5th January 2011

Advice to OAA Members from the OAA Committee:


This report is well written and provides useful additional advice for the management of women with high BMI who make up an increasing percentage of the obstetric population. It contains several recommendations specific to anaesthetic services. These are level 3 evidence.

The OAA recognises that the recommendations are sensible in principle, but may be difficult to achieve within currently available resources, and have responded to CMACE with the following comments:

**Recommendation 7: Anaesthesia in pregnancy and labour**

*Pregnant women with a booking BMI ≥40 should have an antenatal anaesthetic consultation with an obstetric anaesthetist, as recommended by the Joint CMACE/RCOG Guideline on the management of women with obesity in pregnancy. An anaesthetic consultation should allow potential difficulties with venous access, regional or general anaesthesia to be identified and anticipated.*

*Women with a BMI <40 with anticipated problems relating to co-morbidities, airway management, vascular access and regional anaesthetic techniques may also require an antenatal anaesthetic consultation.*

*Maternity services may decide to use a lower BMI threshold, taking into consideration the local prevalence of maternal obesity.*

**OAA Comment:**

There will be a significant workload implication if all women with a BMI >40 have an antenatal face to face consultation with an anaesthetist, especially in regions where there is a higher prevalence of obesity.

All units should investigate the number of cases of BMI >40 to which this recommendation might apply, the workload impact, and make a plan based on a pragmatic response to this information.

Units should establish the BMI threshold that should be used as a mandatory figure, above which all women are assessed. This might be higher than 40, or lower (as suggested in recommendation 7).
Options that might be explored in those units that cannot comply with the recommendation to see all women with BMI > 40 include:

- Screening for low risk women, in whom a consultation is not required e.g. those with previous uncomplicated vaginal deliveries with no anaesthetic intervention.

- Screening and counselling by their midwife and an anaesthetic leaflet given to them, recorded in notes. All women with BMI between 35 and the mandatory level to be given the option to see an anaesthetist if they so wish after reading the leaflet.

- Telephone consultation with an anaesthetist

**Recommendation 7: Anaesthesia in pregnancy and labour**

*Consideration should be given to the timing of an epidural, particularly for women with a BMI $\geq$40.*

**OAA Comment:**

There is general agreement that epidural analgesia can be very beneficial in women with raised BMI, but may be more difficult to site and maintain. Units have different approaches to advising women with raised BMI to have an epidural during (early) labour, from a selective approach to those who would strongly recommend it for all women over a particular BMI threshold. This is taken account of in the OAA ‘High BMI’ information leaflet [www.oaiformothers.info].

The factors involved in the decision to advise early epidural analgesia include the degree of difficulty expected in siting regional analgesia or performing a general anaesthetic, the likelihood of obstetric problems arising during labour and the need for an experienced anaesthetist to site it.

**Recommendation 9: Place and mode of birth**

*An [obstetrician and] anaesthetist at ST6 level or above (or with equivalent experience in a non training post) should be informed and be available for the care of women BMI > 40 during labour including attending any operative vaginal or abdominal delivery and physical review during the medical ward round.*

**OAA Comment:**

The anaesthetic staffing structure in Britain relies on trainees, often at ST5 or below, being resident in hospital, with consultants and senior staff often being non resident on call outside normal working hours. Senior staff will attend high risk cases throughout the hospital as necessary, but if these attendances become very frequent, there will be an impact on job patterns.

As with Recommendation 7, units should investigate the potential impact of this. Many units may currently be staffed by a resident anaesthetist at ST5 level but not ST6.
Where workload can be managed, such as when labour is being induced, this should be timed as far as possible so that the delivery will occur during periods that are better staffed.