YSOA NEWSLETTER

EDITOR: Dr Kay Robins

YORKSHIRE SOCIETY OBSTETRIC ANAESTHETISTS

Issue 21/ August 2022

Presidents Message

Dear YSOA member,

I do hope you are enjoying your summer? Good luck to all those anaesthetists changing hospitals, I hope you enjoy your new workplaces and settle in quickly!

I had the fortune to spend my summer holiday in Anglesey again a couple of weeks ago. It was glorious kayaking in the sea around the little coves of Trearddur Bay and Rhoscolyn, on a baking hot summers' day, but I did think briefly of my poor Yorkshire colleagues travelling, working or trying to sleep after a night shift in the sweltering 38 degree heat. Environmental responsibility within healthcare thankfully is becoming much more of a priority for senior leadership within the NHS. At our YSOA ASM this April, we were treated to a very informative and thought-provoking talk from Dr Orr, Sheffield Teaching Hospitals. You can read a summary of all the presentations further down in the newsletter. Obstetric Anaesthetists put patient safety at the forefront of their work (our other presentations given at the ASM are testament to that) but we are also in a very good position to make environmental responsibility within obstetric theatres a key area of our focus too. If every YSOA member were able to introduce one or two small changes suggested by Dr Orr in their unit and encourage their department and senior leaders within their Trust to make sustainable switches, what differences we could all make together. Go forth dear member – see what little changes you can make!

Dr Sarah Radbourne: YSOA President

Dr Sarah Radbourne—President of YSOA

Hinsley Hall, Leeds, Anniversary Meeting, Friday 30th September 2022

Dates for your diary

YSOA Anniversary Meeting

Friday September 30th 2022

Fee £25, includes Dinner

Contact: Wayne Sheedy at

obstetricday@hotmail.co.uk

YSOA Annual Scientific Meeting 2023

Venue TBC , Tuesday 25th April 2023.

Contact: Wayne Sheedy at

obstetricday@hotmail.co.uk

Membership details

Membership is free to all trainees and consultants in the Yorkshire and Humber region. Membership ensures you receive information regarding upcoming events and this amazing newsletter!

If you wish to become a member please forward the following information to:

obstetricday@hotmail.co.uk

Name:

Grade:

Employing Trust:

Locality if in a training post (East/South/ West)

A reliable contact email address:

YSOA website and Podcasts

Podcasts from the ASM 19 are available to download from our website www.ysoa.org.uk

Username:

Admin

ysoa@gmail.com

Password:
Green42Carwash
%$*ysoahull@$)

Dates of courses

Obstetric Anaesthetic Emergency Course for CT2s

Hull Clinical Skills Facility	tbc
York	tbc
Bradford	tbc

For more information please go to the Yorkshire and Humberside Deanery Website

TOAASTY Advanced Obstetric Course

for senior trainees and consultants

Hull Clinical Skills Facility	Tuesday 18th October 2022

Contact: anju.raina@nhs.net or Claire.pick@nhs.net

Yorkshire Difficult Airway Course

tbc

YSOA 2022 Annual Scientific Meeting Review

Principle Hotel, York, 26th April 2021

It was an absolute delight to be able to hold our Annual Scientific meeting face-to-face this year! If you weren't able to make it, you missed an absolute treat of a day. The Principal Hotel, York, didn't disappoint as a venue and there was such a buzz of conversation during the breaks as colleagues enjoyed an opportunity to catch up over coffee and cake.

We were delighted that our programme received fabulous feedback. We had jam-packed it with an amazing line-up of speakers, and we had numerous comments on what great value for money the day had been.

As always there were a few last minute/ on the day hiccups– two of our speakers were unable to attend in person due to isolation rules, which meant we had to rapidly adapt our programme. Thankfully the AV set-up allowed us to have the speakers presenting remotely and Wayne Sheedy, our administrator was able to save the day.

So the day kicked off with Dr Woolnough from Sheffield speaking to us on Anaesthesia for Placental Adhesive Disorders. Her focus was on the management of Placental Increta (FIGO 2) and Percreta (FIGO 3) as Sheffield is a tertiary referral centre for women with these disorders. Dr Woolnough explained that in such cases, the women would always have a hysterectomy. As not all the placental tissue will be involved in the abnormal adherence, the surgeon would want to "deliver" the uterus before significant blood loss arose from the partially separating placenta. Women have their Haemoglobin and fibrinogen optimised before surgery, cell salvage is employed with a second ODP using the emergency protocol initially, a rapid infuser is primed with 2 units of crossmatched blood before commencing surgery. Patients receive a spinal plus GA for their procedure; a surgical pause is carried before entering the uterus. Average blood loss is 4.75L, fibrinogen concentrate is preferred to cryoprecipitate. Sheffield have managed over 65 cases since 2011.

Dr Shanthi, Regional Anaesthesia anaesthetist from Mid Yorkshire, then followed with an introduction to the use of ultrasound in obstetric anaesthesia. We were fascinated by images of challenging spines where USS would give the anaesthetist a significant advantage in accessing the epidural and intrathecal spaces. Dr Shanthi had some great interactive slides that demonstrated the ultrasound pictures gained at each level of the lumbar spine. An overview of USS for spinal and epidural placement, transverse abdominis plane blocks, Rectus sheath blocks, quadratum lumborum blocks and the challenges encountered in these blocks was given to us. Delegates had the opportunity at each break to observe demonstrations by Dr Shanthi and practice their ultrasound scanning on human models (thank you to Sharwend and Oliver for being great sports!). This station was very popular, and we were very grateful to Sonosite for loaning us ultrasound machines, to make the most out of Dr Shanthi's presentation.

Contact Us

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Mr Wayne Sheedy

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Visit us on the web at www.ysoa.org.uk

Please email any comments or feedback regarding this newsletter to W Sheedy as above.

Please forward this newsletter to your obstetric anaesthetic colleagues and trainees to let them all know all the news – thank you.

Kay Robins , Editor (York)

Dr Goodhall, Consultant Obstetrician and Gynaecologist from Belfast gave a captivating (and slightly anxiety producing) talk on physiological CTG. Her presentation gave a lovely summary on the features of a CTG that will be discussed by the MDT labour ward team. We were shown figures from Each Baby Counts (Nov 2018) which suggested that two-thirds of the 1123 cases of baby injury could have been preventable. Saving Babies Lives 2019 report stated that one of the 5 key elements for good outcomes was effective fetal monitoring during labour. We were reminded that fetal monitoring was only part of the overall assessment of both mother and foetus, and it is used to allow timely detection and intervention of babies who are showing signs of hypoxia, whether it be acute, sub-acute, chronic or gradually evolving. Dr Goodhall reminded us of the influence of human factors; of being task focused, overwork, complacency and norms, involuntary automaticity etc. Her presentation generated lots of questions from the audience!

Dr Tim Orr from Sheffield, then got our brains ticking on a completely different topic- Sustainable Obstetric Anaesthesia. We were shown some alarming statistics of the environmental impact of a rising atmospheric carbon dioxide concentrations, that the NHS is responsible for 4-7% of the UK's carbon emissions, over 25 million tonnes in 2019. Within anaesthesia, Tim highlighted the huge environmental impact that nitrous oxide has on the gas footprint for anaesthesia. Statistics from Sheffield Teaching Hospitals data showed that Entonox and nitrous oxide accounted for over 3600 tonnes of CO_2e (equivalent to driving 14 million miles in a regular diesel car), desflurane 400-600 tonnes, remaining volatiles 100 tonnes. 96% nitrous oxide gas from manifolds was being lost before even reaching the anaesthetic machine. Tim gave evidence to suggest that Nitrous oxide didn't have any effect on reducing awareness or obstetric haemorrhage. Epidural and remifentanil analgesia carry a significantly lower impact on CO2e than entonox, using alternative methods to test regional anaesthesia blocks over ethyl chloride spray, reusable gowns, reducing unnecessary glove use, rationalising spinal packs for plastic waste, inditherm versus plastic Bair huggers are some of the many opportunities he described that anaesthetists can take to reduce anaesthetic carbon footprint.

Chloe Davies, Associate Solicitor from DACBeachcroft kick-started our afternoon sessions with an in depth look at capacity and consent in obstetric anaesthesia. She reviewed the fundamental principles of consent and challenges in achieving valid consent, re-summarised case law for consent and capacity from high profile cases such as Bolam, Chester versus Afshar, Montgomery and the challenges anaesthetists face in meeting these fundamental principles. Alarmingly, Montgomery can be applied retrospectively to surgery carried out prior to the Montgomery case in 2015. Chloe stressed that recording as much detail as possible on the discussions taken with patients about their procedures within the patient's notes as well as on the consent form can give solicitors much more information on the length of time of the discussion with the patient and more intricate detail, especially when consenting for surgery where there may be multiple potential outcomes for the patient. Obstetrics account for 11% of claims brought to the trust, but for 60% of the damages paid out. Reassuringly, anaesthetists account for less than 1% of clinical cases, of which often this is related to incorrect medication being given, the civil or criminal offence of battery, language barriers – unbiased translation to prevent coercion in vulnerable patients, or cultural issues.

Assessment of a patient's capacity is integral to ensuring a clinical has obtains informed consent, MCA 2005. Chloe gave examples of where an application to the court of protection was required to plan for a caesarean section in a patient suffering from a severe mental illness. The patient was then assessed to have capacity 4 weeks later and went on to have a vaginal birth. Chloe discussed circumstances where the woman may lose capacity during her labour and explored whether in that circumstance the pre-labour prepared birth plan should be reverted to, versus acting in best interest, and guided us that clear documentation to explain discussions between health professionals and the decision-making process prior to any intervention is imperative. Chloe looked at consent challenges in children for teenage pregnancies, especially age 16-17 years where they technically can give consent, but they may refuse life-saving treatment. As they are not 18 years the court of protection may override the teenager's refusal of consent.

Chloe discussed the impact of COVID on the management of women's ante-natal and emergency obstetric care. She stressed that it is important to document what was happening at that time "on the ground" to help the solicitor understand the complex and competing circumstances at the time – for example significant staffing shortages due to COVID sickness, how many patients were on labour ward at the time with the increase in birth rate during COVID, delays into theatre due to the requirement for time-consuming PPE application.

Rose Buckley from STHs explored the use of Checklists in Obstetric Anaesthesia. She first looked at the use of a checklist for induction of general anaesthesia for the obstetric patient, referring to the higher risk of difficult or failed intubation and of awareness during obstetric general anaesthesia. Rose explained that STH had experienced a series of failed intubations over a 4-year period; investigations had noticed the common themes of higher BMI, ethnicity, age over 30. STH had also recognised that the use of head scarves by the patients, resulted in a flexed nature of the woman's neck leading to difficult or failed intubation. The subsequent development of the GA checklist took on the mnemonic I AM HAPPY for IV access, Anaesthetic drugs, Monitoring and equipment, History/HELP, Airway assessment, Positioning and cricoid, Pre-oxygenation, Your failed intubation plan. Rose explained that as the anaesthetist and ODP went through the checklist in preparation for induction, the theatre team took this as a prompt to become quiet and enable full attention to prepare for the GA.

Rose showed us examples of the aviation industry checklists and highlighted that although there may have been slight differences in the questions asked, all aviation checklists use the same fonts, size, use of indentations, dots and ordering of sections to reduce error. She showed the use of the challenge/response technique to avoid complacency with the checklist. She also pointed out that checklists can also be used for emergency briefs, Epidural insertions, PPH guidance, Rotem protocols etc.

Dr Debbie Horner from Bradford then gave the YSOA delegates an update of the work she and her team have been doing with the Yorkshire and Humber Maternal Enhanced and Critical Care (MEaCC) Steering Group. Debbie reviewed the MEaCC Critical Care Competency and Training Framework document, EMC and AIMS training and explained to use the need to collect EMC data, noting the challenges in doing this. The MEaCC Data Portal was developed in 2020 and from 2021 all 17 maternity sites across Y&H are now actively collecting MEaCC data. The portal is a similar system to the NELA portal. Initial data has demonstrated that PPH, Hypertensive disorders and Sepsis collectively account for over 80% of the causes that are being logged. Interestingly 90% of the women requiring EMC did not have invasive monitoring and only 7% of the women requiring EMC were transferred to critical Care. Debbie stressed the importance of a daily MDT review, including midwifery, when women were being cared for on Critical Care, ensuring continuing contact with baby when being cared for on critical care and encouraging good links with CCOR.

Alison Coloun and Jamie Douglass ended our packed-out day with a lively discussion/debate on High Flow Nasal Oxygen use in obstetrics. Jamie pointed out that he would be making a distinction between using HFNO for pre-oxygenation, supporting oxygenation for awake patients when undergoing a regional anaesthetic, emergence following GA and for apnoeic oxygenation (THRIVE). HFNO and THRIVE need a patent airway to be successful in supporting oxygenation. Alison explored the use of HFNO post-GA section and the PRIOROB trial, its benefits for use in patients with increased oxygen consumption such as in sepsis or compromised respiratory system such as COVID and a regional technique. Overall, the audience remained in favour of a role for HFNO within obstetrics but were much better informed on the research data and pitfalls in its use.

Regards

Drs Sarah Radbourne,

YSOA President