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THROMBOPROPHYLAXIS IN EMERGENCY LSCS: AN AUDIT CYCLE COMPLETED *Sashidharan, R. Leschinskiy, D. Anaesthesiology, The Royal London Hospital, London, United Kingdom* Thromboembolism remains the major direct cause of maternal deaths in the UK(1).The RCOG has issued reccommendations for thromboprophylaxis(2). Similar to a group in Oxford(3), an audit in our unit in 1999 showed that despite recognition of risk factors, thromboprophylaxis following emergency Caesarean was inadequate(4). A protocol was introduced following this audit. In 1999 and 2001, over a period of 4 months, the risk factors in all mothers having emergency LSCS and the method of prophylaxis were audited. The mothers were classified moderate or high risk as per RCOG profile(2). Staff caring for the mother was not aware of the audit. Following the introduction of protocols thromboprophylaxis dramatically improved. All moderate-risk women received adequate prophylaxis. All high-risk women received some form of prophylaxis although it was inadequate in 50%. This is currently being acted on. Our audit reflects the findings of the most recent CEMD Report, that thromboprophylaxis following emergency LSCS has improved greatly(1). We reiterate their reccommendations that each unit should develop its own guidelines which can be applied within the requirements of their own units. *1. CEMD 1997-1999; Dept of Health, UK* 2. RCOG Working Party on Prophylaxis against Thromboembolism 1995 *3. Rutter S etal. Abstract SOAP Meeting May 2000 4. Akinniranye O etal. Abstract ESOA Meeting June 1999*

	TEDS	Hep+/-TEDS	None
Primary audit			
Mod risk (n=118)	17(14.4%)	5(4.2%)	96(81.4%)
High risk(n=34)	6(17.6%)	5(14.7%)	23(67.7%)
Re-audit			
Mod risk(n=76)	51(67.3%)	25(32.9%)	0
High risk(n=28)	14(50%)	14(50%)	0

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SPINAL ANESTHESIA FOR CESAREAN SECTION FOLLOWING SUBOPTIMAL LABOR EPIDURAL ANALGESIA *Dadarkar, P. Philip, J.; Perez, B.; Makhdumi, A.; Slaymaker, E.; Weidner, C.; Tabaczewska, L.; Wiley, J.; Sharma, S. Anesthesiology and Pain Management, University of Texas Southwestern Medical School, Dallas, TX* Reports suggest a significant risk of high spinal block with spinal anesthesia following a poorly functioning epidural catheter. We present our experience of 106 parturients who received spinal anesthesia for Cesarean section(SC), following suboptimal labor epidural analgesia. Approximately 6000 labor epidurals were sited during the study period. Any dissatisfaction with pain relief at any point was promptly acted upon until analgesia was adequate. 106 cases (1.7%) required urgent CS with insufficient time to manipulate or resite the catheter. These parturients, in whom no prior epidural boluses were given, were offered spinal anesthesia. This was administered using a mean dose of 1.21ml (±0.19ml) of 0.75% hyperbaric bupivacaine with a mean dose of 16.4mcg (±4.2mcg) of fentanyl injected through a 25G Whitacre needle at the L3-L4/L4-L5 interspace in the sitting position. Specific dosing was left to the individual clinician's discretion. The patients were left sitting for 2 minutes and then laid supine with left tilt and uterine displacement. Patients were closely monitored for any symptoms or signs that would suggest a high block. 25% of parturients required ephedrine for hypotension following spinal anesthesia. No parturient developed a high spinal block necessitating intubation and ventilation, and there was no adverse neonatal outcome. Based on our experience with 106 patients we believe that spinal anesthesia can be safely administered for CS following suboptimal epidural labor analgesia. However, certain criteria should be adhered to in order to avoid a high spinal block: 1) boluses of epidural local anesthetic solution should be avoided prior to conducting the subarachnoid block; 2) the dose of spinal anesthetic should be lower than the standard spinal dose for Cesarean section; 3) Positioning should be meticulous. Moreover, vigilance should be maintained throughout the procedure and in recovery, in case the block height spreads rostrally. Data is mean±SD (range); *median (first quartile,third quartile) *IJOA 1994;3 Anesth Analg 1993;77*

Age(y)	24+/-6
Height(cm)	157+/-8 (129.5-175.2)
Weight(kg)	79+/-14 (51.2-127)
Infusion time(h)	10+/-6 (0-31.2)
Dose intrathecal bupivacaine(mg)	9.1+/-1.4mg
Dose intrathecal fentanyl(mcg)	16.4+/-4.2
Pre spinal level*	T8(T7,T10)
Post spinal level*	T3(T2,T4)