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ANALGESIA AFTER CESAREAN SECTION: DOES THE PRE-EMPTIVE EFFECT OF EPIDURAL DIAMORPHINE AFFECT OUTCOME?

Mok, M.U.; Thompson, J.; Vanarase, M.; Grange, C. Nuffield Department of Anaesthetics, Oxford Radcliffe Hospitals NHS Trust, Oxford, United KingdomGood analgesia post cesarean section (C/S) remains paramount. Effects of pre-emptive analgesia are controversial(1,2). Our ongoing study compares patients receiving pre-emptive epidural diamorphine intra-operatively (group 1) with those who received it post-operatively at patient request (group 2). 21 ASA I-II women undergoing C/S were anesthetized using a standard combined spinal-epidural technique with intrathecal heavy bupivacaine (0.5%, 2.5ml) and fentanyl (12.5mcg). Group 1 (10 patients) were given their first dose of 2.5mg epidural diamorphine at the end of the surgery and received additional doses in the recovery room (RR) at maternal request. Group 2 (11 patients) were given their first and subsequent doses of 2.5mg epidural diamorphine in the RR at maternal request. All patients also received regular simple analgesics. Pain, pruritus, nausea and vomiting were each recorded using a scoring system of 0-3 (0 = no symptom, 3 = severe symptom) at 1, 2, 4, 8, 12, 24 hours post surgery and overall 24 hour score. Time of first epidural diamorphine in RR and dosage of other analgesia used were also noted. The demographics of the 2 groups were similar. (Please see table for the summary of results) It appears that giving pre-emptive epidural diamorphine at the end of surgery combined with regional technique may provide better analgesia than administering the epidural diamorphine at patient request after the painful stimulus is perceived. The pre-emptive epidural diamorphine does not seem to increase the incidence of side effects. It is hoped that with larger sample numbers in each group, statistical significance will be achieved which will support the above findings.

1. Anaesthesia 1998; 53: 296 - 8 2. British Journal of Anaesthesia 1992; 69: 1 - 3

	Group 1 (pre-emptive diamorphine) n=10	Group 2 (no pre-emptive diamorphine) n=11
Time interval from intrathecal injection to 1st requested epidural diamorphine in RR	208 min	202 min
Average of 24 hour overall pain score	0.6	1.6
Average of 24 hour overall nausea + vomiting score	0.4	0.3
Average of 24 hour overall pruritus score	0.6	0.8

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EXAMINING THE INFORMATION REQUIREMENTS OF WOMEN HAVING ELECTIVE CESAREAN SECTION.

DR JULIA MÖRCH-SIDDALL, DR VALERIE BYTHELL DEPARTMENT OF ANESTHESIA, ROYAL VICTORIA INFIRMARY, NEWCASTLE UPON TYNE UK Morch-Siddall, J. Bythell, V. Anaesthesia, Royal Victoria Infirmary, Newcastle upon Tyne, United Kingdom We surveyed women having elective cesarean section (CS) pre- and post-operatively to determine where they obtained information about anesthesia, whether the information was adequate and whether it could be improved. All women scheduled for CS in a 4 month period (n=54) self-administered a questionnaire, pre- and post-partum, on the information they had acquired about anesthesia for CS. The questionnaire used graded response multiple choice questions and questions with open ended answers. Thirty completed questionnaires were returned, the average age of woman was 32 years, 20 women had no previous CS. As to why they were having CS, what type of anesthesia to choose and their involvement in those decisions the majority wanted maximum or enough information. Asked who should give the information 26 women felt the hospital doctor should rather than family doctors or midwives, 10 women felt midwives more approachable than doctors. Most women felt hospital staff had enough time to answer their questions but would have preferred alternative information formats for reinforcement e.g. booklets or videos, feeling information existed but unsure how to access it. All women saw an anesthetist pre-operatively and felt the information given clear and easy to understand but 9 women felt the risks of regional anesthesia (RA) were not fully explained. RA was chosen by 29 of the women giving reasons such as 'desire to see my baby', 'have partner there' and 'be more in control'. All women got their chosen anesthetic. Half felt frightened during the CS but felt more information would not have been anxiolytic.The best things about the CS were 'no pain', 'the attentive staff' and 'speed', the worst were 'feeling sick', 'the pulling' and 'being immobile and helpless afterwards'. Four women did not feel involved when they did not get to hold the baby during suturing. When asked for any other comments about the anesthesia and analgesia all were complimentary. Mainly the women were satisfied with the information they acquired and felt it reflected their experiences. However important gaps were revealed, women wanted to know more on the risks of RA, recovery and post-CS analgesia. We have acted on this and changed what women are told pre-CS, revised our CS leaflet to include an appendix of other information sources and increased its availability. The study has changed practice, we wanted to find out what women wanted to know before CS rather than assuming we knew.It has allowed women in our care to set the information agenda.