Practice Guidelines for Obstetric Anesthesia

An Updated Report by the American Society of Anesthesiologists Task Force on Obstetric Anesthesia and the Society for Obstetric Anesthesia and Perinatology*

PRACTICE guidelines are systematically developed recommendations that assist the practitioner and patient in making decisions about health care. These recommendations may be adopted, modified, or rejected according to the clinical needs and constraints and are not intended to replace local institutional policies. In addition, practice guidelines developed by the American Society of Anesthesiologists (ASA) are not intended as standards or absolute requirements, and their use cannot guarantee any specific outcome. Practice guidelines are subject to revision as warranted by the evolution of medical knowledge, technology, and practice. They provide basic recommendations that are supported by a synthesis and analysis of the current literature, expert and practitioner opinion, open-forum commentary, and clinical feasibility data.

This document updates the “Practice Guidelines for Obstetric Anesthesia: An Updated Report by the ASA Task Force on Obstetric Anesthesia,” adopted by ASA in 2006 and published in 2007.†

Methodology

Definition of Perioperative Obstetric Anesthesia

For the purposes of these updated guidelines, obstetric anesthesia refers to peripartum anesthetic and analgesic activities performed during labor and vaginal delivery, cesarean delivery, removal of retained placenta, and postpartum tubal ligation.

Purposes of the Guidelines

The purposes of these guidelines are to enhance the quality of obstetric care for obstetric patients, improve patient safety by reducing the incidence and severity of anesthesia-related complications, and increase patient satisfaction.

Focus

These guidelines focus on the anesthetic management of pregnant patients during labor, nonoperative delivery, and selected aspects of postpartum care and analgesia (i.e., neuraxial opioid for postpartum analgesia after neuraxial anesthesia for cesarean delivery). The intended patient population includes, but is not limited, to pregnant patients during labor, nonoperative delivery, and selected aspects of postpartum care and analgesia (i.e., neuraxial opioids for postpartum analgesia after neuraxial anesthesia for cesarean delivery).

What other guidelines are available on this topic?


• Other guidelines on the topic for the anesthetic management of the parturient have been published by the American College of Obstetricians and Gynecologists in 2002 and reaffirmed in 2010 and 2013.

• Why was this guideline developed?

• In October 2014, the ASA Committee on Standards and Practice Parameters, in collaboration with the Society for Obstetric Anesthesia and Perinatology, elected to collect new evidence to determine whether recommendations in the existing practice guidelines continue to be supported by current evidence. The resultant guidelines, presented in this issue, incorporate an analysis of current scientific literature and expert consultant survey results.

• How does this statement differ from existing guidelines?

• This statement presents new findings from the scientific literature since 2006 and surveys of both expert consultants and randomly selected ASA members.

• This document represents the first practice guideline to be developed as a collaborative effort between the ASA and a subspecialty society (Society for Obstetric Anesthesia and Perinatology) with content expertise relevant to the recommendations.

• Why does the statement differ from existing guidelines?

• The American College of Obstetricians and Gynecologists Practice Bulletin focuses on limited aspects of cesarean anesthesia (e.g., when an anesthesiology consult is appropriate) and labor analgesia (e.g., paracutaneous opioids) that an obstetrician would use to counsel their patients.

• These guidelines also include perianesthetic management of other obstetric procedures and emergencies.

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to intrapartum and postpartum patients with uncomplicated pregnancies or with common obstetric problems. The guidelines do not apply to patients undergoing surgery during pregnancy, gynecological patients, or parturients with chronic medical disease (e.g., severe cardiac, renal, or neurological disease). In addition, these guidelines do not address (1) postpartum analgesia for vaginal delivery, (2) analgesia after tubal ligation, or (3) postoperative analgesia after general anesthesia (GA) for cesarean delivery.

Application
These guidelines are intended for use by anesthesiologists. They also may serve as a resource for other anesthesia providers and healthcare professionals who advise or care for patients who will receive anesthetic care during labor, delivery, and the immediate postpartum period.

Task Force Members and Consultants
In 2014, the ASA Committee on Standards and Practice Parameters requested that the updated guidelines published in 2007 be reevaluated. This current update consists of a literature evaluation and the reporting of new survey findings of expert consultants and ASA members. A summary of recommendations is found in appendix 1.

This update was developed by an ASA-appointed Task Force of 11 members, consisting of anesthesiologists in both private and academic practices from various geographic areas of the United States, and consulting methodologists from the ASA Committee on Standards and Practice Parameters. The Task Force developed these updated guidelines by means of a multistep process. First, original published research studies from peer-reviewed journals published subsequent to the previous update were reviewed. Second, a panel of expert consultants was asked to (1) participate in opinion surveys on the effectiveness of various anesthetic management strategies and (2) review and comment on a draft of the update developed by the Task Force. Third, survey opinions about the guideline recommendations were solicited from a random sample of active members of the ASA. Finally, all available information was used to build consensus within the Task Force to finalize the update.

Availability and Strength of Evidence
Preparation of these guidelines followed a rigorous methodological process. Evidence was obtained from two principal sources: scientific evidence and opinion-based evidence.

Scientific Evidence. Scientific evidence used in the development of these updated guidelines is based on cumulative findings from literature published in peer-reviewed journals. Literature citations are obtained from PubMed and other healthcare databases, direct Internet searches, Task Force members, liaisons with other organizations, and manual searches of references located in reviewed articles.

Findings from the aggregated literature are reported in the text of the guidelines by evidence category, level, and direction. Evidence categories refer specifically to the strength and quality of the research design of the studies. Category A evidence represents results obtained from randomized controlled trials (RCTs), and Category B evidence represents observational results obtained from nonrandomized study designs or RCTs without pertinent comparison groups. When available, Category A evidence is given precedence over Category B evidence for any particular outcome. These evidence categories are further divided into evidence levels. Evidence levels refer specifically to the strength and quality of the summarized study findings (i.e., statistical findings, type of data, and the number of studies reporting/replicating the findings within the evidence categories). In this document, only the highest level of evidence is included in the summary report for each intervention–outcome pair, including a directional designation of benefit, harm, or equivocality for each outcome.

Category A. Randomized controlled trials report comparative findings between clinical interventions for specified outcomes. Statistically significant ($P < 0.01$) outcomes are designated as either beneficial (B) or harmful (H) for the patient; statistically nonsignificant findings are designated as equivocal (E).

Level 1: The literature contains a sufficient number of RCTs to conduct meta-analysis,‡ and meta-analytic findings from these aggregated studies are reported as evidence.

Level 2: The literature contains multiple RCTs, but the number of RCTs is insufficient to conduct a viable meta-analysis for the purpose of these updated guidelines. Findings from these RCTs are reported separately as evidence.

Level 3: The literature contains a single RCT, and findings are reported as evidence.

Category B. Observational studies or RCTs without pertinent comparison groups may permit inference of beneficial or harmful relations among clinical interventions and clinical outcomes. Infered findings are given a directional designation of beneficial (B), harmful (H), or equivocal (E). For studies that report statistical findings, the threshold for significance is a $P$ value of less than 0.01.

Level 1: The literature contains observational comparisons (e.g., cohort and case-control research designs) with comparative statistics between clinical interventions for a specified clinical outcome.

Level 2: The literature contains noncomparative observational studies with associative statistics (e.g., relative risk, correlation, or sensitivity/specificity).
Level 3: The literature contains noncomparative observational studies with descriptive statistics (e.g., frequencies and percentages).

Level 4: The literature contains case reports.

**Insufficient Literature.** The lack of sufficient scientific evidence in the literature may occur when the evidence is either unavailable (i.e., no pertinent studies found) or inadequate. Inadequate literature cannot be used to assess relations among clinical interventions and outcomes because a clear interpretation of findings is not obtained due to methodological concerns (e.g., confounding of study design or implementation), or the study does not meet the criteria for content as defined in the “Focus” of the guidelines.

**Opinion-based Evidence.** All opinion-based evidence (e.g., survey data, Internet-based comments, letters, and editorials) relevant to each topic was considered in the development of these updated guidelines. However, only the findings obtained from formal surveys are reported in the current update. Identical surveys were distributed to expert consultants and a random sample of ASA members who practice obstetric anesthesia.

**Category A: Expert Opinion.** Survey responses from Task Force–appointed expert consultants are reported in summary form in the text, with a complete listing of the consultant survey responses reported in appendix 2.

**Category B: Membership Opinion.** Survey responses from active ASA members are reported in summary form in the text, with a complete listing of ASA member survey responses reported in appendix 2.

Survey responses from expert and membership sources are recorded using a 5-point scale and summarized based on median values.§

- **Strongly Agree:** Median score of 5 (at least 50% of the responses are 5)
- **Agree:** Median score of 4 (at least 50% of the responses are 4 or 4 and 5)
- **Equivocal:** Median score of 3 (at least 50% of the responses are 3, or no other response category or combination of similar categories contain at least 50% of the responses)
- **Disagree:** Median score of 2 (at least 50% of responses are 2 or 1 and 2)
- **Strongly Disagree:** Median score of 1 (at least 50% of responses are 1)

**Category C: Informal Opinion.** Open-forum testimony obtained during the development of these guidelines, Internet-based comments, letters, and editorials are all informally evaluated and discussed during the formulation of guideline recommendations. When warranted, the Task Force may add educational information or cautionary notes based on this information.

**Guidelines**

**Perianesthetic Evaluation and Preparation**

Perianesthetic evaluation and preparation topics include (1) a focused history and a physical examination, (2) an intrapartum platelet count, (3) a blood type and screen, and (4) perianesthetic recording of fetal heart rate patterns.

**History and Physical Examination.**

**Literature Findings:** Although it is a well-accepted clinical practice to review medical records and conduct a physical examination, comparative studies are insufficient to directly evaluate the impact of these practices. Studies with observational findings suggest that certain patient or clinical characteristics (e.g., hypertensive disorders of pregnancy such as preeclampsia and hemolysis, elevated liver enzymes, and low platelet count syndrome, obesity, and diabetes mellitus) may be associated with obstetric complications (Category B2/B3-H evidence).§

**Survey Findings:** The consultants and ASA members both strongly agree (1) to conduct a focused history and physical examination before providing anesthesia care and (2) that a communication system should be in place to encourage early and ongoing contact between obstetric providers, anesthesiologists, and other members of the multidisciplinary team.

**Intrapartum Platelet Count.**

**Literature Findings:** The literature is insufficient to assess whether a routine platelet count can predict anesthesia-related complications in uncomplicated parturients. An observational study reported that platelet count and fibrinogen values are associated with the frequency of postpartum hemorrhage (Category B2 evidence). Other observational studies and case reports suggest that a platelet count may be useful for diagnosing hypertensive disorders of pregnancy, such as preeclampsia; hemolysis, elevated liver enzymes, and low platelet count syndrome; and other conditions associated with coagulopathy (Category B3/B4-B evidence).

**Survey Findings:** The consultants and ASA members strongly agree that the anesthesiologist’s decision to order or require a platelet count should be individualized and based on a patient’s history (e.g., preeclampsia with severe features), physical examination, and clinical signs.

**Blood Type and Screen.**

**Literature Findings:** The literature is insufficient to determine whether obtaining a blood type and screen is associated with fewer maternal anesthetic complications. In addition, the literature is insufficient to determine whether a blood cross-match is necessary for healthy and uncomplicated parturients.

**Survey Findings:** The ASA members agree and the consultants strongly agree that (1) a routine blood cross-match is not

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§ When an equal number of categorically distinct responses are obtained, the median value is determined by calculating the arithmetic mean of the two middle values. Ties are calculated by a predetermined formula.
necessary for healthy and uncomplicated parturients for vaginal or operative delivery and (2) the decision whether to order or require a blood type and screen or cross-match should be based on maternal history, anticipated hemorrhagic complications (e.g., placenta accreta in a patient with placenta previa and previous uterine surgery), and local institutional policies.

**Perianesthetic Recording of Fetal Heart Rate Patterns.**

**Literature findings:** Studies with observational findings and case reports indicate that fetal heart rate patterns may change after the administration of neuraxial anesthetics (*Category B3/B4 evidence*).24–31

**Survey Findings:** The consultants and ASA members strongly agree that fetal heart rate patterns should be monitored by a qualified individual before and after administration of neuraxial analgesia for labor.

**Blood Type and Screen.**

- A routine blood cross-match is not necessary for healthy and uncomplicated parturients for vaginal or operative delivery.
- The decision whether to order or require a blood type and screen or cross-match should be based on maternal history, anticipated hemorrhagic complications (e.g., placenta accreta in a patient with placenta previa and previous uterine surgery), and local institutional policies.

**Perianesthetic Recording of Fetal Heart Rate Patterns.**

- Fetal heart rate patterns should be monitored by a qualified individual before and after administration of neuraxial analgesia for labor.
  - *Continuous* electronic recording of fetal heart rate patterns may not be necessary in every clinical setting and may not be possible during placement of a neuraxial catheter.**

**Aspiration Prevention**

Aspiration prevention includes (1) clear liquids, (2) solids, and (3) antacids, H2-receptor antagonists, and metoclopramide.

**Clear Liquids.**

- *Literature Findings:* There is insufficient published literature to examine the relation between fasting times for clear liquids and the risk of emesis/reflux or pulmonary aspiration during labor.
- *Survey Findings:* The ASA members agree and the consultants strongly agree that (1) oral intake of moderate amounts of clear liquids may be allowed for uncomplicated laboring patients and (2) the uncomplicated patient undergoing elective surgery (e.g., scheduled cesarean delivery or postpartum tubal ligation) may have moderate amounts of clear liquids up to 2 h before induction of anesthesia.

**Solids.**

- *Literature Findings:* A specific fasting time for solids that is predictive of maternal anesthetic complications has not been determined. There is insufficient published literature to address the safety of any particular fasting period for solids in obstetric patients.
- *Survey Findings:* The consultants and ASA members strongly agree that (1) the patient undergoing elective surgery (e.g., scheduled cesarean delivery or postpartum tubal ligation) should undergo a fasting period for solids of 6 to 8 h depending on the type of food ingested (e.g., fat content); (2) laboring patients with additional risk factors for aspiration (e.g., morbid obesity, diabetes mellitus, and difficult airway) or patients at increased risk for operative delivery (e.g., nonreassuring fetal heart rate pattern) may have further restrictions of oral intake, determined on a case-by-case basis; and (3) solid foods should be avoided in laboring patients.

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[2] A specific platelet count predictive of neuraxial anesthetic complications has not been determined.

Antacids, H₂-receptor Antagonists, and Metoclopramide.

**Literature Findings:** Randomized controlled trials indicate that preoperative nonparticulate antacids (e.g., sodium citrate and sodium bicarbonate) are associated with higher gastric pH values during the peripartum period (Category A2-B evidence). And are equivocal regarding gastric volume (Category A2-E evidence). Randomized placebo-controlled trials indicate that H₂-receptor antagonists are associated with higher gastric pH values in obstetric patients (Category A2-B evidence) and are equivocal regarding gastric volume (Category A2-E evidence). Literature is not available that examines the relation between reduced gastric acidity and the frequency of pulmonary aspiration, emesis, morbidity, or mortality in obstetric patients who have aspirated gastric contents.

**Survey Findings:** The consultants and ASA members both agree that before surgical procedures (e.g., cesarean delivery or postpartum tubal ligation), consider the timely administration of nonparticulate antacids, H₂-receptor antagonists, and/or metoclopramide for aspiration prophylaxis.

**Recommendations for Aspiration Prevention††**

**Clear Liquids.**

- The oral intake of moderate amounts of clear liquids may be allowed for uncomplicated laboring patients.
- The uncomplicated patient undergoing elective surgery may have clear liquids up to 2 h before induction of anesthesia.
  - Examples of clear liquids include, but are not limited to, water, fruit juices without pulp, carbonated beverages, clear tea, black coffee, and sports drinks.
  - The volume of liquid ingested is less important than the presence of particulate matter in the liquid ingested.
- Laboring patients with additional risk factors for aspiration (e.g., morbid obesity, diabetes mellitus, and difficult airway) or patients at increased risk for operative delivery (e.g., non-reassuring fetal heart rate pattern) may have further restrictions of oral intake, determined on a case-by-case basis.

**Solids.**

- Solid foods should be avoided in laboring patients.

†† The Task Force recognizes that in laboring patients the timing of delivery is uncertain; therefore, adherence to a predetermined fasting period before nonselective surgical procedures is not always possible.


§§ Note that statements in appendix 3 are intended to provide an overview and are not recommendations.

**Anesthetic Care for Labor and Vaginal Delivery**

Anesthetic care for labor and vaginal delivery includes (1) timing of neuraxial analgesia and outcome of labor, (2) neuraxial analgesia and trial of labor after prior cesarean delivery, and (3) anesthetic/analgesic techniques. Appendix 3 contains an overview of anesthetic care for labor and vaginal delivery.

**Timing of Neuraxial Analgesia and Outcome of Labor.**

**Literature Findings:** Meta-analyses of RCTs report equivocal findings for spontaneous, instrumented, and cesarean delivery when comparing early administration (i.e., cervical dilations of less than 4 or 5 cm) with late administration (i.e., cervical dilations of greater than 4 or 5 cm) of epidural analgesia (Category A1-E evidence). An RCT comparing cervical dilations of less than 2 cm with greater than or equal to 2 cm also reports equivocal findings (Category A3-E evidence). Finally, RCTs comparing early versus late combined spinal–epidural (CSE) analgesia administration report equivocal findings for cesarean, instrumented, and spontaneous delivery (Category A2-E evidence).

**Survey Findings:** The consultants and ASA members strongly agree to (1) provide patients in early labor (i.e., less than 5 cm dilation) the option of neuraxial analgesia when this service is available; (2) offer neuraxial analgesia on an individualized basis; and (3) not withhold neuraxial analgesia on the basis of achieving an arbitrary cervical dilation.

**Neuraxial Analgesia and Trial of Labor after Prior Cesarean Delivery.**

**Literature Findings:** Nonrandomized comparative studies are equivocal regarding mode of delivery, duration of labor, and adverse outcomes when epidural analgesia is used in a trial of labor for previous cesarean delivery patients (Category B1-E evidence).

**Survey Findings:** The consultants and ASA members strongly agree (1) to offer neuraxial techniques to patients attempting vaginal birth after previous cesarean delivery and (2) that for these patients, it is appropriate to consider early placement of a neuraxial catheter that can be used later for labor analgesia or for anesthesia in the event of operative delivery.

**Analgesia/Anesthetic Techniques:** Considerations for neuraxial techniques include (1) early insertion of a neuraxial (i.e., spinal or epidural) catheter for complicated...
parturients, (2) continuous infusion epidural (CIE) analgesia, (3) epidural local anesthetics combined with opioids, (4) higher versus lower concentrations of local anesthetics, (5) single-injection spinal opioids with or without local anesthetics, (6) pencil-point spinal needles, (7) CSE analgesia, and (8) patient-controlled epidural analgesia (PCEA).

Early Insertion of a Neuraxial Catheter for Complicated Parturients.

Literature Findings: The literature is insufficient to assess whether, when caring for the complicated parturient, the early insertion of a neuraxial catheter, with immediate or later administration of analgesia, improves maternal or neonatal outcomes.

Survey Findings: The consultants and ASA members strongly agree to consider early insertion of a neuraxial catheter for obstetric (e.g., twin gestation or preeclampsia) or anesthetic indications (e.g., anticipated difficult airway or obesity) to reduce the need for GA if an emergent procedure becomes necessary.

CIE Analgesia.

Literature Findings: Randomized controlled trials indicate that CIE local anesthetics are associated with reduced maternal pain and discomfort compared with single-shot IV opioids during labor (Category A2-B evidence). The literature is insufficient to evaluate CIE compared with continuous infusion of IV opioids. An RCT reports greater pain relief during labor for CIE when compared with intramuscular opioids (Category A3-B evidence), with equivocal findings for duration of labor and mode of delivery (Category A3-E evidence). A nonrandomized comparative study reports equivocal findings for duration of labor and mode of delivery when CIE local anesthetics are compared with single-injection spinal opioids (Category B1-E evidence).

Survey Findings: The consultants and ASA members strongly agree that (1) continuous epidural infusion may be used for effective analgesia for labor and delivery and (2) when a continuous epidural infusion of local anesthetic is selected, an opioid may be added.

Analgesic Concentrations.

Literature Findings: Meta-analyses of RCTs report improved analgesic quality when comparing epidural local anesthetics combined with opioids versus equal concentrations of epidural local anesthetics without opioids (Category A1-B evidence). Findings were equivocal for frequency of spontaneous delivery, hypotension, pruritus, and 1-min Apgar scores (Category A1-E evidence).

Randomized controlled trials are equivocal for analgesic efficacy and duration of labor when continuous epidural infusion of low concentrations of local anesthetics with opioids are compared with higher concentrations of local anesthetics without opioids for maintenance of analgesia (Category A2-E evidence). Meta-analyses of RCTs are also equivocal regarding spontaneous delivery and neonatal Apgar scores when continuous epidural infusion of low concentrations of local anesthetics with opioids are compared with higher concentrations of local anesthetics without opioids (Category A1-E evidence). A lower frequency of motor block was found for lower concentrations of local anesthetics (Category A1-B evidence).

The literature is insufficient to determine the effects of epidural local anesthetics with opioids on other maternal outcomes (e.g., hypotension, nausea, pruritus, respiratory depression, and urinary retention).

Survey Findings: The consultants and ASA members strongly agree to use dilute concentrations of local anesthetics with opioids to produce as little motor block as possible.

Single-injection Spinal Opioids with or without Local Anesthetics.

Literature Findings: An RCT reports a longer duration of analgesia when a spinal opioid is compared with an IV opioid (Category A1-B evidence). Nonrandomized comparisons are equivocal for duration of labor, mode of delivery, and other adverse outcomes such as nausea, vomiting, headache, and pruritus (Category B1-E evidence). The literature is not sufficient to compare single-injection spinal opioids with local anesthetics versus single-injection spinal opioids without local anesthetics.

Survey Findings: The consultants and ASA members agree that single-injection spinal opioids with or without local anesthetics may be used to provide effective, although time-limited, analgesia for labor when spontaneous vaginal delivery is anticipated. The ASA members agree and the consultants strongly agree that a local anesthetic may be added to a spinal opioid to increase duration and improve quality of analgesia.

Pencil-point Spinal Needles.

Literature Findings: Meta-analysis of RCTs indicate that the use of pencil-point spinal needles reduces the frequency of postdural puncture headache when compared with cutting-bevel spinal needles (Category A1-B evidence).

Survey Findings: The consultants and ASA members strongly agree to use pencil-point spinal needles instead of cutting-bevel spinal needles to minimize the risk of postdural puncture headache.

CSE Analgesia.

Literature Findings: Meta-analyses of RCTs report improved analgesia and a faster onset time when CSE local anesthetics with opioids are compared with epidural local anesthetics with opioids, with equivocal findings for maternal satisfaction with analgesia, mode of delivery, hypotension, pruritus, and 1-min Apgar scores (Category A1-E evidence). Meta-analysis of RCTs report an increased frequency of motor block with CSE (Category A1-H evidence).
Survey Findings: The consultants and ASA members strongly agree that (1) if labor is expected to last longer than the analgesic effects of the spinal drugs chosen, or if there is a good possibility of operative delivery, then consider a catheter technique instead of a single-injection technique and (2) CSE techniques may be used to provide effective and rapid onset of analgesia for labor.

Patient-controlled Epidural Analgesia.

Literature Findings: Meta-analysis of RCTs report reduced analgesic consumption (Category A1-B evidence) when PCEA is compared with CIE. 102–107 Meta-analysis of RCTs report equivocal findings for duration of labor, mode of delivery, motor block, and 1- and 5-min Apgar scores when PCEA is compared with CIE (Category A1-E evidence). 103–116 Meta-analysis of RCTs indicate greater analgesic efficacy for PCEA with a background infusion compared with PCEA without a background infusion (Category A1-B evidence). 117–121 and is equivocal regarding mode of delivery and frequency of motor block (Category A1-E evidence). 117–122

Survey Findings: The consultants and ASA members strongly agree that (1) PCEA may be used to provide an effective and flexible approach for the maintenance of labor analgesia and (2) the use of PCEA may be preferable to fixed-rate CIE for providing fewer anesthetic interventions and reducing dosages of local anesthetics. The consultants and ASA members agree that PCEA may be used with or without a background infusion.

Recommendations for Anesthetic Care for Labor and Vaginal Delivery

Timing of Neuraxial Analgesia and Outcome of Labor.

• Provide patients in early labor (i.e., less than 5 cm dilation) the option of neuraxial analgesia when this service is available.
• Offer neuraxial analgesia on an individualized basis regardless of cervical dilation.

• Reassure patients that the use of neuraxial analgesia does not increase the incidence of cesarean delivery.

Neuraxial Analgesia and Trial of Labor after Prior Cesarean Delivery.

• Offer neuraxial techniques to patients attempting vaginal birth after previous cesarean delivery.
• For these patients, consider early placement of a neuraxial catheter that can be used later for labor analgesia or for anesthesia in the event of operative delivery.

Analgesia/Anesthetic Techniques.

Early Insertion of a Neuraxial Catheter for Complicated Parturients:

• Consider early insertion of a neuraxial catheter for obstetric (e.g., twin gestation or preeclampsia) or anesthetic indications (e.g., anticipated difficult airway or obesity) to reduce the need for GA if an emergent procedure becomes necessary.

• In these cases, the insertion of a neuraxial catheter may precede the onset of labor or a patient’s request for labor analgesia.

CIE Analgesia:

• Continuous epidural infusion may be used for effective analgesia for labor and delivery.
• When a continuous epidural infusion of local anesthetic is selected, an opioid may be added to reduce the concentration of local anesthetic, improve the quality of analgesia, and minimize the motor block.

Analgesic Concentrations:

• Use dilute concentrations of local anesthetics with opioids to produce as little motor block as possible.

Single-injection Spinal Opioids with or without Local Anesthetics:

• Single-injection spinal opioids with or without local anesthetics may be used to provide effective, although time-limited, analgesia for labor when spontaneous vaginal delivery is anticipated.
• If labor duration is anticipated to be longer than the analgesic effects of the spinal drugs chosen, or if there is a reasonable possibility of operative delivery, then consider a catheter technique instead of a single-injection technique.
• A local anesthetic may be added to a spinal opioid to increase duration and improve quality of analgesia.

Pencil-point Spinal Needles:

• Use pencil-point spinal needles instead of cutting-bevel spinal needles to minimize the risk of postdural puncture headache.

CSE Analgesia:

• If labor duration is anticipated to be longer than the analgesic effects of the spinal drugs chosen, or if there is a reasonable possibility of operative delivery, then consider a catheter technique instead of a single-injection technique.
• CSE techniques may be used to provide effective and rapid onset of analgesia for labor.

Patient-controlled Epidural Analgesia:

• Patient-controlled epidural analgesia may be used to provide an effective and flexible approach for the maintenance of labor analgesia.
• The use of PCEA may be preferable to fixed-rate CIE for administering reduced dosages of local anesthetics.
• PCEA may be used with or without a background infusion.

Removal of Retained Placenta

Techniques for removal of retained placenta include (1) anesthetic techniques for removal of retained placenta and (2) nitroglycerin for uterine relaxation.
Anesthetic Techniques.

Literature Findings: The literature is insufficient to assess whether a particular anesthetic technique is more effective than another for removal of retained placenta.

Survey Findings: The consultants and ASA members strongly agree (1) that the hemodynamic status should be assessed before administering neuraxial anesthesia and (2) if an epidural catheter is in place and the patient is hemodynamically stable, consider providing epidural anesthesia. The consultants and ASA members agree to consider aspiration prophylaxis. The consultants and ASA members strongly agree that (1) titration of sedation/analgesia should be performed carefully due to the potential risks of respiratory depression and pulmonary aspiration during the immediate postpartum period and (2) in cases involving major maternal hemorrhage and hemodynamic instability, GA with an endotracheal tube may be considered in preference to neuraxial anesthesia.

Nitroglycerin for Uterine Relaxation.

Literature Findings: Randomized controlled trials comparing IV or sublingual nitroglycerin with placebo for the purpose of uterine relaxation report inconsistent findings for the successful removal of retained placenta (Category A2-E evidence). Observational studies and case reports indicate successful uterine relaxation and successful placental removal after IV or sublingual nitroglycerin administration (Category B3/B4 evidence).

Survey Findings: The ASA members agree and the consultants strongly agree that nitroglycerin may be used as an alternative to terbutaline sulfate or general endotracheal anesthesia with halogenated agents for uterine relaxation during removal of retained placental tissue.

○ Initiating treatment with incremental doses of IV or sublingual (i.e., tablet or metered dose spray) nitroglycerin may be done to sufficiently relax the uterus.

Anesthetic Care for Cesarean Delivery

Anesthetic care for cesarean delivery consists of (1) equipment, facilities, and support personnel; (2) general, epidural, spinal, or CSE anesthesia; (3) IV fluid preloading or colo- loading; (4) ephedrine or phenylephrine; and (5) neuraxial opioids for postoperative analgesia after neuraxial anesthesia.


Literature Findings: The literature is insufficient to evaluate the benefit of providing equipment, facilities, and support personnel in the labor and delivery operating suite comparable to that available in the main operating suite.

Survey Findings: The consultants and ASA members strongly agree that (1) equipment, facilities, and support personnel available in the labor and delivery operating suite should be comparable to those available in the main operating suite; (2) resources for the treatment of potential complications (e.g., failed intubation, inadequate anesthesia, hypotension, respiratory depression, local anesthetic systemic toxicity, pruritus, and vomiting) should also be available in the labor and delivery operating suite; and (3) appropriate equipment and personnel should be available to care for obstetric patients recovering from major neuraxial or GA.

General, Epidural, Spinal, or CSE Anesthesia.

Literature Findings: Randomized controlled trials report higher Apgar scores at 1 and 5 min for epidural anesthesia when compared with GA (Category A2-B evidence) and equivocal findings for umbilical artery pH values (Category A2-E evidence). When spinal anesthesia is compared with GA, RCTs report equivocal findings for 1- and 5-min Apgar scores and umbilical artery pH values (Category A1-E evidence). RCTs also are equivocal regarding total time in the operating room when epidural anesthesia is compared with GA (Category A2-E evidence).

When spinal anesthesia is compared with epidural anesthesia, RCTs are equivocal regarding induction-to-delivery times, hypotension, umbilical pH values, and Apgar scores (Category A2-E evidence). When CSE is compared with epidural anesthesia, RCTs report equivocal findings for the frequency of hypotension and for 1-min Apgar scores (Category A2-E evidence). RCTs report equivocal findings for delivery times, time in the operating room, hypotension, and 1- and 5-min Apgar scores when CSE is compared with spinal anesthesia (Category A2-E evidence).

Survey Findings: The consultants and ASA members strongly agree that (1) the decision to use a particular
anesthetic technique for cesarean delivery should be individualized, based on anesthetic, obstetric, or fetal risk factors (e.g., elective vs. emergency), the preferences of the patient, and the judgment of the anesthesiologist; (2) uterine displacement (usually left displacement) should be maintained until delivery regardless of the anesthetic technique used; (3) consider selecting neuraxial techniques in preference to GA for most cesarean deliveries; (4) if spinal anesthesia is chosen, use pencil-point spinal needles instead of cutting-bevel spinal needles; (5) for urgent cesarean delivery, an indwelling epidural catheter may be used as an alternative to initiation of spinal anesthesia; and (6) GA may be the most appropriate choice in some circumstances (e.g., profound fetal bradycardia, ruptured uterus, severe hemorrhage, severe placental abruption, umbilical cord prolapse, and preterm footling breech).

IV Fluid Preloading or Coloading.

**Literature Findings:** Randomized controlled trial findings are inconsistent regarding the frequency of maternal hypotension when IV fluid preloading or coloading for spinal anesthesia is compared with no fluids (Category A2-E evidence). Meta-analyses of RCTs are equivocal for maternal hypotension when IV fluid preloading is compared with coloading (Category A2-E evidence).

**Survey Findings:** The consultants and ASA members agree that IV fluid preloading may be used to reduce the frequency of maternal hypotension after spinal anesthesia for cesarean delivery. The ASA members agree and the consultants strongly agree that, although fluid preloading reduces the frequency of maternal hypotension, it does not delay the initiation of spinal anesthesia in order to administer a fixed volume of IV fluid.

**Ephedrine or Phenylephrine.**

**Literature Findings:** Meta-analysis of double-blind placebo-controlled RCTs report reduced maternal hypotension during anesthesia for cesarean delivery when IV ephedrine is administered compared with placebo (Category A1-B evidence). RCTs are equivocal for hypotension when intramuscular ephedrine is compared with placebo (Category A2-E evidence). RCTs comparing phenylephrine with placebo report a lower frequency of hypotension when higher dosages of phenylephrine are administered (Category A2-B evidence) and equivocal findings when lower dosages are administered (Category A2-E evidence). Meta-analysis of double-blind RCTs report lower frequencies of patients with hypotension when infusions of phenylephrine are compared with ephedrine (Category A1-B evidence); higher umbilical artery pH values are reported for phenylephrine when compared with ephedrine (Category A1-H evidence).

**Survey Findings:** The consultants and ASA members strongly agree that IV ephedrine and phenylephrine both may be used for treating hypotension during neuraxial anesthesia.

**Neuraxial Opioids for Postoperative Analgesia.**

**Literature Findings:** Randomized controlled trials comparing epidural opioids with intermittent injections of IV or intramuscular opioids report improved postoperative analgesia for epidural opioids after cesarean delivery (Category A2-B evidence); meta-analysis of RCTs report equivocal findings for nausea, vomiting, and pruritus (Category A1-E evidence). RCTs report improved postoperative analgesia when PCEA is compared with IV patient-controlled analgesia (Category A2-B evidence) with equivocal findings for nausea, vomiting, pruritus, and sedation (Category A2-E evidence).

**Survey Findings:** The consultants and ASA members strongly agree that for postoperative analgesia after neuraxial anesthesia for cesarean delivery, selecting neuraxial opioids rather than intermittent injections of parenteral opioids should be considered.

**Recommendations for Anesthetic Care for Cesarean Delivery**

**Equipment, Facilities, and Support Personnel.**

- Equipment, facilities, and support personnel available in the labor and delivery operating suite should be comparable to those available in the main operating suite.
- Resources for the treatment of potential complications (e.g., failed intubation, inadequate analgesia/anesthesia, hypotension, respiratory depression, local anesthetic systemic toxicity, pruritus, and vomiting) should also be available in the labor and delivery operating suite.
- Appropriate equipment and personnel should be available to care for obstetric patients recovering from neuraxial or GA.

**General, Epidural, Spinal, or CSE Anesthesia.**

- The decision to use a particular anesthetic technique for cesarean delivery should be individualized, based on anesthetic, obstetric, or fetal risk factors (e.g., elective vs. emergency), the preferences of the patient, and the judgment of the anesthesiologist.
  - Uterine displacement (usually left displacement) should be maintained until delivery regardless of the anesthetic technique used.
  - Consider selecting neuraxial techniques in preference to GA for most cesarean deliveries.
  - If spinal anesthesia is chosen, use pencil-point spinal needles instead of cutting-bevel spinal needles.
  - For urgent cesarean delivery, an indwelling epidural catheter may be used as an alternative to initiation of spinal or GA.
  - GA may be the most appropriate choice in some circumstances (e.g., profound fetal bradycardia, ruptured uterus, severe hemorrhage, and severe placental abruption).
IV Fluid Preloading or Colloading.
• IV fluid preloading or colloading may be used to reduce the frequency of maternal hypotension after spinal anesthesia for cesarean delivery.
• Do not delay the initiation of spinal anesthesia in order to administer a fixed volume of IV fluid.

Ephedrine or Phenylephrine.
• Either IV ephedrine or phenylephrine may be used for treating hypotension during neuraxial anesthesia.
• In the absence of maternal bradycardia, consider selecting phenylephrine because of improved fetal acid–base status in uncomplicated pregnancies.

Neuraxial Opioids for Postoperative Analgesia.
• For postoperative analgesia after neuraxial anesthesia for cesarean delivery, consider selecting neuraxial opioids rather than intermittent injections of parenteral opioids.

Postpartum Tubal Ligation

Literature Findings: The literature is insufficient to evaluate the benefits of neuraxial anesthesia compared with GA for postpartum tubal ligation. In addition, the literature is insufficient to evaluate the impact of the timing of a postpartum tubal ligation on maternal outcome.

Survey Findings: The consultants and ASA members strongly agree (1) that before postpartum tubal ligation, the patient should have no oral intake of solid foods within 6 to 8 h of the surgery, depending on the type of food ingested (e.g., fat content), and (2) that both the timing of the procedure and the decision to use a particular anesthetic technique (i.e., neuraxial vs. general) should be individualized based on anesthetic risk factors, obstetric risk factors (e.g., blood loss), and patient preferences. The ASA members agree and the consultants strongly agree to consider selecting neuraxial techniques in preference to GA for most postpartum tubal ligations.

Recommendations for Postpartum Tubal Ligation
• Before a postpartum tubal ligation, the patient should have no oral intake of solid foods within 6 to 8 h of the surgery, depending on the type of food ingested (e.g., fat content).††
• Consider aspiration prophylaxis.
• Both the timing of the procedure and the decision to use a particular anesthetic technique (i.e., neuraxial vs. general) should be individualized, based on anesthetic and obstetric risk factors (e.g., blood loss), and patient preferences.
• Consider selecting neuraxial techniques in preference to GA for most postpartum tubal ligations.
  ◦ Be aware that gastric emptying will be delayed in patients who have received opioids during labor.
  ◦ Be aware that an epidural catheter placed for labor may be more likely to fail with longer postdelivery time intervals.
  ◦ If a postpartum tubal ligation is to be performed before the patient is discharged from the hospital, do not attempt the procedure at a time when it might compromise other aspects of patient care on the labor and delivery unit.##

Management of Obstetric and Anesthetic Emergencies
Management of obstetric and anesthetic emergencies consists of (1) resources for management of hemorrhagic emergencies, (2) equipment for management of airway emergencies, and (3) cardiopulmonary resuscitation.

Resources for Management of Hemorrhagic Emergencies.
Case reports suggest that the availability of resources for hemorrhagic emergencies may be associated with reduced maternal complications (Category B3/B4-B evidence).212–219

Survey Findings: The consultants and ASA members strongly agree that institutions providing obstetric care should have resources available to manage hemorrhagic emergencies.

Equipment for Management of Airway Emergencies.
Case reports suggest that the availability of equipment for the management of airway emergencies may be associated with reduced maternal, fetal, and neonatal complications (Category B4-B evidence).220–228

Survey Findings: The consultants and ASA members strongly agree that labor and delivery units should have personnel and equipment readily available to manage airway emergencies consistent with the ASA Practice Guidelines for Management of the Difficult Airway, to include a pulse oximeter and carbon dioxide detector.

Cardiopulmonary Resuscitation.

Literature Findings: The literature is insufficient to evaluate the efficacy of cardiopulmonary resuscitation in the obstetric patient during labor and delivery. In cases of cardiac arrest, the American Heart Association has stated that 4 to 5 min is the maximum time rescuers will have to determine whether the arrest can be reversed by Basic Life Support and Advanced Cardiac Life Support interventions.*** Delivery of the fetus may improve cardiopulmonary resuscitation of the mother by relieving aortocaval compression. The American Heart Association further notes that “the best survival rate for infants more than 24 to 25 weeks in gestation occurs when the delivery of the infant occurs no more than 5 min after the mother’s heart stops beating.

** The American College of Obstetricians and Gynecologists (ACOG) has indicated that postpartum tubal ligation “should be considered an urgent surgical procedure given the consequences of a missed procedure and the limited time frame in which it may be performed.” ACOG Committee Opinion No. 559: Access to postpartum sterilization. Obstet Gynecol 2012; 120:212–5.
Table 1. Suggested Resources for Obstetric Hemorrhagic Emergencies

- Large-bore IV catheters
- Fluid warmer
- Forced-air body warmer
- Availability of blood bank resources
- Massive transfusion protocol
- Equipment for infusing IV fluids and blood products rapidly. Examples include, but are not limited to, hand-squeezed fluid chambers, hand-inflated pressure bags, and automatic infusion devices.

The items listed represent suggestions. The items should be customized to meet the specific needs, preferences, and skills of the practitioner and healthcare facility.

Table 2. Suggested Resources for Airway Management during Initial Provision of Neuraxial Analgesia in a Labor Delivery Room Setting

- Laryngoscope and assorted blades
- Endotracheal tubes, with styles
- Oxygen source
- Suction source with tubing and tonsil suction tip
- Self-inflating bag and mask for positive-pressure ventilation
- Medications for blood pressure support, muscle relaxation, and hypnosis

The items listed represent suggestions. The items should be customized to meet the specific needs, preferences, and skills of the practitioner and healthcare facility.

**Survey Findings:** The consultants and ASA members strongly agree that (1) basic and advanced life-support equipment should be immediately available in the operative area of labor and delivery units and (2) if cardiac arrest occurs during labor and delivery, initiate standard resuscitative measures with accommodations for pregnancy such as left uterine displacement and preparing for delivery of the fetus.

**Recommendations for Management of Obstetric and Anesthetic Emergencies**

**Resources for Management of Hemorrhagic Emergencies.**

- Institutions providing obstetric care should have resources available to manage hemorrhagic emergencies (table 1).
  - In an emergency, type-specific or O-negative blood is acceptable.
  - In cases of intractable hemorrhage, when banked blood is not available or the patient refuses banked blood, consider intraoperative cell salvage if available.† † †


† † † Practice guidelines for management of the difficult airway. Anesthesiology 2013; 118:251–70.


Table 3. Suggested Contents of a Portable Storage Unit for Difficult Airway Management for Cesarean Section Rooms

- Rigid laryngoscope blades of alternate design and size
- Videolaryngoscopic devices
- Endotracheal tubes of assorted size
- Endotracheal tube guides. Examples include (but are not limited to) semirigid styles, light wands, and forceps designed to manipulate the distal portion of the endotracheal tube.
- At least one device suitable for emergency nonsurgical airway ventilation consisting of a face mask or supraglottic airway device (e.g., laryngeal mask airway, intubating laryngeal mask airway, and laryngeal tube).
- Equipment suitable for emergency surgical airway access (e.g., cricothyotomy)

The items listed represent suggestions. The items should be customized to meet the specific needs, preferences, and skills of the practitioner and healthcare facility.

Adapted from the Practice guidelines for the management of the difficult airway: An updated report by the American Society of Anesthesiologists. Anesthesiology 2013; 118:251–70.

**Equipment for Management of Airway Emergencies.**

- Labor and delivery units should have personnel and equipment readily available to manage airway emergencies consistent with the ASA Practice Guidelines for Management of the Difficult Airway.† † † to include a pulse oximeter and carbon dioxide detector.
  - Basic airway management equipment should be immediately available during the provision of neuraxial analgesia (table 2).
  - Portable equipment for difficult airway management should be readily available in the operative area of labor and delivery units (table 3).
  - A preformulated strategy for intubation of the difficult airway should be in place.
  - When tracheal intubation has failed, consider ventilation with mask and cricoid pressure or with a supraglottic airway device (e.g., laryngeal mask airway, intubating laryngeal mask airway, or laryngeal tube) for maintaining an airway and ventilating the lungs.
  - If it is not possible to ventilate or awaken the patient, a surgical airway should be performed.

**Cardiopulmonary Resuscitation.**

- Basic and advanced life-support equipment should be immediately available in the operative area of labor and delivery units.
  - If cardiac arrest occurs, initiate standard resuscitative measures.
  - If maternal circulation is not restored within 4 min, cesarean delivery should be performed by the obstetrics team. §§§


Appendix 1. Summary of Recommendations

Peri-anesthetic Evaluation and Preparation

History and Physical Examination

- Conduct a focused history and physical examination before providing anesthesia care.
  - This should include, but is not limited to, a maternal health and anesthetic history, a relevant obstetric history, a baseline blood pressure measurement, and an airway, heart, and lung examination, consistent with the American Society of Anesthesiologists (ASA) “Practice Advisory for Preanesthesia Evaluation.”
  - When a neuraxial anesthetic is planned or placed, examine the patient’s back.
  - Recognition of significant anesthetic or obstetric risk factors should encourage consultation between the obstetrician and the anesthesiologist.
  - A communication system should be in place to encourage the early and ongoing contact between obstetric providers, anesthesiologists, and other members of the multidisciplinary team.

Intrapartum Platelet Count

- The anesthesiologist’s decision to order or require a platelet count should be individualized and based on a patient’s history (e.g., preeclampsia with severe features), physical examination, and clinical signs.
  - A routine platelet count is not necessary in the healthy parturient.

Blood Type and Screen

- A routine blood cross-match is not necessary for healthy and uncomplicated parturients for vaginal or operative delivery.
  - The decision whether to order or require a blood type and screen or cross-match should be based on maternal history, anticipated hemorrhagic complications (e.g., placenta accreta in a patient with placenta previa and previous uterine surgery), and local institutional policies.

Peri-anesthetic Recording of Fetal Heart Rate Patterns

- Fetal heart rate patterns should be monitored by a qualified individual before and after administration of neuraxial analgesia for labor.


Aspiration Prevention

Clear Liquids

- The oral intake of moderate amounts of clear liquids may be allowed for uncomplicated laboring patients.
  - The uncomplicated patient undergoing elective surgery may have clear liquids up to 2 h before induction of anesthesia.
  - Examples of clear liquids include, but are not limited to, water, fruit juices without pulp, carbonated beverages, clear tea, black coffee, and sports drinks.
  - The volume of liquid ingested is less important than the presence of particulate matter in the liquid ingested.

Solids

- Solid foods should be avoided in laboring patients.
  - The patient undergoing elective surgery (e.g., scheduled cesarean delivery or postpartum tubal ligation) should undergo a fasting period for solids of 6 to 8 h depending on the type of food ingested (e.g., fat content).

Antacids, H2-receptor Antagonists, and Metoclopramide

- Before surgical procedures (e.g., cesarean delivery and postpartum tubal ligation), consider the timely administration of nonparticulate antacids, H2-receptor antagonists, and/or metoclopramide for aspiration prophylaxis.

Anesthetic Care for Labor and Delivery

Timing of Neuraxial Analgesia and Outcome of Labor

- Provide patients in early labor (i.e., less than 5 cm dilation) the option of neuraxial analgesia when this service is available.
- Offer neuraxial analgesia on an individualized basis regardless of cervical dilation.
- Reassure patients that the use of neuraxial analgesia does not increase the incidence of cesarean delivery.

Neuraxial Analgesia and Trial of Labor after Prior Cesarean Delivery

- Offer neuraxial techniques to patients attempting vaginal birth after previous cesarean delivery.
Combined spinal–epidural techniques may be used to

- If labor duration is anticipated to be longer than the analgesic effects of the spinal drugs chosen, or if there is a reasonable possibility of operative delivery, then consider a catheter technique instead of a single-injection technique.
- A local anesthetic may be added to a spinal opioid to increase duration and improve quality of analgesia.

**Pencil-point Spinal Needles.**

- Use pencil-point spinal needles instead of cutting-bevel spinal needles to minimize the risk of postdural puncture headache.

**Combined Spinal–Epidural Analgesia.**

- If labor duration is anticipated to be longer than the analgesic effects of the spinal drugs chosen, or if there is a reasonable possibility of operative delivery, then consider a catheter technique instead of a single-injection technique.
- Combined spinal–epidural techniques may be used to provide effective and rapid onset of analgesia for labor.

**Patient-controlled Epidural Analgesia.**

- Patient-controlled epidural analgesia (PCEA) may be used to provide an effective and flexible approach for the maintenance of labor analgesia.
- The use of PCEA may be preferable to fixed-rate continuous infusion epidural analgesia for administering reduced dosages of local anesthetics.
- PCEA may be used with or without a background infusion.

**Removal of Retained Placenta**

**Anesthetic Techniques**

- In general, there is no preferred anesthetic technique for removal of retained placenta.
  - If an epidural catheter is in place and the patient is hemodynamically stable, consider providing epidural anesthesia.
  - Assess hemodynamic status before administering neuraxial anesthesia.
  - Consider aspiration prophylaxis.
  - Titrate sedation/analgesia carefully due to the potential risks of respiratory depression and pulmonary aspiration during the immediate postpartum period.
  - In cases involving major maternal hemorrhage with hemodynamic instability, general anesthesia with an endotracheal tube may be considered in preference to neuraxial anesthesia.

**Nitroglycerin for Uterine Relaxation**

- Nitroglycerin may be used as an alternative to terbutaline sulfate or general endotracheal anesthesia with halogenated agents for uterine relaxation during removal of retained placental tissue.
  - Initiating treatment with incremental doses of IV or sublingual (i.e., tablet or metered dose spray) nitroglycerin may be done to sufficiently relax the uterus.

**Anesthetic Care for Cesarean Delivery**

**Equipment, Facilities, and Support Personnel**

- Equipment, facilities, and support personnel available in the labor and delivery operating suite should be comparable to those available in the main operating suite.
- Resources for the treatment of potential complications (e.g., failed intubation, inadequate analgesia/anesthesia, hypotension, respiratory depression, local anesthetic systemic toxicity, pruritus, and vomiting) should also be available in the labor and delivery operating suite.
- Appropriate equipment and personnel should be available to care for obstetric patients recovering from neuraxial or general anesthesia.
General, Epidural, Spinal, or Combined Spinal–Epidural Anesthesia

- The decision to use a particular anesthetic technique for cesarean delivery should be individualized, based on anesthetic, obstetric, or fetal risk factors (e.g., elective vs. emergency), the preferences of the patient, and the judgment of the anesthesiologist.
  - Uterine displacement (usually left displacement) should be maintained until delivery regardless of the anesthetic technique used.
- Consider selecting neuraxial techniques in preference to general anesthesia for most cesarean deliveries.
- If spinal anesthesia is chosen, use pencil-point spinal needles instead of cutting-bevel spinal needles.
- For urgent cesarean delivery, an indwelling epidural catheter may be used as an alternative to initiation of spinal or general anesthesia.
- General anesthesia may be the most appropriate choice in some circumstances (e.g., profound fetal bradycardia, ruptured uterus, severe hemorrhage, severe placental abruption, umbilical cord prolapse, and preterm footling breech).

IV Fluid Preloading or Coloading

- IV fluid preloading or coloading may be used to reduce the frequency of maternal hypotension after spinal anesthesia for cesarean delivery.
- Do not delay the initiation of spinal anesthesia in order to administer a fixed volume of IV fluid.

Ephedrine or Phenylephrine

- Either IV ephedrine or phenylephrine may be used for treating hypotension during neuraxial anesthesia.
- In the absence of maternal bradycardia, consider selecting phenylephrine because of improved fetal acid–base status in uncomplicated pregnancies.

Neuraxial Opioids for Postoperative Analgesia

- For postoperative analgesia after neuraxial anesthesia for cesarean delivery, consider selecting neuraxial opioids rather than intermittent injections of parenteral opioids.

Postpartum Tubal Ligation

- Before a postpartum tubal ligation, the patient should have no oral intake of solid foods within 6 to 8 h of the surgery, depending on the type of food ingested (e.g., fat content).###
  - Consider aspiration prophylaxis.
  - Both the timing of the procedure and the decision to use a particular anesthetic technique (i.e., neuraxial vs. general) should be individualized, based on anesthetic and obstetric risk factors (e.g., blood loss) and patient preferences.
- Consider selecting neuraxial techniques in preference to general anesthesia for most postpartum tubal ligations.
  - Be aware that gastric emptying will be delayed in patients who have received opioids during labor.
  - Be aware that an epidural catheter placed for labor may be more likely to fail with longer postdelivery time intervals.
  - If a postpartum tubal ligation is to be performed before the patient is discharged from the hospital, do not attempt the procedure at a time when it might compromise other aspects of patient care on the labor and delivery unit.###

Management of Obstetric and Anesthetic Emergencies

Resources for Management of Hemorrhagic Emergencies

- Institutions providing obstetric care should have resources available to manage hemorrhagic emergencies (table 1).
  - In an emergency, type-specific or O-negative blood is acceptable.
  - In cases of intractable hemorrhage, when banked blood is not available or the patient refuses banked blood, consider intraoperative cell salvage if available.†††

Equipment for Management of Airway Emergencies

- Labor and delivery units should have personnel and equipment readily available to manage airway emergencies consistent with the ASA Practice Guidelines for Management of the Difficult Airway,‡‡‡ to include a pulse oximeter and carbon dioxide detector.
  - Basic airway management equipment should be immediately available during the provision of neuraxial analgesia (table 2).
  - Portable equipment for difficult airway management should be readily available in the operative area of labor and delivery units (table 3).
  - A preformulated strategy for intubation of the difficult airway should be in place.
  - When tracheal intubation has failed, consider ventilation with mask and cricoid pressure or with a supraglottic airway device (e.g., laryngeal mask airway, intubating laryngeal mask airway, and laryngeal tube) for maintaining an airway and ventilating the lungs.
  - If it is not possible to ventilate or awaken the patient, a surgical airway should be performed.

Cardiopulmonary Resuscitation

- Basic and advanced life-support equipment should be immediately available in the operative area of labor and delivery units.
• If cardiac arrest occurs, initiate standard resuscitative measures.
  - Uterine displacement (usually left displacement) should be maintained.
  - If maternal circulation is not restored within 4 min, cesarean delivery should be performed by the obstetrics team.§§§

Appendix 2. Methods and Analyses

For these updated guidelines, a review of studies used in the development of the previous update was combined with studies published subsequent to approval of the update in 2006.† The scientific assessment of these guidelines was based on evidence linkages or statements regarding potential relations between clinical interventions and outcomes. The interventions listed below were examined to assess their relation to a variety of outcomes related to obstetric anesthesia.****

Preanesthetic Evaluation and Preparation

- Conducting a focused history (patient condition)
- Conducting a physical examination
- Communication between anesthetic and obstetric providers
- Laboratory tests
  - Routine intrapartum platelet count
  - Platelet count for suspected preeclampsia or coagulopathy
  - Blood type and screen or cross-match
  - Recording of fetal heart rate patterns

Aspiration Prevention

- Oral intake of clear liquids for laboring patients
- Oral intake of solids for laboring patients
- A fasting period for solids of 6 to 8 h before an elective cesarean
- Nonparticulate antacids versus no antacids before operative procedures (excluding operative vaginal delivery)
- H₂-receptor antagonists (e.g., cimetidine, ranitidine, or famotidine) versus no H₂ antagonists before operative procedures (excluding operative vaginal delivery)
- Metoclopramide versus no metoclopramide before operative procedures (excluding operative vaginal delivery)

Anesthetic Care for Labor and Vaginal Delivery

- Early versus late administration of neuraxial analgesia (e.g., cervical dilations of less than 5 cm or greater than 5 cm or less than 4 cm, greater than 4 cm)
- Neuraxial techniques for patients attempting vaginal birth after prior cesarean delivery for labor

**** Unless otherwise specified, outcomes for the listed interventions refer to the reduction of maternal, fetal, and neonatal complications.

- Prophylactic neuraxial catheter insertion for obstetric (e.g., twin gestation or preeclampsia) or anesthetic indications (e.g., anticipated difficult airway or obesity)
- Continuous infusion epidural (CIE) of local anesthetics
  - CIE of local anesthetics (with or without opioids) versus intramuscular opioids for labor
  - CIE of local anesthetics (with or without opioids) versus IV opioids for labor
  - CIE of local anesthetics with or without opioids versus spinal opioids with or without local anesthetics for labor
- Analgesic concentrations
  - Induction of epidural analgesia using local anesthetics with opioids versus equal concentrations of epidural local anesthetics without opioids for labor
  - Induction of epidural analgesia using local anesthetics with opioids versus higher concentrations of epidural local anesthetics without opioids for labor
  - Maintenance of epidural infusion of lower concentrations of local anesthetics with opioids versus higher concentrations of local anesthetics without opioids for labor
  - Maintenance of epidural infusion with bupivacaine concentrations less than 0.125% with opioids versus bupivacaine concentrations greater than 0.125% without opioids for labor
- Single-injection spinal opioids
  - Single-injection spinal opioids with or without local anesthetics versus parenteral opioids for labor
  - Single-injection spinal opioids with local anesthetics versus spinal opioids without local anesthetics for labor
- Pencil-point spinal needles
  - Pencil-point spinal needles versus cutting-bevel spinal needles
- Combined spinal–epidural (CSE) local anesthetics with opioids
  - CSE local anesthetics with opioids versus epidural local anesthetics with opioids for labor
- Patient-controlled epidural analgesia (PCEA)
  - PCEA versus CIE for labor
  - PCEA with a background infusion versus PCEA without a background infusion for labor
- Removal of retained placenta
  - Anesthetic techniques
  - Administration of nitroglycerin for uterine relaxation
Anesthetic Care for Cesarean Delivery

- Equipment, facilities, and support personnel
  - Availability of equipment, facilities, and support personnel
- General, epidural, spinal, or CSE anesthesia
  - General anesthesia (GA) versus epidural anesthesia
  - Epidural versus spinal anesthesia
  - CSE anesthesia versus epidural anesthesia
  - CSE anesthesia versus spinal anesthesia
- In situ epidural catheter versus no epidural anesthesia in hemodynamically stable patients for removal of retained placenta
  - GA versus neuraxial anesthesia in cases involving major maternal hemorrhage for removal of retained placenta
- IV fluid preloading or coloading
  - IV fluid preloading or coloading versus no IV fluid preloading or coloading for spinal anesthesia to reduce maternal hypotension
  - IV fluid preloading versus coloading
- Ephedrine or phenylephrine
  - Ephedrine versus placebo or no ephedrine
  - Phenylephrine versus placebo or no phenylephrine
- Neuraxial opioids for postoperative analgesia
  - Neuraxial opioids versus intermittent injections of parenteral opioids for postoperative analgesia after neuraxial anesthesia for cesarean
  - PCEA versus IV patient-controlled analgesia for postoperative analgesia after neuraxial anesthesia for cesarean
  - Addition of nonsteroidal antiinflammatory drugs versus no nonsteroidal antiinflammatory drugs for postoperative analgesia after neuraxial anesthesia for cesarean

Postpartum Tubal Ligation

- A fasting period for solids of 6 to 8 h before postpartum tubal ligation
- Aspiration prophylaxis for postpartum tubal ligation
- Neuraxial anesthesia versus GA for postpartum tubal ligation
- Postpartum tubal ligation within 8 h of delivery

Management of Obstetric and Anesthetic Emergencies

Resources for Management of Hemorrhagic Emergencies

- Resources for management of hemorrhagic emergencies (e.g., red blood cells, platelets, and cell salvage)
- Invasive hemodynamic monitoring for severe preeclamptic patients

Resources for Management of Airway Emergencies

- Equipment for management of airway emergencies

Cardiopulmonary Resuscitation

- Basic and advanced life-support equipment in the labor and delivery suite

State of the Literature. For the literature review, potentially relevant clinical studies were identified via electronic and manual searches of the literature. The updated searches covered an 11-yr period from January 1, 2005 to July 31, 2015. New citations were reviewed and combined with pre-2005 articles used in the previous update, resulting in a total of 478 articles that contained direct linkage-related evidence. Search terms consisted of the interventions indicated above guided by the appropriate inclusion/exclusion criteria as stated in the “Focus” section of these Guidelines. A complete bibliography used to develop these guidelines, organized by section, is available as Supplemental Digital Content 2, http://links.lww.com/ALN/B220.

Each pertinent outcome reported in a study was classified by evidence category and level, and designated as either beneficial, harmful, or equivocal. Findings were then summarized for each evidence linkage. Literature pertaining to 13 evidence linkages contained enough studies with well-defined experimental designs and statistical information sufficient to conduct meta-analyses (table 4). These linkages were (1) early versus late epidural anesthetics, (2) epidural local anesthetics with opioids versus equal concentrations of epidural local anesthetics without opioids, (3) CIE of local anesthetics with opioids versus higher concentrations of local anesthetics without opioids, (4) pencil-point versus cutting-bevel spinal needles, (5) CSE local anesthetics with opioids versus epidural local anesthetics with opioids, (6) PCEA versus CIE anesthetics, (7) PCEA with a background infusion versus PCEA, (8) GA versus epidural anesthesia for cesarean delivery, (9) CSE anesthesia versus epidural anesthesia for cesarean delivery, (10) fluid preloading versus coloading for cesarean delivery, (11) ephedrine versus placebo for cesarean delivery, (12) ephedrine versus phenylephrine for cesarean delivery, and (13) neuraxial versus parenteral opioids for postoperative analgesia.

General variance-based effect-size estimates or combined probability tests were obtained for continuous outcome measures, and Mantel–Haenszel odds ratios were obtained for dichotomous outcome measures. Two combined probability tests were used as follows: (1) the Fisher combined test, producing chi-square values based on logarithmic
transformations of the reported \( P \) values from the independent studies, and (2) the Stouffer combined test, providing weighted representation of the studies by weighting each of the standard normal deviates by the size of the sample. An odds ratio procedure based on the Mantel–Haenszel method for combining study results using \( 2 \times 2 \) tables was used with outcome frequency information. An acceptable significance level was set at a \( P \) value of less than 0.01 (one tailed). Tests for heterogeneity of the independent studies were conducted to assure consistency among the study results. DerSimonian–Laird random-effects odds ratios were obtained when significant heterogeneity was found \( (P < 0.01) \). To control for potential publishing bias, a “fail-safe n” value was calculated. No search for unpublished studies was conducted, and no reliability tests for locating research results were done. To be accepted as significant findings, Mantel–Haenszel odds ratios must agree with combined test results whenever both types of data are assessed. In the absence of Mantel–Haenszel odds ratios, findings from both the Fisher and weighted Stouffer combined tests must agree with each other to be acceptable as significant.

For the previous update, interobserver agreement among Task Force members and two methodologists was established by interrater reliability testing. Agreement levels using a \( \kappa \) statistic for two-rater agreement was as follows: (1) type of study design, \( \kappa = 0.83 \) to 0.94; (2) type of analysis, \( \kappa = 0.71 \) to 0.93; (3) evidence linkage assignment, \( \kappa = 0.87 \) to 1.00; and (4) literature inclusion for database, \( \kappa = 0.74 \) to 1.00. Three-rater chance-corrected agreement values were as follows: (1) study design, \( \text{Sav} = 0.884, \text{Var (Sav)} = 0.004 \); (2) type of analysis, \( \text{Sav} = 0.805, \text{Var (Sav)} = 0.009 \); (3) linkage assignment, \( \text{Sav} = 0.911, \text{Var (Sav)} = 0.002 \); (4) literature database inclusion, \( \text{Sav} = 0.660, \text{Var (Sav)} = 0.024 \). These values represent moderate to high levels of agreement.

**Consensus-based Evidence.** For the previous update, consensus was obtained from multiple sources, including (1) survey opinion from consultants who were selected based on their knowledge or expertise in obstetric anesthesia or maternal and fetal medicine, (2) survey opinions solicited from active members of the American Society of Anesthesiologists (ASA), (3) testimony from attendees of publicly-held open forums at two national anesthesia meetings, (4) Internet commentary, and (5) Task Force opinion and interpretation. The survey rate of return was 75% \( (n = 76 \text{ of } 102) \) for the consultants, and 2,326 surveys were received from active ASA members. Results of the surveys are reported in tables 5 and 6, and in the text of the guidelines.

The consultants were asked to indicate which, if any, of the evidence linkages would change their clinical practices if the guidelines were instituted. The rate of return was 35% \( (n = 36) \). The percent of responding consultants expecting no change associated with each linkage were as follows: perianesthetic evaluation: 97%; aspiration prophylaxis: 83%; anesthetic care for labor and delivery: 89%; removal of retained placenta: 97%; anesthetic choices for cesarean delivery: 97%; postpartum tubal ligation: 97%; and management of complications: 94%. Ninety-seven percent of the respondents indicated that the guidelines would have no effect on the amount of time spent on a typical case. One respondent indicated that there would be an increase of 5 min in the amount of time spent on a typical case with the implementation of these guidelines.

**Appendix 3. Overview of Anesthetic Care for Labor and Delivery††††**

Not all women require anesthetic care during labor or delivery. For women who request pain relief for labor and/or delivery, there are many effective analgesic techniques available. Maternal request represents sufficient justification for pain relief. In addition, maternal medical and obstetric conditions may warrant the provision of neuraxial techniques to improve maternal and neonatal outcome.

The choice of analgesic technique depends on the medical status of the patient, progress of labor, and resources at the facility. When sufficient resources \( (e.g., \text{anesthesia and nursing staff}) \) are available, neuraxial catheter techniques should be one of the analgesic options offered. The choice of a specific neuraxial technique should be individualized and based on anesthetic risk factors, obstetric risk factors, patient preferences, progress of labor, and resources at the facility.

When neuraxial techniques are used for analgesia during labor or vaginal delivery, the primary goal is to provide an adequate maternal analgesia with minimal motor block \( (e.g., \text{achieved with the administration of local anesthetics at low concentrations with or without opioids}) \).

When a neuraxial technique is chosen, appropriate resources for the treatment of complications \( (e.g., \text{hypotension, systemic toxicity, and high spinal anesthesia}) \) should be available. If an opioid is added, treatments for related complications \( (e.g., \text{pruritus, nausea, and respiratory depression}) \) should be available. An IV infusion should be established before the initiation of neuraxial analgesia or general anesthesia and maintained throughout the duration of the neuraxial analgesic or anesthetic. However, administration of a fixed volume of IV fluid is not required before neuraxial analgesia is initiated.
Table 4. Meta-analysis Summary

<table>
<thead>
<tr>
<th>Evidence Linkages</th>
<th>N</th>
<th>Fisher Chi-square</th>
<th>Weighted Stouffer Zc</th>
<th>P Value</th>
<th>P Value</th>
<th>Effect Size</th>
<th>Mantel-Haenszel OR</th>
<th>CI</th>
<th>Significance</th>
<th>Effect Size</th>
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<tr>
<td><strong>Early vs. late epidural anesthetics</strong>&lt;sup&gt;44–48&lt;/sup&gt;</td>
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<tr>
<td>Spontaneous delivery</td>
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<td>1.03</td>
<td>0.94–1.13</td>
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<tr>
<td>Instrumented delivery</td>
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<td>1.90</td>
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<td>Cesarean delivery</td>
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<tr>
<td><strong>Epidural local anesthetics with opioids vs. equal concentrations of local anesthetics without opioids</strong>&lt;sup&gt;61–73&lt;/sup&gt;</td>
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<tr>
<td>Analgesia (pain relief)</td>
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<td>Pruritus</td>
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<td>1 min Apgar</td>
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<td><strong>CIE of low concentrations of local anesthetics with opioids vs. higher concentrations of local anesthetics without opioids</strong>&lt;sup&gt;64–80&lt;/sup&gt;</td>
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<td><strong>Pencil-point vs. cutting-bevel spinal needles</strong>&lt;sup&gt;85–89&lt;/sup&gt;</td>
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<td><strong>CSE with opioids vs. epidural local anesthetics with opioids</strong>&lt;sup&gt;95–101&lt;/sup&gt;</td>
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<td>Analgesic use</td>
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<td>Duration of labor first stage</td>
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<td>Analgesia (pain relief)</td>
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<td>Spontaneous delivery</td>
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<td>Motor block</td>
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<td><strong>Fluid preloading vs. coloading for cesarean delivery</strong>&lt;sup&gt;168,170–174&lt;/sup&gt;</td>
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<td>Hypotension</td>
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<td>0.99–2.17</td>
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<td>Hypotension (colloids only)</td>
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(Continued)
Table 4. (Continued)

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<th>Weighted Stouffer Zc</th>
<th>P Value</th>
<th>Effect Size</th>
<th>Mantel-Haenszel OR</th>
<th>CI</th>
<th>Heterogeneity</th>
<th>Significance</th>
<th>Effect Size</th>
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<tr>
<td>IV ephedrine vs. placebo for cesarean delivery177–181</td>
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<td>Hypotension</td>
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<td>IV phenylephrine vs. ephedrine for cesarean delivery188–199</td>
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<tr>
<td>Hypotension*</td>
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<td></td>
<td>1.36</td>
<td>0.81–2.29</td>
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<td>Umbilical artery pH*</td>
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<td>−5.78</td>
<td>0.001</td>
<td>0.34</td>
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<td>Neuraxial vs. parenteral opioids for postoperative analgesia200–204,206–211</td>
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<td>Nausea</td>
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<td>1.13</td>
<td>0.57–2.22</td>
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<td>Vomiting</td>
<td>6</td>
<td></td>
<td>1.02</td>
<td>0.37–2.81</td>
<td>0.314</td>
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<tr>
<td>Pruritus</td>
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<td>6.23</td>
<td>3.32–11.68</td>
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</table>

* Double-blind studies only; † DerSimonian–Laird random-effects OR.
CIE = continuous infusion epidural; CSE = combined spinal–epidural; OR = odds ratio; PCEA = patient-controlled epidural analgesia.

Table 5. Consultant Survey Responses

<table>
<thead>
<tr>
<th>Percent Responding to Each Item</th>
<th>N</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perianesthetic evaluation and preparation</td>
<td>61</td>
<td>90.2*</td>
<td>91.8*</td>
<td>77.0*</td>
<td>81.7*</td>
<td>56.7*</td>
</tr>
<tr>
<td>1. Conduct a focused history and physical examination before providing anesthetic care</td>
<td>61</td>
<td>90.2*</td>
<td>6.6</td>
<td>1.6</td>
<td>1.6</td>
<td>0.0</td>
</tr>
<tr>
<td>2. A communication system should be in place to encourage early and ongoing contact between obstetric providers, anesthesiologists, and other members of the multidisciplinary team</td>
<td>61</td>
<td>91.8*</td>
<td>8.2</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
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<tr>
<td>Intrapartum platelet count</td>
<td>61</td>
<td>77.0*</td>
<td>21.3</td>
<td>0.0</td>
<td>1.6</td>
<td>0.0</td>
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<tr>
<td>3. The anesthesiologist’s decision to order or require a platelet count should be individualized and based on a patient’s history (e.g., severe preeclampsia), physical examination, and clinical signs</td>
<td>61</td>
<td>77.0*</td>
<td>21.3</td>
<td>0.0</td>
<td>1.6</td>
<td>0.0</td>
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<tr>
<td>Blood type and screen</td>
<td>60</td>
<td>56.7*</td>
<td>35.0</td>
<td>3.3</td>
<td>3.3</td>
<td>1.7</td>
</tr>
<tr>
<td>4. A routine blood cross-match is not necessary for healthy and uncomplicated parturients for vaginal or operative delivery</td>
<td>60</td>
<td>56.7*</td>
<td>35.0</td>
<td>3.3</td>
<td>3.3</td>
<td>1.7</td>
</tr>
<tr>
<td>5. The decision whether to order or require a blood type and screen or cross-match should be based on maternal history, anticipated hemorrhagic complications (e.g., placenta accreta in a patient with placenta previa and previous uterine surgery), and local institutional policies</td>
<td>60</td>
<td>75.0*</td>
<td>16.7</td>
<td>1.7</td>
<td>3.3</td>
<td>3.3</td>
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<tr>
<td>Perianesthetic recording of fetal heart rate</td>
<td>60</td>
<td>81.7*</td>
<td>18.3</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>6. The fetal heart rate should be monitored by a qualified individual before and after administration of neuraxial analgesia for labor</td>
<td>60</td>
<td>81.7*</td>
<td>18.3</td>
<td>0.0</td>
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<tr>
<td>Aspiration prevention</td>
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<td>63.3*</td>
<td>35.0</td>
<td>0.0</td>
<td>1.7</td>
<td>0.0</td>
</tr>
<tr>
<td>7. The oral intake of moderate amounts of clear liquids may be allowed for uncomplicated laboring patients</td>
<td>60</td>
<td>63.3*</td>
<td>35.0</td>
<td>0.0</td>
<td>1.7</td>
<td>0.0</td>
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<tr>
<td>8. The uncomplicated patient undergoing elective surgery (e.g., scheduled cesarean delivery or postpartum tubal ligation) may have moderate amounts of clear liquids up to 2 h before induction of anesthesia</td>
<td>60</td>
<td>53.3*</td>
<td>30.0</td>
<td>6.7</td>
<td>8.3</td>
<td>1.7</td>
</tr>
<tr>
<td>9. The patient undergoing elective surgery (e.g., scheduled cesarean delivery or postpartum tubal ligation) should undergo a fasting period for solids of 6–8 h depending on the type of food ingested (e.g., fat content)</td>
<td>60</td>
<td>76.7*</td>
<td>16.7</td>
<td>3.3</td>
<td>3.3</td>
<td>0.0</td>
</tr>
<tr>
<td>10. Laboring patients with additional risk factors for aspiration (e.g., morbid obesity, diabetes mellitus, and difficult airway) or patients at increased risk for operative delivery (e.g., nonreassuring fetal heart rate pattern) may have further restrictions of oral intake, determined on a case-by-case basis</td>
<td>60</td>
<td>55.0*</td>
<td>33.3</td>
<td>5.0</td>
<td>6.7</td>
<td>0.0</td>
</tr>
<tr>
<td>11. Solid foods should be avoided in laboring patients</td>
<td>60</td>
<td>51.7*</td>
<td>26.7</td>
<td>15.0</td>
<td>6.7</td>
<td>0.0</td>
</tr>
</tbody>
</table>

(Continued)
12. Before surgical procedures (e.g., cesarean delivery or postpartum tubal ligation), consider the timely administration of nonparticulate antacids, H₂-receptor antagonists, and/or metoclopramide for aspiration prophylaxis.

Timing of neuraxial analgesia and outcomes of labor

13. Provide patients in early labor (i.e., < 5 cm dilation) the option of neuraxial analgesia when this service is available.

14. Offer neuraxial analgesia on an individualized basis.

15. Do not withhold neuraxial analgesia on the basis of achieving an arbitrary cervical dilation.

Neuraxial analgesia and trial of labor after prior cesarean delivery

16. Offer neuraxial techniques to patients attempting vaginal birth after previous cesarean delivery.

17. For these patients, it is appropriate to consider early placement of a neuraxial catheter that can be used later for labor analgesia or for anesthesia in the event of operative delivery.

Early insertion of a neuraxial (i.e., spinal or epidural) catheter for complicated parturients

18. Consider early insertion of a neuraxial catheter for obstetric (e.g., twin gestation or preeclampsia) or anesthetic indications (e.g., anticipated difficult airway or obesity) to reduce the need for general anesthesia if an emergent procedure becomes necessary.

CIE analgesia

19. Continuous epidural infusion may be used for effective analgesia for labor and delivery.

20. When a continuous epidural infusion of local anesthetic is selected, an opioid may be added.

Analgesc concentrations

21. Use dilute concentrations of local anesthetics with opioids to produce as little motor block as possible.

Single-injection spinal opioids with or without local anesthetics

22. Single-injection spinal opioids with or without local anesthetics may be used to provide effective, although time-limited, analgesia for labor when spontaneous vaginal delivery is anticipated.

23. A local anesthetic may be added to a spinal opioid to increase duration and improve quality of analgesia.

Pencil-point spinal needles

24. Use pencil-point spinal needles instead of cutting-bevel spinal needles to minimize the risk of postdural puncture headache.

CSE analgesia

25. If labor is expected to last longer than the analgesic effects of the spinal drugs chosen, or if there is a good possibility of operative delivery, then consider a catheter technique instead of a single-injection technique.

26. CSE techniques may be used to provide effective and rapid onset of analgesia for labor.

PCEA

27. PCEA may be used to provide an effective and flexible approach for the maintenance of labor analgesia.

28. The use of PCEA may be preferable to fixed-rate CIE for providing fewer anesthetic interventions and reducing dosages of local anesthetics.

29. PCEA may be used with or without a background infusion.

Anesthetic techniques for removal of retained placenta

30. Assess hemodynamic status before administering neuraxial anesthesia.

31. If an epidural catheter is in place and the patient is hemodynamically stable, consider providing epidural anesthesia.

32. Consider aspiration prophylaxis.

33. Titrate sedation/analgesia carefully due to the potential risks of respiratory depression and pulmonary aspiration during the immediate postpartum period.

34. In cases involving major maternal hemorrhage with hemodynamic instability, general anesthesia with an endotracheal tube may be considered in preference to neuraxial anesthesia.
Table 5. (Continued)

<table>
<thead>
<tr>
<th>Percent Responding to Each Item</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nitroglycerin for uterine relaxation</strong></td>
<td></td>
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</tr>
<tr>
<td>35. Nitroglycerin may be used as an alternative to terbutaline sulfate or general endotracheal anesthesia with halogenated agents for uterine relaxation during removal of retained placental tissue</td>
<td>60</td>
<td>73.3*</td>
<td>25.0</td>
<td>1.7</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Equipment, facilities, and support personnel</strong></td>
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</tr>
<tr>
<td>36. Equipment, facilities, and support personnel available in the labor and delivery operating suite should be comparable to those available in the main operating suite</td>
<td>60</td>
<td>93.3*</td>
<td>5.0</td>
<td>1.7</td>
<td>0.0</td>
</tr>
<tr>
<td>37. Resources for the treatment of potential complications (e.g., failed intubation, inadequate analgesia, hypotension, respiratory depression, pruritus, and vomiting) should also be available in the labor and delivery operating suite</td>
<td>60</td>
<td>96.7*</td>
<td>3.3</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>38. Appropriate equipment and personnel should be available to care for obstetric patients recovering from major neuraxial or GA</td>
<td>60</td>
<td>100*</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>General, epidural, spinal, or CSE anesthesia</strong></td>
<td></td>
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<tr>
<td>39. The decision to use a particular anesthetic technique for cesarean delivery should be individualized, based on anesthetic, obstetric, or fetal risk factors (e.g., elective vs. emergency), the preferences of the patient, and the judgment of the anesthesiologist</td>
<td>60</td>
<td>93.3*</td>
<td>6.7</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>40. Uterine displacement (usually left displacement) should be maintained until delivery regardless of the anesthetic technique used</td>
<td>60</td>
<td>60.0*</td>
<td>25.0</td>
<td>11.7</td>
<td>3.3</td>
</tr>
<tr>
<td>41. Consider selecting neuraxial techniques in preference to general anesthesia for most cesarean deliveries</td>
<td>60</td>
<td>91.7*</td>
<td>8.3</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>42. If spinal anesthesia is chosen, use pencil-point spinal needles instead of cutting-bevel spinal needles</td>
<td>60</td>
<td>95.0*</td>
<td>3.3</td>
<td>1.7</td>
<td>0.0</td>
</tr>
<tr>
<td>43. For urgent cesarean delivery, an indwelling epidural catheter may be used as an alternative to initiation of spinal anesthesia</td>
<td>59</td>
<td>83.0*</td>
<td>15.2</td>
<td>1.7</td>
<td>0.0</td>
</tr>
<tr>
<td>44. General anesthesia may be the most appropriate choice in some circumstances (e.g., profound fetal bradycardia, ruptured uterus, severe hemorrhage, and severe placental abruption)</td>
<td>60</td>
<td>80.0*</td>
<td>20.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>IV fluid preloading</strong></td>
<td></td>
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<tr>
<td>45. IV fluid preloading may be used to reduce the frequency of maternal hypotension after spinal anesthesia for cesarean delivery</td>
<td>60</td>
<td>25.0</td>
<td>26.7*</td>
<td>25.0</td>
<td>18.3</td>
</tr>
<tr>
<td>46. Although fluid preloading reduces the frequency of maternal hypotension, do not delay the initiation of spinal anesthesia in order to administer a fixed volume of IV fluid</td>
<td>60</td>
<td>68.3*</td>
<td>26.7</td>
<td>5.0</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Ephedrine or phenylephrine</strong></td>
<td></td>
<td></td>
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<tr>
<td>47. IV ephedrine and phenylephrine both may be used for treating hypotension during neuraxial anesthesia</td>
<td>60</td>
<td>60.0*</td>
<td>33.3</td>
<td>3.3</td>
<td>1.7</td>
</tr>
<tr>
<td><strong>Neuraxial opioids for postoperative analgesia</strong></td>
<td></td>
<td></td>
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<tr>
<td>48. For postoperative analgesia after neuraxial anesthesia for cesarean delivery, consider selecting neuraxial opioids rather than intermittent injections of parenteral opioids</td>
<td>60</td>
<td>85.0*</td>
<td>11.7</td>
<td>1.7</td>
<td>1.7</td>
</tr>
<tr>
<td><strong>Postpartum tubal ligation</strong></td>
<td></td>
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<tr>
<td>49. Before postpartum tubal ligation, the patient should have no oral intake of solid foods within 6–8 h of the surgery, depending on the type of food ingested (e.g., fat content)</td>
<td>60</td>
<td>55.0*</td>
<td>28.3</td>
<td>6.7</td>
<td>10.0</td>
</tr>
<tr>
<td>50. Both the timing of the procedure and the decision to use a particular anesthetic technique (i.e., neuraxial vs. general) should be individualized, based on anesthetic risk factors, obstetric risk factors (e.g., blood loss), and patient preferences</td>
<td>60</td>
<td>78.3*</td>
<td>18.3</td>
<td>1.7</td>
<td>1.7</td>
</tr>
<tr>
<td>51. Consider selecting neuraxial techniques in preference to general anesthesia for most postpartum tubal ligations</td>
<td>60</td>
<td>73.3*</td>
<td>18.3</td>
<td>6.7</td>
<td>0.0</td>
</tr>
<tr>
<td><strong>Management of hemorrhagic emergencies</strong></td>
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<tr>
<td>52. Institutions providing obstetric care should have resources available to manage hemorrhagic emergencies</td>
<td>58</td>
<td>100.0*</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>53. Labor and delivery units should have personnel and equipment readily available to manage airway emergencies consistent with the ASA Practice Guidelines for Management of the Difficult Airway, to include a pulse oximeter and carbon dioxide detector</td>
<td>58</td>
<td>98.3*</td>
<td>1.7</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>54. Basic and advanced life-support equipment should be immediately available in the operative area of labor and delivery units</td>
<td>58</td>
<td>100.0*</td>
<td>0.0</td>
<td>0.0</td>
<td>0.0</td>
</tr>
<tr>
<td>55. If cardiac arrest occurs during labor and delivery, initiate standard resuscitative measures with accommodations for pregnancy such as left uterine displacement and preparing for delivery of the fetus</td>
<td>58</td>
<td>98.3*</td>
<td>1.7</td>
<td>0.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>

* Median response.

ASA = American Society of Anesthesiologists; CIE = continuous infusion epidural; CSE = combined spinal–epidural; GA = general anesthesia; N = the number of consultants who responded to each item; PCEA = patient-controlled epidural analgesia.
### Table 6. ASA Membership Survey Responses

<table>
<thead>
<tr>
<th>Percent Responding to Each Item</th>
<th>N</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Peri-anesthetic evaluation and preparation</strong></td>
<td></td>
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</tr>
<tr>
<td>1. Conduct a focused history and physical examination before providing anesthetic care</td>
<td>373</td>
<td>73.2°</td>
<td>21.4</td>
<td>3.2</td>
<td>1.3</td>
<td>0.8</td>
</tr>
<tr>
<td>2. A communication system should be in place to encourage early and ongoing contact between obstetric providers, anesthesiologists, and other members of the multidisciplinary team</td>
<td>373</td>
<td>81.0°</td>
<td>16.6</td>
<td>2.1</td>
<td>0.0</td>
<td>0.3</td>
</tr>
<tr>
<td><strong>Intrapartum platelet count</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3. The anesthesiologist’s decision to order or require a platelet count should be individualized and based on a patient’s history (e.g., severe preeclampsia), physical examination, and clinical signs</td>
<td>370</td>
<td>51.3°</td>
<td>29.7</td>
<td>5.9</td>
<td>10.8</td>
<td>2.2</td>
</tr>
<tr>
<td><strong>Blood type and screen</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>4. A routine blood cross-match is not necessary for healthy and uncomplicated parturients for vaginal or operative delivery</td>
<td>367</td>
<td>38.4</td>
<td>38.7°</td>
<td>8.2</td>
<td>12.0</td>
<td>2.7</td>
</tr>
<tr>
<td>5. The decision whether to order or require a blood type and screen or cross-match should be based on maternal history, anticipated hemorrhagic complications (e.g., placenta accreta in a patient with placenta previa and previous uterine surgery), and local institutional policies</td>
<td>367</td>
<td>49.3</td>
<td>33.0°</td>
<td>4.1</td>
<td>11.4</td>
<td>2.2</td>
</tr>
<tr>
<td><strong>Peri-anesthetic recording of fetal heart rate</strong></td>
<td></td>
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</tr>
<tr>
<td>6. The fetal heart rate should be monitored by a qualified individual before and after administration of neuraxial analgesia for labor</td>
<td>366</td>
<td>68.3°</td>
<td>24.3</td>
<td>6.3</td>
<td>0.6</td>
<td>0.6</td>
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<tr>
<td><strong>Aspiration prevention</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7. The oral intake of moderate amounts of clear liquids may be allowed for uncomplicated laboring patients</td>
<td>357</td>
<td>30.0</td>
<td>47.3°</td>
<td>9.5</td>
<td>10.4</td>
<td>2.8</td>
</tr>
<tr>
<td>8. The uncomplicated patient undergoing elective surgery (e.g., scheduled cesarean delivery or postpartum tubal ligation) may have moderate amounts of clear liquids up to 2h before induction of anesthesia</td>
<td>357</td>
<td>21.3</td>
<td>36.7°</td>
<td>9.0</td>
<td>25.5</td>
<td>7.6</td>
</tr>
<tr>
<td>9. The patient undergoing elective surgery (e.g., scheduled cesarean delivery or postpartum tubal ligation) should undergo a fasting period for solids of 6–8h depending on the type of food ingested (e.g., fat content)</td>
<td>357</td>
<td>70.3°</td>
<td>27.7</td>
<td>0.3</td>
<td>0.8</td>
<td>0.8</td>
</tr>
<tr>
<td>10. Laboring patients with additional risk factors for aspiration (e.g., morbid obesity, diabetes mellitus, and difficult airway) or patients at increased risk for operative delivery (e.g., nonreassuring fetal heart rate pattern) may have further restrictions of oral intake, determined on a case-by-case basis</td>
<td>357</td>
<td>56.9°</td>
<td>37.8</td>
<td>3.1</td>
<td>1.7</td>
<td>0.6</td>
</tr>
<tr>
<td>11. Solid foods should be avoided in laboring patients</td>
<td>357</td>
<td>63.0°</td>
<td>28.3</td>
<td>5.0</td>
<td>3.1</td>
<td>0.6</td>
</tr>
<tr>
<td>12. Before surgical procedures (e.g., cesarean delivery and postpartum tubal ligation), consider the timely administration of nonparticulate antacids, H₂-receptor antagonists, and/or metoclopramide for aspiration prophylaxis</td>
<td>355</td>
<td>43.9</td>
<td>38.6°</td>
<td>13.8</td>
<td>2.2</td>
<td>1.4</td>
</tr>
<tr>
<td><strong>Timing of neuraxial analgesia and outcomes of labor</strong></td>
<td></td>
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</tr>
<tr>
<td>13. Provide patients in early labor (i.e., &lt; 5 cm dilation) the option of neuraxial analgesia when this service is available</td>
<td>354</td>
<td>62.7°</td>
<td>31.9</td>
<td>3.1</td>
<td>1.9</td>
<td>0.3</td>
</tr>
<tr>
<td>14. Offer neuraxial analgesia on an individualized basis</td>
<td>354</td>
<td>57.1°</td>
<td>28.8</td>
<td>8.2</td>
<td>4.8</td>
<td>1.1</td>
</tr>
<tr>
<td>15. Do not withhold neuraxial analgesia on the basis of achieving an arbitrary cervical dilation</td>
<td>354</td>
<td>66.1°</td>
<td>26.5</td>
<td>5.1</td>
<td>1.7</td>
<td>0.6</td>
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<tr>
<td><strong>Neuraxial analgesia and trial of labor after prior cesarean delivery</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>16. Offer neuraxial techniques to patients attempting vaginal birth after previous cesarean delivery</td>
<td>354</td>
<td>64.1°</td>
<td>28.2</td>
<td>4.8</td>
<td>1.7</td>
<td>1.1</td>
</tr>
<tr>
<td>17. For these patients, it is appropriate to consider early placement of a neuraxial catheter that can be used later for labor analgesia or for anesthesia in the event of operative delivery</td>
<td>354</td>
<td>53.4°</td>
<td>32.8</td>
<td>10.2</td>
<td>1.7</td>
<td>2.0</td>
</tr>
<tr>
<td><strong>Early insertion of a neuraxial (i.e., spinal or epidural) catheter for complicated parturients</strong></td>
<td></td>
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</tr>
<tr>
<td>18. Consider early insertion of a neuraxial catheter for obstetric (e.g., twin gestation or preeclampsia) or anesthetic indications (e.g., anticipated difficult airway or obesity) to reduce the need for general anesthesia if an emergent procedure becomes necessary</td>
<td>352</td>
<td>56.2°</td>
<td>32.1</td>
<td>7.7</td>
<td>3.4</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>CIE analgesia</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>19. Continuous epidural infusion may be used for effective analgesia for labor and delivery</td>
<td>351</td>
<td>82.6°</td>
<td>15.7</td>
<td>1.4</td>
<td>0.3</td>
<td>0.0</td>
</tr>
<tr>
<td>20. When a continuous epidural infusion of local anesthetic is selected, an opioid may be added</td>
<td>351</td>
<td>80.3°</td>
<td>17.1</td>
<td>2.0</td>
<td>0.6</td>
<td>0.0</td>
</tr>
</tbody>
</table>

(Continued)
### Table 6. (Continued)

<table>
<thead>
<tr>
<th>Percent Responding to Each Item</th>
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</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Analgesic concentrations</strong></td>
</tr>
<tr>
<td>21. Use dilute concentrations of local anesthetics with opioids to produce as little motor block as possible</td>
</tr>
<tr>
<td>Strongly Agree</td>
</tr>
<tr>
<td>N = 351</td>
</tr>
<tr>
<td>Single-injection spinal opioids with or without local anesthetics</td>
</tr>
<tr>
<td>22. Single-injection spinal opioids with or without local anesthetics may be used to provide effective, although time-limited, analgesia for labor when spontaneous vaginal delivery is anticipated</td>
</tr>
<tr>
<td>Strongly Agree</td>
</tr>
<tr>
<td>N = 349</td>
</tr>
<tr>
<td>23. A local anesthetic may be added to a spinal opioid to increase duration and improve quality of analgesia</td>
</tr>
<tr>
<td>Strongly Agree</td>
</tr>
<tr>
<td>N = 349</td>
</tr>
<tr>
<td><strong>Pencil-point spinal needles</strong></td>
</tr>
<tr>
<td>24. Use pencil-point spinal needles instead of cutting-bevel spinal needles to minimize the risk of postdural puncture headache</td>
</tr>
<tr>
<td>Strongly Agree</td>
</tr>
<tr>
<td>N = 349</td>
</tr>
<tr>
<td><strong>CSE analgesia</strong></td>
</tr>
<tr>
<td>25. If labor is expected to last longer than the analgesic effects of the spinal drugs chosen, or if there is a good possibility of operative delivery, then consider a catheter technique instead of a single-injection technique</td>
</tr>
<tr>
<td>Strongly Agree</td>
</tr>
<tr>
<td>N = 348</td>
</tr>
<tr>
<td>26. CSE techniques may be used to provide effective and rapid onset of analgesia for labor</td>
</tr>
<tr>
<td>Strongly Agree</td>
</tr>
<tr>
<td>N = 348</td>
</tr>
<tr>
<td><strong>PCEA</strong></td>
</tr>
<tr>
<td>27. PCEA may be used to provide an effective and flexible approach for the maintenance of labor analgesia</td>
</tr>
<tr>
<td>Strongly Agree</td>
</tr>
<tr>
<td>N = 344</td>
</tr>
<tr>
<td>28. The use of PCEA may be preferable to fixed-rate CIE for providing fewer anesthetic interventions and reducing dosages of local anesthetics</td>
</tr>
<tr>
<td>Strongly Agree</td>
</tr>
<tr>
<td>N = 344</td>
</tr>
<tr>
<td>29. PCEA may be used with or without a background infusion</td>
</tr>
<tr>
<td>Strongly Agree</td>
</tr>
<tr>
<td>N = 344</td>
</tr>
<tr>
<td><strong>Anesthetic techniques for removal of retained placenta</strong></td>
</tr>
<tr>
<td>30. Assess hemodynamic status before administering neuraxial anesthesia</td>
</tr>
<tr>
<td>Strongly Agree</td>
</tr>
<tr>
<td>N = 344</td>
</tr>
<tr>
<td>31. If an epidural catheter is in place and the patient is hemodynamically stable, consider providing epidural anesthesia</td>
</tr>
<tr>
<td>Strongly Agree</td>
</tr>
<tr>
<td>N = 344</td>
</tr>
<tr>
<td>32. Consider aspiration prophylaxis</td>
</tr>
<tr>
<td>Strongly Agree</td>
</tr>
<tr>
<td>N = 344</td>
</tr>
<tr>
<td>33. Titrate sedation/analgesia carefully due to the potential risks of respiratory depression and pulmonary aspiration during the immediate postpartum period</td>
</tr>
<tr>
<td>Strongly Agree</td>
</tr>
<tr>
<td>N = 344</td>
</tr>
<tr>
<td>34. In cases involving major maternal hemorrhage with hemodynamic instability, general anesthesia with an endotracheal tube may be considered in preference to neuraxial anesthesia</td>
</tr>
<tr>
<td>Strongly Agree</td>
</tr>
<tr>
<td>N = 344</td>
</tr>
<tr>
<td><strong>Nitroglycerin for uterine relaxation</strong></td>
</tr>
<tr>
<td>35. Nitroglycerin may be used as an alternative to terbutaline sulfate or general endotracheal anesthesia with halogenated agents for uterine relaxation during removal of retained placental tissue</td>
</tr>
<tr>
<td>Strongly Agree</td>
</tr>
<tr>
<td>N = 344</td>
</tr>
<tr>
<td><strong>Equipment, facilities, and support personnel</strong></td>
</tr>
<tr>
<td>36. Equipment, facilities, and support personnel available in the labor and delivery operating suite should be comparable to those available in the main operating suite</td>
</tr>
<tr>
<td>Strongly Agree</td>
</tr>
<tr>
<td>N = 342</td>
</tr>
<tr>
<td>37. Resources for the treatment of potential complications (e.g., failed intubation, inadequate analgesia, hypotension, respiratory depression, pruritus, and vomiting) should also be available in the labor and delivery operating suite</td>
</tr>
<tr>
<td>Strongly Agree</td>
</tr>
<tr>
<td>N = 342</td>
</tr>
<tr>
<td>38. Appropriate equipment and personnel should be available to care for obstetric patients recovering from major neuraxial or general anesthesia</td>
</tr>
<tr>
<td>Strongly Agree</td>
</tr>
<tr>
<td>N = 342</td>
</tr>
<tr>
<td><strong>General, epidural, spinal, or CSE anesthesia</strong></td>
</tr>
<tr>
<td>39. The decision to use a particular anesthetic technique for cesarean delivery should be individualized, based on anesthetic, obstetric, or fetal risk factors (e.g., elective vs. emergency), the preferences of the patient, and the judgment of the anesthesiologist</td>
</tr>
<tr>
<td>Strongly Agree</td>
</tr>
<tr>
<td>N = 340</td>
</tr>
<tr>
<td>40. Uterine displacement (usually left displacement) should be maintained until delivery regardless of the anesthetic technique used</td>
</tr>
<tr>
<td>Strongly Agree</td>
</tr>
<tr>
<td>N = 340</td>
</tr>
<tr>
<td>41. Consider selecting neuraxial techniques in preference to general anesthesia for most cesarean deliveries</td>
</tr>
<tr>
<td>Strongly Agree</td>
</tr>
<tr>
<td>N = 340</td>
</tr>
<tr>
<td>42. If spinal anesthesia is chosen, use pencil-point spinal needles instead of cutting-bevel spinal needles</td>
</tr>
<tr>
<td>Strongly Agree</td>
</tr>
<tr>
<td>N = 340</td>
</tr>
</tbody>
</table>
Acknowledgments

Support was provided solely from institutional and/or departmental sources.

Competing Interests

The authors declare no competing interests.

Correspondence

Address correspondence to the American Society of Anesthesiologists: 1061 American Lane, Schaumburg, Illinois 60173. These updated Practice Guidelines, and all ASA Practice Parameters, may be obtained at no cost through the Journal Web site, www.anesthesiology.org.

References


PRACTICE PARAMETERS

Table 6. (Continued)

Percent Responding to Each Item

<table>
<thead>
<tr>
<th>N</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>...</td>
<td>...</td>
<td>...</td>
<td>...</td>
<td>...</td>
</tr>
</tbody>
</table>

Note: * Median response.

ASA = American Society of Anesthesiologists; CIE = continuous infusion epidural; CSE = combined spinal–epidural; N = the number of members who responded to each item; PCEA = patient-controlled epidural analgesia.


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