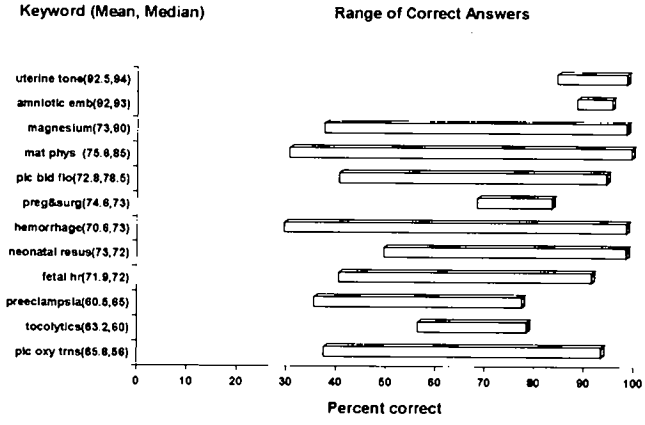
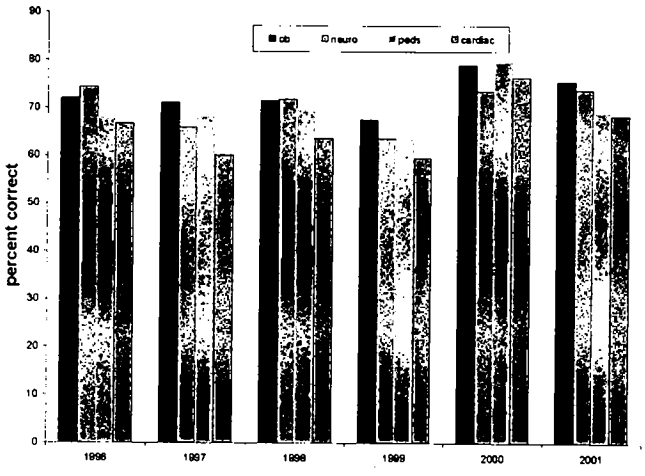
P-5

NATIONAL IN-TRAINING EXAM TRENDS: BACK TO THE FUTURE OR FORWARD TO THE PAST *Glassenberg, R.* Anesthesia, Northwestern, Chicago, IL Introduction: In acquiring basic knowledge: (1) How does OB anesthesia compare to other anesthesia subspecialties (2) Are the specific deficits in pathology, pharmacology, or physiology? Methods: The test scores of CA-3 residents taking the ABA/ASA In-Training exam were reviewed for the years 1996-2001. Key word phrases were divided into sections for OB, neuro, pediatric, and cardiac subspecialties. The percent of each item answered correctly was averaged for each of the four subdivisions. The questions that pertained to OB anesthesia were then regrouped into 12 categories ranked from lowest to the highest median score. Conclusion: Test results ranged from 60% to 90% correct for each subspecialty. In OB anesthesia, the lowest score was found in comprehension of factors affecting placental blood flow and oxygen transport, areas which may best be suited for teaching by computer simulation. These results were confirmed by a recent British survey of OB anesthetists. *References: Kinsella, Int J Obstet Anaes 2000; 9; 15-19*





P-6

COMBINED SPINAL-EPIDURAL WITH PATIENT-CONTROL EPIDURAL ANALGESIA FOR LABOR: QUALITY ASSURANCE SURVEY FROM A UNIVERSITY HOSPITAL IN SWITZERLAND *Landau, . Giraud, .; Kern, . Anesthesiology, Hôpitaux Universitaires de Genève (HUG), Geneva, Switzerland* Combined spinal-epidural (CSE) for labor analgesia is extremely popular, despite ongoing concern resulting from the relative paucity of randomized prospective studies regarding maternal and fetal safety with this technique (1). As part of a quality assurance (QA) program, we standardized our labor analgesic practice and initiated our team to CSE with patient-control epidural analgesia (PCEA). With Institutional approval, data was gathered from all parturients delivering with neuraxial analgesia in the Geneva University Hospital Maternity from 7.20.01 to 1.20.02. Choice of epidural or CSE was made by anesthesiologist. CSE (Tuohy 18G and Whitacre 27G) consisted of spinal 2.5mg bupivacaine + 25mcg fentanyl, followed immediately by PCEA bupivacaine 0.0625% + fentanyl 2mcg/cc (10cc continuous infusion, 5cc bolus, 15 min. lock-out). For epidurals, bupivacaine 0.125% 10cc + 50mcg fentanyl was given, followed by same PCEA settings. Demographics, anesthetic technique, obstetrical and neonatal outcomes were gathered on a QA sheet in the Labor Room, with a 24-48h post-partum follow-up. Complications and maternal satisfaction were recorded. Data were analyzed using chi squared and t-tests as appropriate ($p<0.05$ significant). This prospective observational study recorded 958 cases over 6 months. Results are presented in Table 1. We conclude that CSE with PCEA, introduced with standardized guidelines in a teaching hospital, can be safely performed with few maternal complications and good neonatal outcome, while providing excellent maternal satisfaction. *1. Norris M. Anesthesiology 2001;95:913-20.*

	Epidural (n=194)	CSE (n=764)	p value
Spontaneous vaginal delivery	57%	63%	NS
Instrumental delivery	16%	23%	NS
Urgent CS	26%	14%	<0.01
Nulliparity	59%	63%	NS
Cervical dilation (cm ± SD)	1.7±2.4	2.7±2.7	<0.01
Time to delivery (min ± SD)	410±333	345±224	=0.01
Paraesthesia	16%	12%	NS
IV catheter, immediately replaced	2.5%	2.7%	NS
No CSF during CSE	-	4.7%	-
Wet tap (cath. replaced)	n=1	n=0	NS
Spinal catheter	0.05%	0.07%	NS
Failed analgesia → cath. replaced	3.6%	3%	NS
Failed analgesia → GA for CS	2.0%	0.1%	<0.01
Uterine hypertonus -> fetal bradycardia	1.0%	3.1%	NS
Post-dural puncture headache	1.0%	0.9%	NS
Blood patch	n=2	n=3	NS
Neurological deficit	1.0%	0.6%	NS
Pruritis	10.3%	10.9%	NS
Insufficient 1st stage analgesia	8.2%	4.3%	<0.05
Insufficient 2nd stage analgesia	8.7%	10.6%	NS
Motor block	1.5%	2.2%	NS
Satisfaction score (VAS 0-10 cm,± SD)	9.0±1.8	9.2±1.6	NS

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