What do Obstetricians want Anaesthetists to know (Even if we don’t mention it at the time!)

Dr Andrew Pesce, Obstetrician and Gynaecologist, Westmead Hospitals
## It was all going so well.....

<table>
<thead>
<tr>
<th>Clinical Scenario</th>
<th>Anticipate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple previous caesareans</td>
<td>Scar tissue, difficult extraction of fetus, increased blood loss</td>
</tr>
<tr>
<td>Twin delivery</td>
<td>Difficulty with 2\textsuperscript{nd} twin. Potential need uterine relaxation or urgent CS</td>
</tr>
<tr>
<td>Preterm caesarean, esp non cephalic</td>
<td>Poorly formed lower segment, may need vertical incision or extension of lower segment incision, head entrapment.</td>
</tr>
<tr>
<td>Preterm vaginal breech</td>
<td>Head entrapment in incompletely dilated cervix. Potential need for uterine relaxation or cervical incision.</td>
</tr>
<tr>
<td>Shoulder dystocia</td>
<td>Uterine relaxation can facilitate delivery of posterior arm when preceding manoeuvres have failed.</td>
</tr>
<tr>
<td>Cord prolapse</td>
<td>Urgent CS. Suggest filling the maternal bladder to elevate presenting part.</td>
</tr>
</tbody>
</table>
Multiple previous caesareans

• More likely to lead to difficult extraction of the fetus (scar tissue doesn’t stretch)
• Increased blood loss, even with normal placentation.
• Placenta accreta incidence now 1:550 * https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Placenta-Accreta
• Increased risk of placenta accreta in placenta praevia with previous CS:

<table>
<thead>
<tr>
<th>No. Prev CS</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk of Accreta (%)</td>
<td>1</td>
<td>3</td>
<td>10</td>
<td>40</td>
<td>60</td>
<td>70</td>
</tr>
</tbody>
</table>
2nd Twin Delivery

- Internal podalic version can sometimes be difficult, especially if T2 rotates to transverse lie with back down.
- Uterine relaxation with GTN can be extremely helpful with difficult 2nd twins.
- Caesarean delivery doesn’t necessarily avoid difficult T2
Preterm caesarean

- Lower segment poorly formed until 3rd trimester, especially if non cephalic fetus
- May require classical uterine incision, and be associated with increased blood loss.
- Entrapment of fetal head may require uterine relaxation or extension of initial uterine incision.
Preterm vaginal breech

- Head entrapment is very uncommon in term vaginal breech delivery.
- More likely in preterm delivery, as fetal head is significantly larger than breech, and is obstructed by an incompletely dilated cervix.
- Uterine relaxation with GTN can be very helpful, otherwise incision of cervix may be required.

#OBSIG18
Cord Prolapse

• Poor outcome if occurs out of hospital
• Outcome can be good if occurs in hospital
  • Replacement of cord
  • Elevation of presenting part (IDC and filling of bladder, positioning of patient, manual elevation of presenting part
  • Uterine relaxation if there is uterine activity
  • Caesarean delivery ASAP, unless fully dilated, instrumental delivery might be quicker
Shoulder Dystocia

• Manoeuvres for severe dystocia helped in severe cases by uterine relaxation and absence of maternal effort

• In severe cases Zavanelli Manoeuvre (replacement of fetal head, followed by CS)
Whither obstetrics?

- Transition from VMO appointments to Staff Specialist positions
- Few opportunities in private practice for newer graduates, and those are mainly in the private hospital system.
- More obstetricians, fewer private deliveries. Are similar pressures operating for new anaesthetic specialists?
- Rebates cover costs, out of pocket = retained earnings. Previous expectations of net incomes won’t be sustainable.

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>2013/14</th>
<th>2014/5</th>
<th>2015/16</th>
<th>2016/17</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>88242</td>
<td>87127</td>
<td>83195</td>
<td>81573</td>
<td>78466</td>
</tr>
<tr>
<td>(% decrease from 2012)</td>
<td>1.3%</td>
<td>5.8%</td>
<td>7.5%</td>
<td>11.1%</td>
<td></td>
</tr>
</tbody>
</table>
What do women want?

• Continuity of care
• A healthy outcome
• A sense of respect and responsiveness to their needs/preferences. Most expectations impose system burdens rather than clinically significant (continuity, input into decision making, flexible appointments, preferences for birth experience, postnatal care)
• Will pay for care, but cost pressures are becoming significant. Private hospitals will move to protect their income: expect proposals for new models of medical care in private maternity units.

#OBSIG18