GUIDELINES FOR REGIONAL ANAESTHESIA IN PRE-ECLAMPSIA

Coagulopathy

Isolated HT without proteinuria does not need platelet counts or clotting.

<table>
<thead>
<tr>
<th>Platelet count</th>
<th>Action</th>
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<tbody>
<tr>
<td>&gt; 70 x 10^9/l</td>
<td>Proceed</td>
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| 50-70 x 10^9/l | Check clotting.  
                 | Consider platelet transfusion before R.A.  
                 | Decide individual risk - benefit compared to other courses of action.  
                 | Discuss theoretical increased risk of epidural haematoma with patient if appropriate. |
| <50 x 10^9/l   | Contraindication to RA, especially epidural for analgesia  
                 | Consider platelet transfusion and repeat platelet count before R.A./surgery. |


DICLOFENAC IS NOT TO BE GIVEN TO PRE-ECLAMPTICS, NOR TO CASES WITH POSSIBLE PRE-RENAL INSULT, E.G. MASSIVE PPH

Technique For Caesarean Section in Pre-eclampsia/Eclampsia

Spinal anaesthesia is now becoming increasingly accepted as technique of choice as the evidence suggests that previous concerns of rapid onset causing cardiovascular instability are unfounded.

The alternative is low dose CSE [spinal 1.5 ml hyperbaric bupivacaine 0.5%; wait a few minutes and then extend the block with epidural local anaesthetic].
PRESSOR RESPONSE TO LARYNGOSCOPY IN PRE-ECLAMPSIA

Obtunding the response should be considered in all mothers with PET even if BP is well controlled since the response to laryngoscopy is still exaggerated. However each case must be treated individually and therapeutic intervention tailored to meet requirements. The use of a combination of agents appears to give optimum attenuation of the response.

SUGGESTED PROTOCOLS:

Magnesium Sulphate 30 mg per kg (2 g in 70 kg woman)
+ Alfentanil 7.5 μg per kg (0.5 mg in 70 kg woman)

(Ashton BJA 1991;67:741)

N.B. Magnesium comes as 50% solution: 1 g = 2ml (bottles are very similar to sodium bicarbonate)

N.B. The paediatrician MUST be informed that opiate has been given

1. If mother has recently received a loading dose of magnesium within last 30 minutes or is on an infusion with signs of adequate therapeutic effect then no further magnesium need be given.

1. In severe preeclampsia, when no magnesium sulphate has been given to mother & time permits, consider 4 g loading dose over 5 min as for seizure prophylaxis.

Beta blocker

If the above measures do not adequately control the blood pressure after laryngoscopy then the use of esmolol should be considered. Esmolol should be given as an IV bolus of 1 - 2 mg/kg (0.1 - 0.2ml/kg of 100mg/10ml solution).

If esmolol is administered before the baby is delivered then the paediatrician must be informed in case of neonatal hypoglycaemia and/or bradycardia.

Extubation

The pressor response to extubation may be just as dangerous to the mother and is still exaggerated.

If BP is still poorly controlled prior to extubation, a further dose of esmolol 1-2mg/kg might be appropriate.