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Use of Labor-Delivery-Recovery Rooms

To the Editor:—A national survey supported by American Society of Anesthesiologists (ASA) and the American College of Obstetricians and Gynecologists (ACOG) questioned obstetricians and anesthesiologists about their practices on labor and delivery including use of labor-delivery-recovery (LDR) rooms.[1] Hospitals were grouped by the size of their delivery services: Stratum I = ≥ 1,500 deliveries per year, Stratum II = 500–1,499, and Stratum III = < 500. A stratified random sample of hospitals was drawn from the American Hospital Association registry, and 740 hospitals responded.

Overall, LDR rooms were used in 87% of the surveyed hospitals, with no differences between the smallest and largest delivery services. The types of procedures permitted are shown in table 1. Most hospitals allow spontaneous and forceps-assisted vaginal deliveries; roughly half allow complex vaginal deliveries (breech or twins), but a minority allow postpartum curettage or cesarean section. The smaller services are significantly more likely to allow forceps and breech deliveries to occur outside a traditional delivery or operating room. Although hospital policy may *allow* such procedures, the survey did not specifically ask how often LDR room were actually used for procedures such as cesarean section.

The anesthetics that are permitted in LDR rooms are shown in table 2. Essentially all services allow parenteral narcotics, and a majority allow regional techniques. However, spinal anesthesia with local anesthetics, inhalational analgesia, and general anesthesia are not permitted in most reporting services. Larger services are significantly more likely to allow epidural anesthetics, but significantly less likely to allow inhalational analgesia or general anesthesia to be performed. This may reflect the need for an anesthesia machine, which most units are unlikely to provide outside an operating room setting.

Labor-delivery-recovery rooms provide combined units with a more home-like setting, allowing freer interaction between the family and their newborn. ACOG and The American Academy of Pediatrics (AAP) have issued guidelines for equipping and staffing such facilities.[2] In contrast to traditional delivery rooms, there may not be an anesthesia machine or complete anesthesia cart immediately available, and the anesthetic techniques and delivery procedures permitted there vary depending on hospital policy. These data give an indication of clinical practices in LDR rooms in this country and may be helpful for services developing policies in this area.

Table 1. The Type of Procedures That May Be Done in LDR Rooms

	Stratum I (≥1,500)	Stratum II (500–1,499)	Stratum III (<500)	Average
SVD	100	100	100	100
Low forceps	88	98*	98*	95
Mid forceps	58	71*	71*	67
Vaginal breech	38	50	60*	51
Twins	37	48	45	45
Cesarean section	3	3	7	5
Postpartum curettage	29	27	23	26

Values are percent of responses; values in parentheses are deliveries per year. Percentages do not add to 100% because more than one response could be checked.

LDR = SVD = spontaneous vaginal delivery.

* Significantly different from Stratum I at $P < 0.05$ (chi-square).

Table 2. The Type of Analgesia/Anesthesia That May Be Provided in LDR Rooms

	Stratum I (≥1,500)	Stratum II (500–1,499)	Stratum III (<500)	Average
Parenteral medications	100	100	98	99
Paracervical block	79	85	87	83
Inhalational analgesia	9*	12	18	13
Epidural	98*	94*	81	91
Spinal (opioids)	62	57	53	57
Spinal (local anesthesia)	34	38	30	34
General anesthesia	7*	10	16	11
Other	2	6	0	3

Values are percent of responses; values in parentheses are deliveries per year. Percentages do not add to 100% because more than one response could be checked.

LDR =

* Significantly different from Stratum III at $P < 0.05$ (chi-square).

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