

Never confuse a single defeat with a final defeat: what to do when the drugs don't work

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Introduction

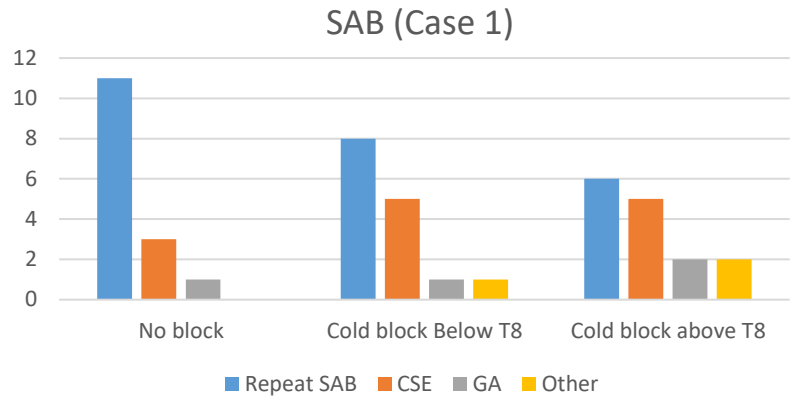
Spinal anaesthesia is the commonest anaesthetic technique for caesarean section (CS) in the UK. The RCoA recommended standard is for >85% of category 2 and 3 CS to be performed under neuraxial anaesthesia[1]. Adequacy of block remains controversial in terms of what modality is tested. However, block of cold sensation to at least T4 seems to be universally accepted as the minimum requirement. What do you do if the block is not adequate, but time or clinical circumstance does not mandate conversion to general anaesthesia (GA) prior to starting.

Methods

We performed a literature search and found one local guideline with advice for failed regional pre-incision. We then developed a survey for anaesthetists in our department. We presented two clinical cases with three possible outcomes. The first (Case 1) was a low-risk woman having a category 2 or 3 CS who had been administered a subarachnoid block (SAB) with 0.5% hyperbaric bupivacaine 2..5 mL and diamorphine 300 µg. The second case (Case 2) was also low-risk but with working labour epidural topped up with 0.5% bupivacaine 20 ml. We then asked what they would do if faced with either no block, cold block below T8 or cold block above T8. We picked T8 somewhat arbitrarily, based on use in the aforementioned local guideline[2].

Results

We collected 15 responses. 9 consultant and 6 non-consultant grades. 73% would repeat SAB if no block developed after 20 min. 20% would perform a CSE and 7% would perform a GA. If faced with partial block above T8, the results were more varied. 40% would repeat SAB with varying reductions of dose. 33.3% would perform a CSE, 13.3% would perform GA, and 13.3% chose for 'other' (Call consultant). In the second case, 93% of responders would remove the catheter and perform a SAB if no block developed. With a partial block above T8, 40% would continue to top up. 53% would remove the catheter and perform SAB; and 7% would convert to GA.



Discussion

Our small numbers show a variety of responses to different clinical scenarios. Despite the high percentage of practitioners who would repeat SAB, there was a spread of doses.

With partial block above T8, there was more of a divergence in practice. Given the apprenticeship style of training in anaesthesia perhaps our results should not be surprising. Is this important? Repeated neuraxial techniques involve risk of complications, unnecessary general anaesthetics increase risk. Perhaps a guide, similar to the OAA failed intubation guideline, with various different situational factors to consider, may aid in decision making if faced with a failed regional technique prior to starting a case. A larger survey, and one that studies interdepartmental practice and differences may be both interesting and useful.

References

1. Raising the Standards:RCoA quality improvement compendium 4th edition, 2020. https://www.rcoa.ac.uk/sites/default/files/documents/2020-08/21075%20RCoA%20Audit%20Recipe% 20Book_Combined_Final_25.08.2020_0.pdf 2. Guidelines for inadequate regional anaesthesia during LSCS https://www.oaa-anaes.ac.ukhttp://abstracts.oaaanaes.ac.uk//assets/_managed/editor/File/Guidelines/Inadequate% 20regional% 20block/inadequate_regional_LSCS_Eason_Sunderland.pdf