Outpatient anaesthetic consultations for pregnant patients

To the Editor:

The preoperative anaesthesia visit is considered by many to be the most important part of any anaesthetic. It is at this time that we establish rapport with the patient, calm her "fears," explain the risks and finally, satisfy ourselves that the risks and benefits of the various anaesthetic techniques are understood and accepted by the patient. There are, however, many patients that are not seen except immediately before entry to the operating room, e.g., outpatients and obstetrical patients. While the absence of a preanaesthetic visit for these patients appears to be standard practice, it was our impression that selective obstetrical patients would benefit by being seen prior to the onset of labour.

We instituted an outpatient consultation service for pregnant patients and the following is a review of the first five years (1982–87). One hundred and thirty-nine patients were seen. The reasons for referral can be broadly split into three groups: medical reasons (60 per cent) (Table I); history of a complication of epidural anaesthesia or previous unpleasant experience with epidural anaesthesia (25 per cent) (Table II); and patients who were concerned about the risks of obstetric anaesthesia (15 per cent) (Table II).

Six patients were referred because they were concerned about previous anaesthetic complications (Table II). In one, a generalized seizure had occurred after an intravascular injection. Severe paraesthesia occurred in one other patient but she had no postoperative neurological deficit.

TABLE I Outpatient referral for medical reasons (n = 83)

Allergy	8
MH susceptibility	8
Plasma cholinesterase deficiency	2
Low back pain and degenerative disc disease	24
Back surgery	
Harrington rod	6
Spinal fusion	3
Spinal deformity	10
Neurologic disease	
Multiple sclerosis and possible early MS	10
Other	6
Coagulation disorder	
Van Willebrand's disease	1
Heparin Rx for DVT	1
Haemophilia A carrier	1
ITP	1
Idiopathic hypertrophic subaortic stenosis	1
Sickle cell disease	1

TABLE II Previous unpleasant experience with epidurals or anxiety about risks of anaesthesia (n = 56)

Epidural complications	6
Unpleasant experience with epidural	
Poor analgesia	10
Difficult insertion	17
Postpartum backache	2
Concerned about risk	21

Hypotension developed in two patients; one lost consciousness and the other had nausea and vomiting. There were two patients who developed arm weakness with the perineal dose for vaginal delivery.

When the service was established in 1982, two of the major aims were to meet both partners in a stress-free surrounding and to obtain a more complete history. If necessary, additional laboratory tests were requested and radiographs reviewed. Consultation reports from other specialties could also be requested. It became clear, however, that an important part of these consultations was patient education and this was true whether the patient was healthy or had a disease with major anaesthetic implications. The risks and benefits of epidural analgesia in comparison with the other forms of analgesia were discussed. Hopefully, a more informed consent could be obtained from both partners.

It is difficult to prove that we decreased the risk of anaesthesia. Nevertheless, if one believes that better informed anaesthetists and patients contribute to safety, then these anaesthetic consultations should be continued and promoted. We feel that every obstetrical centre with anaesthetic services should have a program in which obstetrical patients can be seen before the onset of labour. The mechanism of referral should be common knowledge to all concerned and all patients should be given the opportunity and encouraged to speak to the anaesthetic staff if they have questions about anaesthesia.

In all, we have been satisfied with the development of this service and we feel that it serves a worthwhile function in our anaesthetic practice today.

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