

POSTER REVIEW #3

A80 **(Poster 49)**
NEONATAL RESUSCITATION AND THE ANESTHESIOLOGIST
Gaiser, R.R.; Lewin, S.B.; Cheek, T.G.; Gutsche, B.B. Anesthesia, University of Pennsylvania, Philadelphia, PA **Introduction:** The ASA recommends a person other than the anesthesiologist be responsible for resuscitation of the newborn.(1) However, Hawkins reported that anesthesiologists provided neonatal resuscitation in 10% of cesarean deliveries.(2) We feel that the majority of anesthesiologists are not certified in neonatal resuscitation (Cert) and used a survey to test our hypothesis. **Methods:** With IRB approval, graduates from our residency between 1989 and 1999 were mailed an anonymous survey regarding the type of practice, whether obstetrics (OB) was part of the practice, current Cert, and interest in Cert. Those who had OB as part of their practice were queried regarding the # of deliveries, personnel responsible for the resuscitation, and involvement in neonatal resuscitation (Neo Resus). Those individuals who failed to return a survey within three months were resent another. Data analysis: chi-square and relative risk with confidence intervals. **Results:** 212 individuals completed the residency. Addresses were available for 189 (89%) and the response rate was 156 (82%). See table. Those with OB were statistically greater in the private practice group. The frequency of the Neo Resus: 35% - 0; 23% - 1/yr; 24% - 6/yr; 14.5% - 1/month. If the hospital had <1000 deliveries per year, a significantly greater percentage of the respondents were involved in Neo Resus with the relative risk for an anesthesiologist having to perform a resuscitation being 11.0 (CI, 1.4 - 86). **Conclusions:** Anesthesiologists are involved in the resuscitation of the newborn. The majority are not certified, but are interested in becoming certified. ASA or SOAP should establish programs to offer the opportunity to learn and reinforce these skills. **Reference:** 1. ASA: Guidelines for Regional Anesthesia in Obstetrics, 2000 Directory of Members, 65: 488-9. 2. Hawkins J, Gibbs CP, Orleans M, et al. Obstetric Anesthesia Work Force Survey, 1981 versus 1992. Anesthesiology 1997; 87: 135-43.

	OB	Cert	OB and Cert	OB and Interest in Cert	Interest in Cert	OB and Neo Resus
Academic (n=51)	53%	14%	22%	85%	71%	52%
Private Practice (n=105)	79%	13%	14%	80%	73%	68%

A81 **(Poster 50)**
BMI PREDICTS CS IN MULTICENTER PROSPECTIVE COHORT STUDY
Bell, E.¹; Hartle, A.¹; Mayer, D.²; Olufolabi, A.¹; Phillips-Bute, B.¹; Spielman, F.² 1. Anesthesiology, Duke, Durham, NC; 2. Anesthesiology, University of North Carolina, Chapel Hill, NC **Introduction:** We previously demonstrated that Body Mass Index (BMI) at presentation for delivery predicts the incidence of CS at our institution. We hypothesized that BMI predicts incidence of CS in other populations as well. **Methods:** A prospective cohort of all patients presenting in the same two weeks at four US centers (two academic centers and two community hospitals) were followed. Data on mode of delivery, BMI, estimated gestational age, single versus multiple gestation, age, race and weight in pounds were analyzed. **Results:** Data were collected on 1,007 patients. Logistical regression analysis demonstrated all variables were significant independent predictors of CS. An increase in BMI of 10 kg/m² increased the odds of CS by 3.13. A BMI over 40 kg/m² had twice the incidence of CS as a BMI under 40 kg/m². The rate of CS varied between centers, but all showed an increasing incidence in CS with increasing BMI. **Conclusions:** BMI at delivery appears to be a significant independent predictor of operative delivery. Specifically, a BMI greater than 40 kg/m² results in a two-fold increase in CS rate. This relationship holds true in different institutions with varying CS rates.

