Testing Spinal Anaesthesia Prior to Caesarean Section

The following is the consensus view of the AMH anaesthetists.

“Spinal anaesthesia has a very high success rate. Injecting the right volume of the right agents in the right place leads to this very high success rate.”

No test of spinal block will reliably predict all those that will fail. There is neither a consensus nor scientifically sound evidence that testing touch is superior to testing for cold.

The decision whether to proceed under a spinal requires assessment of several factors. Worrying signs are cold sensation at T4 or lower, touch sensation at T8 or lower and/or a poor motor block in the legs. The context of the individual case must also be considered when deciding if a spinal is adequate.

If the block is doubtful the mother should, if possible, be included in the discussion about how to proceed.

Remember that being over-cautious and unnecessarily repeating spinals may also cause problems with high spinals or undetected nerve damage due to pre-existing numbness. Similarly a GA is not without risk.

Assessment and management of spinals is part of the training during the Maternity block so please discuss any concerns with the consultants at this time.

This guidance is intended to supplement and not replace current teaching.

Colleagues are encouraged to use their attachments in the Maternity hospital to develop their practice in this area, and to discuss these issues with consultant colleagues.

Management of Inadequate Spinal Anaesthesia

These circumstances are always easier to handle if a proper preoperative discussion has taken place.

If inadequate pre-op: Repeat spinal if it was straightforward and no urgency to deliver, otherwise GA. See Dr Knox’s Recipe Book for more advice.

If inadequate intra-op: Conversion to GA is almost always the best option if problems occur early on in the surgery. Always make a positive decision, one way or the other, prior to uterine incision because delivery should not be delayed once this has been performed. Also any prior discomfort is likely to get worse at this stage. Options other than GA include intermittent IV opioids (e.g. Alfentanil), Entonox and low doses of Ketamine all of which can be used pre delivery. Local infiltration by the surgeon can be useful if the problem occurs at closure.

Ensure the patient is followed up post-op, preferably by yourself. Provide an honest explanation of what happened and answer any questions or concerns they may have. Arrange for further follow-up by senior staff if the patient was
severely distressed or remains traumatised. Inform them that, should they become pregnant again, they can ask for an appointment to see an anaesthetist to discuss these events again and plan anaesthetic management for their next delivery.

**Document everything** intra-op and post-op, including reasons why particular decisions were made.

**Report all such cases on Datix** (see Critical Incident Reporting (Datix)).