POSTER REVIEW #3

A98 (Poster68)

POSTOPERATIVE PAIN AFTER "MINOR" SURGERY (POSTPARTUM TUBAL LIGATION) IS NOT MINOR *Marcus MD, R.L.; Wong MD, C.A.; Strauss-Hoder MS, T.; Maly MD, J.; Cummings, C.; Avram PhD, M. Anesthesiology, Northwestern University, Chicago, IL* **Introduction:** Postoperative postpartum tubal ligation (PPTL) pain is often under appreciated. We hypothesized that PPTL patients have signifcant pain that is often undertreated. **Methods:** An IRB-approved retrospective chart review compared analgesic requirements for 24 h for PPTL and cohort patients (next term multiparous patient with a vaginal delivery). In an IRB-approved prospective study, verbal rating scores (VRS) were collected at regular intervals for 24 h for consecutive PPTL patients and a cohort. Data from the PPTL and cohort groups were compared using Fisher's exact test and student's t-test. $P<0.05$ was considered significant. **Results:** There were no differences between groups in either study in age, height and weight. For both studies, significantly more PPTL patients were African-American or Hispanic-white. All patients had spinal or epidural anesthesia without neuraxial opioids. Significantly more PPTL patients required IM/IV opioids (14/34 vs. 1/34). There was no difference in ibuprofen dose (1182 ± 668 vs. 1177 ± 730 mg, mean ± SD), but the PPTL group required significantly more acetaminophen/hydrocodone (2500 ± 1237 vs. 1529 ± 1300 mg acetaminophen). Five PPTL patients and one control patient received > 4 g acetaminophen in 24 h. There was a significant difference in pain scores between the two groups. A higher percent of pain scores in the PPTL group indicated moderate to severe pain (VRS≥4) (Table). **Conclusions:** Despite using significantly more analgesics, a significant number of PPTL patients have moderate to severe pain. Alternative methods of postoperative analgesia should be investigated.

Group	N	Number of Observations per Patient (S.D.)	Mean VRS (S.D.)	% of VRS ≥ 4
COHORT	25	4.4(2.1)	2.5(1.6)	38.2
PPTL	26	5.1(1.9)	4.6(1.7)	72.5

A99 (Poster 69)

ILIOHYPOGASTRIC-ILIOINGUINAL (IHII) NERVE BLOCKS MAY OFFER NO BENEFIT AS AN ADJUNCT TO NEURAXIAL MORPHINE FOR POST CESAREAN SECTION (CS) ANALGESIA. *Schultz, J.R.; Bell, E.A.; Muir, H.A.; Phillips-Bute, B.; Reynolds, J.D. Division of Women's Anesthesia, Duke University Medical Center, Durham, NC* **Introduction:** We previously determined that IHII nerve blocks could reduce post CS IV morphine use but do not reduce the incidence of opioid-related side effects. For the present study, we hypothesized the theoretical benefits of the IHII block for post CS analgesia would become evident when combined with neuraxial morphine; providing similar analgesia when using a decreased dose of neuraxial morphine which likewise should show a reduction in the incidence of nausea and pruritus. **Method:** With IRB approval and written informed consent, women presenting for elective CS with regional anesthesia were randomized to receive neuraxial morphine with or without an IHII block. Study patients received morphine (spinal 0.1-mg epidural 2.0-mg) with IHII block (30cc of 0.5% ropivacaine with 5-mcg/ml of epinephrine. Control patients received a higher dose of morphine (spinal 0.2-mg epidural 3.0-mg) and saline injections along the IHII nerves. All patients received naproxen sodium 500 mg po every 12-h. Standard medicine for break through pain, pruritus and nausea was used. Scores for pain, pruritus, nausea, and patient satisfaction, using 100-mm un-hatched linear VAS were obtained every 8-hs. The need for additional medications was noted. **Results:** Fifty-two parturients were studied; 27 in the study group and 25 in the control group. Interim analysis revealed that VAS scores for pain, pruritus, and nausea were similar for the two treatments. The need for additional analgesics, anti-nauseants and anti-pruritics was similar between groups. In contrast, satisfaction scores for the IHII study group were significantly less than from women in the control group. **Discussion:** These preliminary results suggest the use of IHII blocks as an adjunct to neuraxial opioids offer little patient benefit for post CS analgesia. The study is ongoing.

A100 (Poster 70)

CAN SPINAL ANESTHESIA REDEEM A FAILED EXTERNAL VERSION? *Cherayil, G.[1]; Feinberg, B.[2]; Robinson, J.[2]; Tsen, L.C.[1] 1. Anesthesiology, Perioperative & Pain Medicine, Brigham & Women's Hospital, Boston, MA; 2. Obstetrics & Gynecology, Brigham & Women's Hospital, Boston, MA* **Introduction:** Epidural anesthesia has been demonstrated to facilitate external cephalic version of breech presentation (1). While spinal analgesia has been reported to make no difference for versions (2), the use of spinal anesthesia remains in question. We report an ongoing retrospective study of singleton breech version attempts with regional anesthesia following a failed version attempt without anesthesia. **Methods:** After approval by the hospital's Human Research Committee, all medical records of versions performed during the years 1995–2000 were evaluated. Data were collected on maternal and fetal characteristics, the version procedure, and the anesthetic intervention. All versions were first attempted without anesthesia; immediately afterwards, consenting patients were re-attempted under either spinal or epidural anesthesia. **Results:** A total of 77 versions, all performed with a standardized approach by a single obstetrician, were attempted without anesthesia, of which 39 (50%) were unsuccessful. 16 patients consented to an attempt with anesthesia. With spinal and epidural anesthesia, 5/7 (71%) and 8/9 (89%) were successful, respectively. No differences were observed in terms of maternal and fetal demographics between patients undergoing versions with and without anesthesia. **Conclusions:** Our preliminary findings demonstrate that anesthesia, whether given by spinal or epidural techniques, results in successful versions. Moreover, in comparison to other studies, this may suggest that spinal anesthesia, and not analgesia, is necessary for version success. **Reference:** Neiger R, Hennessy MD, Patel M. Am J Obstet Gynecol 1998;179;1136–9. Dugoff L, Stamm CA, Jones OW, et al. Obstet Gynecol 1999;93:345–9.

A101 (Poster 71)

CHOICE OF ANESTHETIC TECHNIQUE FOR CESAREAN SECTION IN WOMEN WITH PLACENTA PREVIA *Rutter, S.; Marfin, A.; Russell, R.; Grange, C. Nuffield Department of Anaesthetics, John Radcliffe Hospital, Oxford, United Kingdom* **Introduction:** Anesthetic choice for cesarean section (CS) in parturients with placenta previa remains controversial, regional anesthesia (RA) being revisited as an acceptable technique1. The aim of our study was to assess factors affecting choice in our unit. **Methods:** We analysed factors affecting the primary choice of anesthetic technique (RA or GA) in 66 consecutive cases requiring CS for placenta previa. Duration of surgery, blood loss, conversion to GA, cesarean hysterectomy and/or blood transfusion were recorded. **Results:** RA was preferred or considered in 94% of women and performed as a primary technique in 83% of women. In three women RA was converted to GA, with 2 requiring hysterectomy. Median duration of surgery was 38 min (range 22–152); median blood loss was 775 ml (range 300-5000ml). 11 patients received a primary GA; main indications included moderate/severe antepartum hemorrhage (5 cases), obstetrician's and/or anesthetist's preference (3 cases), mother's preference (2 cases) and fetal distress (1 case). Of these 11 cases, one required blood transfusion and none needed cesarean hysterectomy. Median duration of surgery was 43 min (range 26–51) and median blood loss was 750ml (range 500-3000). **Conclusion:** Our results indicate that RA may be a suitable alternative for CS in women with placenta previa. **Reference:** 1. Parech N, Husaini SWU, Russell IF. Caesarean section for placenta previa: a retrospective study of anaesthetic management. Br J Anaesth 2000; 84: 725–30

Preferred anesthetic	Number	Percentage
RA preferred	49	74
Undecided	13	20
GA preferred	2	3
No choice	2	3

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