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DOES INCREASED INTRAVENOUS HYDRATION DECREASE THE INCIDENCE OF NAUSEA/VOMITING FOLLOWING CESAREAN SECTION? *Gaiser, R.R. Dong, Y.; Cheek, T.G.; Gutsche, B.B. Anesthesiology, University of Pennsylvania, Philadelphia, PA* Nausea and vomiting represent a common occurrence after cesarean section. Multiple factors account for this nausea including surgical factors and epidurally administered opioids. In the ambulatory anesthesia, increased intravenous hydration has been shown to decrease the incidence of nausea from 30% to 10%.(1) We studied whether intravenous hydration alters the incidence of nausea following cesarean section. This study received IRB approval. Written informed consent was obtained from each patient. Study candidates included patients presenting for the first elective cesarean section of the day. One hour prior to cesarean section, all patients received a fluid preload of 20 cc/kg normal saline. Epidural anesthesia consisted of 1.5% lidocaine with epinephrine and fentanyl. Following completion of the preload, patients were begun on a maintenance rate based upon weight. Normal saline was replaced for blood loss on a 3:1 ratio. At the conclusion of surgery, duramorph 4 mg was administered epidurally. Patients were randomized by sealed envelope to one of two groups. The control group received only maintenance fluid. The experimental group received a fluid bolus of 20 cc/kg normal saline over 30 minutes and then begun on a maintenance rate. The number of episodes of nausea and vomiting were recorded over a 24 hour period. The use of rescue emetics and supplemental opioids was recorded. Statistical analysis included chi-square and t-test. Values are presented as the mean (standard deviation). A total of 10 patients have been studied to date. There was no statistical difference in maternal demographics. The only difference was in total fluids. There was no difference in the incidence of nausea/vomiting or in the need for anti-emetics or supplemental opioids. There was no difference in the incidence of nausea or vomiting following cesarean section if the patient was vigorously hydrated. There was a trend toward a greater incidence of nausea in the hydration group, although there are too few patients. This ongoing study does not support the vigorous hydration of patients to prevent nausea or vomiting. *Yogendran S, Asokumar B, Cheng DCH, Chung F. A prospective randomized double-blinded study of the effect of intravenous fluid therapy on adverse outcomes on outpatient surgery. Anesth Analg 1995; 80: 682-6.*

	Age (yrs)	Height (cm)	Weight (kg)	EBL (cc)	Total Fluids (cc)	Nausea (0-12 hr)	Nausea (12-24 hr)	Vomiting (0-12 hr)	Vomiting(12-24hr)
Control (n=5)	25.6 (8.3)	160.5 (7.2)	87.6 (7.8)	760 (40)	2850 (670)	60%	0%	40%	0%
Hydration (n=5)	32.8 (2.5)	165.6 (6.6)	88.9 (22.1)	790 (20)	4420 (750)	100%	40%	80%	0%
					p<0.05				

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GENERAL ANESTHESIA FOR CESAREAN SECTION: CURRENT PRACTICE PATTERNS *Satya-Krishna, R.; Grange, C. Russell, R. John Radcliffe Hospital, Oxford, United Kingdom* (a) This study was aimed at investigating the incidence and factors contributing to use of general anesthesia (GA) for cesarean section (CS) in a busy university hospital in UK. (b) This retrospective study was performed to cover a period of eight months between January and August 2001. The Oxford Obstetric Anesthetic Database was used to generate a list of patients who underwent GA for CS. The following data was collected from these patients' records: grade of anesthesiologist and surgeon, degree of emergency, time of operation, decision to delivery time, conversion of regional anesthesia (RA) to GA, method of testing RA and view at laryngoscopy. (c) A total of 69 case records were analysed accounting for 86.2% of GA performed for CS during this period. This represents 2.8% of all elective and 12.3% of all emergency CS. 56.5% of cases were done out-of-hours, 31.9% after midnight. A senior anesthesiologist was present in 66.6% of in-hours and 10.3% of out-of-hours general anesthetics. Trainee anesthesiologists administered the remaining anesthetics. In 27 cases, the CS was classed a crash section, in 18 the indication was fetal distress. In 23.2% cases, GA was employed after failed RA. The failed techniques were: epidural for labour top-up in 8, combined spinal-epidural in 3, spinal in 2 and one case each of epidural block and damaged epidural catheter. In 4 cases, GA was induced after the incision was made. RA was tested most commonly with cold spray, but 56.3% of case records did not specify the mode of testing. Where a failed RA was encountered, the mean decision to delivery time was 53 minutes. Mean cord arterial pH was 7.220 when RA failed. Difficult airway was detected preoperatively in 2 patients who were managed with planned awake fibre optic intubation. In the remaining 67 patients, there was only one recorded use of a bougie to facilitate intubation for a grade II laryngoscopic view. Grade I laryngoscopic views were seen in 50 patients, grade II views in 4 patients and in the rest, there was no mention of any difficulty with the intubation process. (d) In conclusion, this study identifies the indications and factors affecting the choice of GA for CS. Although overall GA rate was well within published guidelines, failed RA made up a significant proportion. This is possibly due to the fact that junior anesthesiologists performed most blocks, working mainly out-of-hours. Failed RA prolonged delivery time but was not associated with significant fetal acidosis. The incidence of difficult airway was 4.3% with one unanticipated difficult intubation. *Russell IF. Technique of anesthesia for Cesarean section. In: Raising the standard. London: The Royal College of Anaesthetists, 2000.*