Recap Day 1&2

Day 1 - Physiological changes

- A – more difficult intubation
- B – Quicker desaturation – 1minute
  - high oxygen demand, lower FRC
  - pre-oxygenate – gives 2-3 mins
- C – Vena Cava Syndrome
  - Wedge Wedge Wedge
  - lower Hb – increased blood volume
- Increased risk for aspiration

Always do RSI if GA in pregnant woman or newly delivered (retained placenta etc)

- Preoxygenate!
- Suction available!
- Sodium Citrate
- Thiopentone/Ketamine
- Suxamethonium
- Cricoid pressure
- Intubate

Golden Rules

- A
- B
- C
- Oxygen
- Lateral position
- IV access
- Fluid

- First sign of ongoing haemorrhage and shock is tachycardia
- Communication between surgeons and anaesthetists v important
- Ventilate if cant intubate RSI – hypoxia more dangerous than aspiration
- Retained placenta
  - Spinal (low dose) or GA
  - NOT mask (high aspiration risk)

Day 2

Neonatal Resus

- Blue, floppy newborn. What are the first things to do?

- Call for help!
- Tactile stimulation
- Keep baby warm & dry
- Start clock

- ABC
  - Colour, tonus, breathing
  - A – position, suction mouth if needed
  - B - Ventilate
    - how much pressure?
    - how fast?
    - for how long?

- As little pressure as poss, max 25-30cm H_20

- 60/min

- 30 seconds (30 breaths)

- Suction in trachea?

- Rarely necessary!

- C - listen heart.
  - If <60 – compressions. How?

- Between nipples
- Hand encircling / finger technique
- 1/3 of thorax
- 100/min
- 3:1 compressions:breaths

- IV cannula – where?

- Front wrist
- Scalp
- foot
- External jugular
- Femoral

- In tube

- Adrenaline – dose?

- 10mcg/kg

- If 1mg/ml adrenaline (=1000mcg/ml)
  - dilute with 9 ml Nacl = 100mcg/ml
  - give 0.1ml/kg
  - 0.3ml to 3kg baby

- Other drugs
  - Buffer
  - IV fluid/blood 10ml/kg

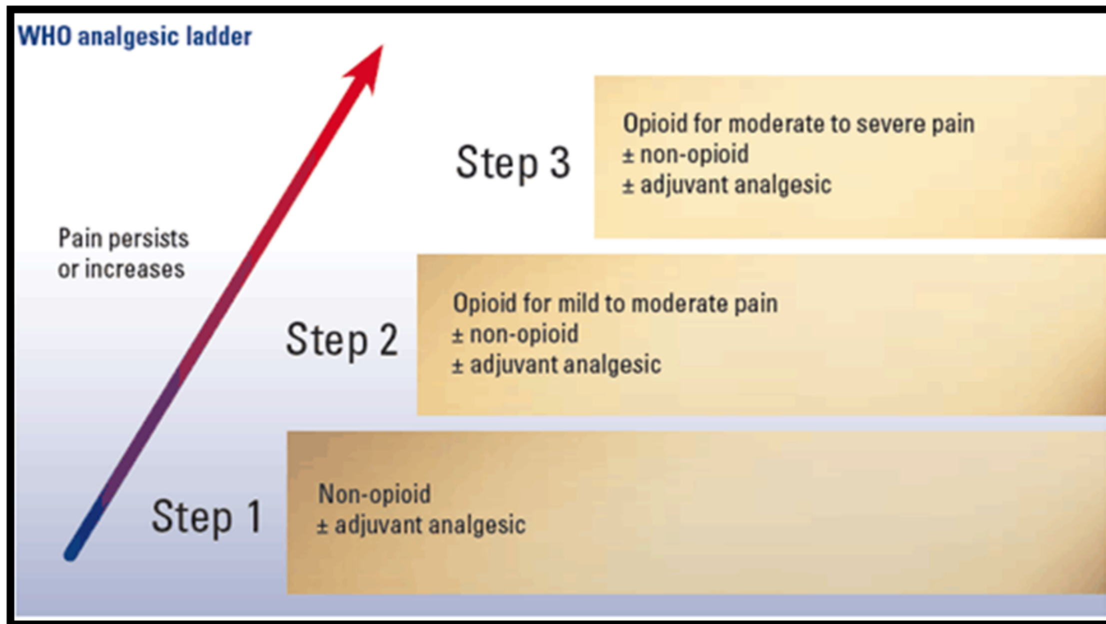
- Intubate – which size tube?

- 3 – 3.5

Pain

- Ask patient how much pain
- Have a pain scale
  - 0, +, ++
  - Mild, moderate, severe
  - VAS 0-10
- Document pain

WHO Pain Ladder



”Strong” opioids

”Weak” opioids

Paracetamol, NSAID

PCM

- Give to all pain, mild, moderate, severe!
- Helps even severe pain (together with stronger drug)
- Can be given pre-op orally (like other drugs, not aspiration risk if only small amount water)

- Liver failure

NSAIDS

- Very useful
- Contraindications?

- Pregnancy – closes Ductus Arteriosus
- Atonic uterus

- Kidney failure
- Peptic ulcer
- Haemorrhage/ bleeding problem
- (Asthma)

- Morphine sc/im/iv (sc good)
  - 0.1mg/kg = 5-10mg prn or qds

- Pethidine 1mg/kg = 50-100 mg prn or qds

- Don’t worry about resp depression or addiction if in pain!

Spinal anaesthesia

- Spinal better than GA for C/S – why?

- Less mortality (failed intubation, aspiration)

- Awareness
- Effect on newborn
- Uterine atony

- Bupivicaine best (12.5mg gives 2hrs anaesthesia)
- 5% Lidocaine ok, but what are problems?

- Shorter duration
- Transient neurological symptoms (rare)

- Contra-indications for spinal?

- Hypovolaemia – most important!
- Coagulation problem
- Local infection
- Sepsis
- Patient refuses

- (immediate C/S)
- (spinal failure)

How to conduct spinal

- Aim L3-L4
- Concurrent NaCl / Ringer FAST
- Vasopressor (Ephedrine 5mg) immediately
- Lie patient down
- Wedge Wedge Wedge!
- Check BP & HR every minute if poss
- Check blockade – up to which level?

- T4-T5
- If incomplete blockade – what can you do?

- New spinal – not recommended
- GA – which drugs, how to do?

- RSI!

- Oxytocin – what dose?

- 5 IU IV SLOWLY! (can be repeated)

Thurs timetable

- 8am Recap
- 8.30 Eclampsia / Pre-eclampsia
- 9.30 Oxford Handbook Anaesthesia

10.00 Coffee

- 10.30 Pre-op
- 11.30 Post-op
- 12.30 Test

13.00 Lunch

- 13.45 Feedback
- 14.15 Test discussion & Certificates
- 14.45 Closing speech
- 15.00 End