For an Australian, tracking out to Serbia is a major undertaking; so when the opportunity to visit this country comes up with the OAA, it took little convincing. My connection is made through Dr Geraldine O’Sullivan, current Chair of the International Committee of the OAA, the host of my sabbatical leave from the Royal Women’s Hospital, Melbourne.

This year, the international refresher course was held at Sremska Mitrovica, Serbia. I flew with the English faculty of the meeting to Belgrade on Friday 23rd November. We were greeted by Dr Mirjana Kendrisic, Chair of the local organising committee, and her colleagues. Dr Kendrisic is the Chief of Anaesthesia at the Sremska Mitrovica Health Centre. Maria Theresa of Austria (1816-1867) founded the hospital, primarily as a military hospital. Today, it is the second largest regional hospital in Serbia.

Belgrade is about a 3 hour flight from London. In the course of its history it has survived attacks from over 40 armies, having been a city of the Federal Republic of Yugoslavia, then of the State Union of Serbia and Montenegro, and now of the Republic of Serbia. It has a population of approximately 2.5 million. The unemployment rate is officially reported as 25%, however, the locals say that this is rather conservative – it is more like 40% to 50%. Another statistic is that 38% of the senior citizens carry firearms.

Kalemegdan Park, with its fortress, overlooking the confluence of the Danube and Sava Rivers dominates Belgrade city (Picture courtesy of Dr Paul Howell, and adapted by Maggie Wong).

The meeting, “Providing Anaesthesia and Analgesia in Obstetrics”, was held in the City Hall which was filled to full capacity (about 300). It attracted registrations from anaesthetists, obstetricians and midwives from Serbia and neighbouring countries. Some delegates travelled hours by coach to attend this course. Most of the presentations were delivered in English with excellent simultaneous translation.

Medically, Serbia is less developed than its neighbours such as Croatia and Macedonia. Regional anaesthesia is rather infrequently used. A 2005 local survey, with responses from 97 anaesthetists working in 4 obstetric clinics and 8 regional hospitals, showed that 93% elective and 99% emergency Caesarean sections were done under general anaesthesia. When regional anaesthesia is used, the reported postdural puncture headache rate is 10%. Pencil point spinal needles are not readily available. Some surprising reasons given for preferring general anaesthesia in obstetrics include the belief that it is a safer option, and that regional anaesthesia is associated with “hypotensive crisis” (38% surveyed stated this). On Sunday 25th November, we were taken on a tour of the local hospital. The Sremska Mitrovica Health Centre has over 500 beds. It performs approximately 17,000 operations and 1800 deliveries per annum. Types of procedures include ENT, general, gynaecological, ophthalmological and orthopaedic surgery. The Caesarean section rate is about 20%-25%. Surgical patients are virtually all inpatients; few, if any are admitted and discharged on the same day of surgery.

There are 5 operating theatres and an intensive care unit which is very simply equipped. In the delivery suite, women labour in a 6 bedded shared room, then transfer to cubicles for vaginal delivery. Both antenatal and postnatal wards are noted for the lack of nursing staff. There is a nominal obstetric HDU, but again a lack of trained staff and medical equipment for its proper utilisation. Caesarean section is done in the one delivery suite operating theatre. Although the rate of general anaesthesia is high, capnography is not always readily available.

Dr Mirjana Kendrisic and her team should be congratulated for organising a very successful meeting.

Finally, I would once again like to thank the OAA for giving me the opportunity to see one of their projects close up.

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Wednesday 27 February 2008 saw the Annual Cases and Controversies in Obstetric Anaesthesia Meeting. This year the meeting returned to Church House Conference Centre in Westminster which has been refurbished and was a splendid venue.

The meeting opened with two cases. Dr Monaghan from Manchester presented a cautionary tale of the complications of using interventional radiology in massive obstetric haemorrhage and a summary of the evidence for the use of intravascular balloon catheters. Dr Ramasamy from Leicester presented a case of Sickle cell Anaemia and a comprehensive review of the anaesthetic and obstetric management of this condition.

The first controversy debate occurred next. Dr Russell proposed the motion “Routine use of the sitting position for spinal anaesthesia should be abandoned”. Dr Dresner opposed the motion. Dr Russell argued that the lateral position is better for mother and fetus especially in an emergency situation and also gives better results and that routine use of the sitting position was detrimental to the production of a properly trained anaesthetic workforce. Dr Dresner argued that there were multiple factors affecting the effectiveness of spinal anaesthesia. Prior to the debate only 11% of the audience supported the motion, increasing to 34% by the end.

The next two cases were presented by Drs Dresner and Misra and provided a forum for debate about the management and detection of misplaced epidural catheters.

After lunch we were treated to a fascinating controversies debate. Dr Mignon proposed the motion that “Genetic Variability has no practical implications for the obstetric anaesthetist” and was opposed by Dr Landau. The many practical, economic and ethical problems of using genetic information in a clinical setting were covered, but many in the audience had their eyes opened by Dr Landau to the potential benefits of Pharmacogenetics. 37% voted for the motion and against 49% by the end.

The next two cases were presented by Drs Lyons and Misra and concerned the management of twin deliveries. Attention was particularly given to the second twin who runs increased risks and needs speedy delivery if things go wrong.

The final controversy was “Remifentanil PCA should be routinely available for use in Labour.” The proposer was Dr Hill from Belfast who showed us how popular it was with women in his unit and how it was being used safely and satisfactorily. He was opposed by Dr Van de Velde who examined the scientific evidence and compared remifentanil unfavourably with the gold standard of an epidural and expressed concerns over safety and efficacy. Dr Van de Velde managed to sway the audience. Only 30% were against the motion at the start, but 51% were against by the end.

In all it was a thoroughly enjoyable and educational day and the organisers and all the speakers deserve to be warmly congratulated and thanked.

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