The Shrewsbury and Telford Hospital NHS Trust

Standard Operating Procedure (SOP)

SOP Title	**Women who require obstetric anaesthetic referral.**		
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Care Group	Women and Children's		
Version Number	5.0		
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Author	Dr G Dashputre		
Approved by	Maternity Guideline Group, Maternity Governance		
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Distribution	All Maternity Areas		
Location	Maternity Services		

Document Control				
Version	Date	Author	Status	Comments
1	20th June 2014	Guidelines Midwife	New	New SOP
2.0	30th January 2017	Lorien Branfield	Full review	
3.0	February 2021	Lorien Branfield	Full review	Bring in line with national guidance RCOA ACSA.
4.0	May 2023	Lorien Branfield	Minor updates	
5.0	February 2024	Dr Dashputre	Reviewed	No changes

SOP Objectives	▪ To identify and provide the safest and highest quality analgesia and anaesthesia to mothers before, during and after the birth of their baby. ▪ To allow a detailed antenatal assessment of the high-risk mother and to identify the need for any additional services they may be require. ▪ To prepare an individualised peri partum multi disciplinary care plan for these women, with an aim to improve effective communication and facilitate teamwork on the labour ward. This should also avoid unanticipated difficulties in case of emergency presentation. ▪ The clinic provides an opportunity for women to discuss methods of labour analgesia and the appropriate anaesthetic technique in case of operative delivery.
Scope	Risk Assessment and Support Midwives/Obstetricians
References	OAA/AAGBI (2013) Guidelines for Obstetric Anaesthetic Services www.aagbi.org/sites/default/files/obstetric_anaesthetic_services_2013.pdf

Number	Brief	Responsibility
1	More and more women with co-existing medical conditions are becoming pregnant. These women are an increased risk of morbidity and mortality during birth. Antenatal anaesthetic clinic permits early identification and detailed assessment of high-risk mothers. It is a requirement that there should be a formal system to ensure that these women are seen and assessed by a senior anaesthetist within a suitable time frame, preferably in early pregnancy.	
2	**Indications for referral** The following list is not exhaustive, for any additional advice concerning referral, contact Dr G Dashputre directly or the on call Obstetric Anaesthetist **Past/family history or potential problems with anaesthesia** ▪ Difficult or failed intubation or anticipated difficult airway. ▪ Anaphylaxis. ▪ Suxamethonium apnoea. ▪ Malignant Hyperthermia susceptibility. ▪ Porphyria. ▪ Previous painful labour or operation in a patient who fears a repeat experience. ▪ Problems or complaints after previous general or regional anaesthesia. ▪ Severe needle phobia. ▪ Difficult venous access in the past, or predicted difficult venous access in the future, where it is likely that a peripheral cannula would be impossible to site even with appropriate expertise. Examples would include chronic IV drug users or chemotherapy patients where central venous access is predicted to be required **Spinal** ▪ Previous back trauma or surgery (e.g. Harrington rods, discectomy, laminectomy). ▪ Congenital abnormalities (e.g. kyphoscoliosis, myelomeningocoele, spina bifida). **Neurological** ▪ Multiple sclerosis ▪ Myasthenia gravis ▪ Spinal cord injury **Cardiorespiratory** Pregnant women who have a history of cardiac disease should have full documentation available in their Maternity and Medical notes. The consultant cardiologist will be informed of the pregnancy and advice sought on collaborative management. Women with complex cardiac disease should be managed in a tertiary centre. Patients with severe respiratory disease should have their management optimised by the respiratory consultant prior to anaesthetic referral. **Haematological disorders** ▪ Von Willebrand's disease, haemophilia, or other inherited coagulation disorders. ▪ Platelet deficiencies (thrombocytopenia with count <100) or platelet dysfunction. ▪ Therapeutic anticoagulation (not thromboprophylaxis). ▪ Sickle cell disease.	Obstetric Anaesthetist

	Other • Patients who decline blood products, including Jehovah's witnesses • Systemic disease (e.g. systemic lupus erythematosus, rheumatoid arthritis, ankylosing spondylitis). • Pre-existing renal disease and renal transplants • BMI > 35 with other co-morbidities • Diabetes (either gestational or pre-existing) with the following- ➢ Blood sugars consistently above 10 despite maximum medical management ➢ Has presented to hospital 2 or more times in pregnancy with diabetic ketoacidosis (DKA) ➢ Is known to have very poor compliance leading to high sugars and/ or DKAs.	
3	**Exceptions/Exclusions for referral** ▪ Referrals for **BMI equal to or more than 40** are automatically made using the Maternity Information System (MIS) and **do not require** a referral letter. ▪ **Chronic backache** or **slipped intervertebral discs** are not contra-indications to regional anaesthesia and **do not require** an ante-natal anaesthetic assessment.	
4	**Method of Referral** Referrals can be made by either a Midwife or Obstetrician, via the maternity information system (MIS). Any difficulty is encountered when making a referral via the MIS, contact the anaesthetic secretaries at either PRH or RSH who will help you. **All referrals should contain the following information** Name and unit number, address, referring clinician, assigned Consultant Obstetrician, clinical indication for referral and pregnant woman's **EDD** this is really important, as helps with when to book appointments. Ensure the women is aware the reason for the referral to the Obstetric Anaesthetist. Please ensure any special requirements are communicated such as a need for an interpreter.	Risk Assessment and Support Midwife/Obstetrician