it is a possibility in any urgent obstetric operation. We help you with this in several ways.

Medicines to control bleeding

We use medicines that make your uterus contract, such as oxytocin or ergometrine, and we can also use TXA (tranexamic acid) to make your blood clot more effectively.

Red cell salvage

We offer this routinely for caesarean delivery, but it cannot be used for other urgent operations. We can collect the blood lost at caesarean delivery, which is about 500ml, or just over a pint. If you lose more than this, then we can process the blood and return it to you. Blood is returned for about 1 in 12 women having caesarean delivery.

If you have sickle cell haemoglobin in your blood, we may need to check levels before giving blood back.

If you have rhesus-negative blood group and we use cell salvage, it is rarely possible that you may need a slightly higher dose of anti-D after the delivery.

Blood transfusion

We avoid this unless it is really needed, usually because of heavy bleeding or severe anaemia. About 1 in 100 women may receive one at some point during or after a caesarean, and the risk is a bit higher for other operations. You can ask for information about the risks and benefits of blood transfusion.

Iron drip in recovery or iron tablets for 3 months

If your haemoglobin level is low or you bleed a bit more than average, we may prescribe iron tablets for 3 months. If the iron tablets won't be enough on their own, then we may prescribe an iron drip (Ferinject) for you in theatre recovery.

Pain relief after obstetric operations

Good pain relief is important so that you can move, protect yourself from complications, and go home. Some people need more pain relief than others. It is much easier to relieve pain if it is dealt with before it gets too bad. Pain relief can be increased, given more often, or given in different combinations.

Occasionally, pain is a warning sign that all is not well. Therefore, you should always report it to your midwives and seek their advice and help.

Our standard pain relief routine uses a number of medicines to help you cope. These medicines will cross to your baby in breastfeeding, but in very low concentrations, and they will not harm your baby.

- **Numbing injection** for your skin before using venous or spinal needles.
- **Diamorphine** in with a spinal or epidural anaesthetic if possible. This will give you excellent pain relief for about 12 to 24 hours after the operation, the most difficult time. However, it does make many women itchy. About one in twenty (1 in 20) women will need a medicine to reduce the itching.

- **Diclofenac by suppository** (in your rectum or bottom). 1 or 2 doses, 12 hours apart before changing to **ibuprofen tablets**, 4 times a day. Tell us if you cannot take these drugs, possibly because you have asthma. If you know that these drugs do not make your chest tight, then they are safe even for people with asthma.
- **Paracetamol tablets,** 4 times a day.

  You will need to take the paracetamol and ibuprofen for a few days after you go home for caesarean delivery or perineal repair (birth canal stitches).

  If you cannot take ibuprofen, we will usually prescribe regular **dihydrocodeine** tablets, 4 times a day.
- **Morphine liquid,** by mouth as you need it, while you are in hospital.

Preventing blood clots after the operation

You will need compression stockings, and sometimes blood thinning injections to reduce the risk of blood clots in your legs. These are sometimes called Clexane injections. The injections are not painkillers. They are given to reduce your risk of blood clots. The midwife will explain to you before you go home how to use these and for how long you should give yourself the injections.

Further information

Image from “Information overload! Patient positioning for neuraxial anaesthesia” is adapted from www.painfreebirthing.com and used in this leaflet with the kind permission of Dr B. Kodali MD

The Trust has access to interpreting and translation services. If you need this information in another language or format, please contact us and we will do our best to meet your needs.

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