**OB Anesthesia Core Rotation**

Welcome back! You have already completed your one-week obstetric anesthesia orientation; you may have taken several OB calls, and have become somewhat familiar with the daily L&D schedule. The goal of this one-month block is to give you a more in-depth education in OB anesthesia.

The education schedule is divided into four one-week blocks that will allow you to have repeated exposure to new information and skills. Because there may be two CA-1 residents rotating through the service at one time, the order of the weeks may be different for you.

- Week A: Cesarean Section (C/S)
- Week B: L&D Floor, the laboring patient, and Obstetric Care
- Week C: Pregnancy, Pre- And Post-Partum
- Week D: High Risk and Co-morbidity

We are looking forward to having you here for one month and ensuring that you will become a proficient and pro-active member of the OB team. Remember, OB anesthesia is a team effort. No matter what your general assignment is for the day, you are expected to help out with all of the duties on the floor.
**Week 1**  
*Cesarean Section*

The goal will be to expose you to the most common obstetric procedure: Cesarean delivery. During this week you will be assigned most often as the resident performing the anesthetic for cesarean deliveries. You will be involved in all (or most) cesareans, including the scheduled C/S (starting at 8.00am) and emergent/non-scheduled C/S that happen throughout the day. Approximately one quarter of all parturients deliver by cesarean, so you must become an expert in all respects.

*Tasks:*
The patients are pre-op’d in two ways: phone survey conducted by the resource nurse (for healthy patients with no significant issues) and a formal in-house pre-op visit. As often as is possible, you should try to perform the in-house pre-ops, as you may be conducting their care. All pre-ops should be reviewed with an attending the day before.

The morning of surgery, you should meet the scheduled patient, review her history, obtain consent, and ensure that the OR is ready. A ready OR is one that does not require ANY additional materials. This is essential! Obstetric anesthesia can be very high-risk, even with the most ‘low-risk’ patient.

It cannot be stressed enough that the L&D OR’s must be set up as the first thing in the morning. Both OR’s must be ready to go at a moment’s notice. There are very few ‘stats’ that are as active and fast as a stat cesarean delivery; the operating room must not become a place of chaos. When one OR is being used, the other must be available for all emergencies. This means that the pillow must be in place, the ecg leads set, the hip wedge in place, etc. There is no time to find a missing armboard, for example.

Even though all of the patients are seen the following day, you should see all of your post-op’s, too. Anesthesia is more than a procedure.

**Relevant Reading:** All chapters are from Chestnut
- Anesthesia for C/S Ch. 26
- Difficult airway management Ch. 30
- Resuscitation of the newborn Ch. 9
- Pulmonary Aspiration of gastric contents Ch. 29
- Anesthesia related Maternal Mortality Ch 39
Week Two
L&D Floor, the laboring patient, and Obstetric Care

During this week you will be learning about labor and delivery. You have already learned how to place neuraxial analgesics (LEA, CSE), and you should be fairly comfortable with the straightforward case. Good! Placing an epidural is like starting an IV in the main OR. It is essential that you can do it, but is just the start of you education. Now you can start to concentrate on the patients, their medical, obstetric, and psychological issues.

This week will be devoted to studying various co-existing medical problems that may be present in many of the laboring patients. Many of these medical problems have anaesthetic implications and therefore will be important for you to be aware of potentially dangerous situations and offer alternative anaesthetic options (e.g. von Willebrand’s deficiency and regional anesthesia).

Tasks:
You should work in conjunction with the floor manager to gain an overall understanding of the L&D floor. You should try to perform the anesthetic assessment of most laboring patients, and should find out about those that you didn’t see yourself. It would be ideal if all members of the team had frequent communication and discussion about the patients on the floor. All complex issues should be common knowledge to all members of the team; everyone should share one plan. All preparations should be… well, prepared.

After seeing a patient, find the floor manager to discuss it. Just about every parturient has some issue that can lead to a discussion. Also, there are many high-risk cases that will form the basis for daily talks. The parturients that you see should become a springboard for education.

This week you should be involved in most of the labor analgesics. While it is impossible to do all of the procedures, you should try to involve yourself with the care of all of the patients. There are many lessons that can be learned from the success and failure of labor analgesia.

Relevant Reading:
- Anesthesia for Preterm Labor and delivery Ch. 34
- Regional Anesthesia for Labor and Delivery Ch. 12
- Anesthesia for Postpartum Sterilization Ch 25
- Abnormal Presentation and Multiple Gestations Ch 35
- Hematologic and Coagulation Disorders Ch 43
Week 3
Pregnancy, Pre- and Post-Partum, and Anesthetic complications

During this week you will be trying to gather a global understanding of pregnancy. You should acquire an in depth knowledge of the changes that occur throughout pregnancy, and in the post-partum period. For example, what are the issues concerning non-obstetric surgery during pregnancy? Which drugs are safe for nursing mothers? What are the potential complications form anesthesia in the post-partum period?

Also, during this week you should learn extensively about the complications of anesthesia/ analgesia in the parturient. This should focus you on the considerations that you must have when evaluating a parturient for either labor analgesia or operative anesthesia. For example, parturients who have a difficult labor are more likely to suffer a neurologic complication. How do you approach this problem?

Tasks:
You should be involved with post-op visits of patients who have had anesthetic interventions on the L&D floor. These patients are usually recovering on Feldberg 5 and 6. The evaluation covers adequacy of the anesthetic technique, a quick survey for potential complications, and patient satisfaction with the overall anesthetic care. Complications do arise, and you will have to gain knowledge of what causes them, how to treat them.

Relevant Reading:
- Embolic Disorders Ch 38
- Neurologic complications of Pregnancy and Neuraxial Anesthesia Ch. 32
- Anesthesia for Non-obstetric surgery during Pregnancy Ch. 17
- Nonanesthetic Drugs during Pregnancy and Lactation Ch 14
Week 4  
High Risk Obstetrics

As a tertiary care center BIDMC has a high percentage of "High Risk" pregnancies. As a member of the anesthesia team you will often be consulted on these patients and will need to understand the relevant physiology and offer management options. You will work with a senior member in the OB anesthesia team during this week.

Tasks:
You will be expected to attend the morning OB resident signout. During this signout, the high-risk board is reviewed. Each day you will round on the high-risk patients and follow their progress through the week. You will be responsible for ensuring that our service’s information on these patients is current. It is not infrequent that we identify the need for work-up of medical issues or the need for tests (e.g. type and screen outdating) During sign out in the afternoon, you will inform the on call team about the high-risk patients and the management options.

Relevant reading:
- Antepartum and post partum hemorrhage Ch. 37
- Auto immune disorders Ch. 40
- Hypertensive Disorders Ch. 45
- Cardiovascular Diseases Ch. 41
- Endocrine Disorders Ch. 42
- Obesity Ch 50
- Respiratory disease in Pregnancy Ch. 52