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Essay

Problems in obstetric analgesia[☆]

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ABSTRACT

Despite countless statements from international agencies, pain management during labor and delivery is insufficient due to the hurdles imposed by the health system, and also to the misconceptions regarding epidural analgesia among patients, but worse still, among nurses, obstetricians and anesthesiologists.

This article mentions the point of view of outstanding international institutions on the subject, the problems that may be attributed to the health system, and the limitations imposed by specialists, emphasizing in particular the views prevailing among obstetricians and gynecologists that explain why a large proportion of women in childbirth experience pain unnecessarily.

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Los problemas de la analgesia obstétrica

RESUMEN

A pesar de las múltiples declaraciones de los organismos internacionales, el manejo del espacio dolor en el trabajo de parto y el parto es insuficiente debido a las barreras que impone el espacio sistema de salud, pero también por las concepciones equivocadas sobre la analgesia epidural espacio de las pacientes y, peor aún, también de enfermeras, obstetras y anestesiólogos.

El presente artículo menciona el punto de vista de reconocidas instituciones internacionales sobre el tema, los problemas atribuibles al sistema de salud y discute las limitaciones espacio que imponen los especialistas médicos, enfatizando, de manera particular, en las prevalecientes concepciones de obstetras y anestesiólogos, por las cuales una gran proporción de espacio las maternas sufren, innecesariamente, de dolor durante el trabajo de parto y el parto.

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Palabras clave:

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The Universal Declaration of Human Rights¹ states that every individual has a right to social security and is entitled to realization of rights indispensable for his dignity, and motherhood and childhood must be the object of special care and assistance. Likewise, the 1979 United Nations Convention on Women² and the Panama Declaration of Latin American Societies dedicated to the Study and Treatment of Pain and Palliative Care³ also state that: "...during the course of their lives, countless human beings experience unnecessary suffering from painful conditions for which there are viable treatment alternatives capable of minimizing or eliminating that suffering. . ."

Many organizations recognize the human prerogative of not having to suffer pain and to die with dignity, and work to ensure that this prerogative is recognized as a fundamental human right. Once categorized as such, governments and health systems would be obliged to act accordingly.^{4,5}

Viable treatment options for labor pain have been available for over half a century. However, a vast majority of pregnant women, particularly in the lowest income brackets, experience that pain unnecessarily.

In 2012, 662,554 babies were born in Colombia, 365,353 (55%) by spontaneous delivery, and 288,897 (43%) by cesarean section.⁶ According to European statistics, obstetric epidural analgesia is used in 25% to 58% of cases. In Colombia, only women covered by health insurance or private health-care plans have unrestricted access to this form of analgesia. Assuming that epidural analgesia in vaginal delivery is given in 30% of cases, it is estimated that nearly a quarter million mothers suffer unnecessary pain during labor and childbirth.

Part of the problem is explained by the healthcare system, as was already discussed in a recent article of this journal.⁷ Colombian health management organizations (EPS), created by Law 100 of 1993, receive Capitation Payment Rates for their work in meeting the healthcare needs of their affiliates. A percentage of this payment is their profit and the rest goes to the agreements with the healthcare providers (IPS). Maternal care is special in the sense that it is independent of the final healthcare requirements, for example, regardless of whether delivery is vaginal or by C-section, or whether obstetric analgesia is used or not.

Epidural analgesia represents an expense for healthcare providers that is not specifically designated as part of the healthcare package. Consequently, there are exceptionally few maternity services where it is used routinely, and most of them reserve it for patients in greater pain or for adolescents, and a significant proportion of centers do not even consider it. The basic rationale behind the origin of the problem from the system's perspective is that the lower the cost of healthcare, the higher the profitability.

Analgesia for labor and delivery is requested by the obstetrician, almost always in advanced stages of effacement and dilatation, as a result of very old entrenched ideas that still prevail today, even in academic settings, that preach that no analgesia is required during the early phase and that epidural analgesia must be given in the middle of the active phase, once cervical dilatation is 6 or 7 cm. This is in spite of the evidence that epidural analgesia initiated during the early phase is not associated with a higher rate to C-sections.⁸⁻¹²

Although it has been determined that pain intensity during labor increases as effacement and dilatation proceed,^{13,14} some women may experience moderate to severe pain during the early stage depending on factors such as parity, maternal age, oxytocin use, and the meaning of motherhood for each individual patient. Therefore, analgesia should be initiated as soon as the mother asks for it.

A principle in the management of acute pain determines that early treatment is required in order to avoid deleterious effects, and also because the longer treatment is delayed the more difficult it will be to control the pain. On the other hand, maternal cooperation at the time of placing the epidural catheter will be better when the pain is less intense.

Early placement of the epidural catheter and early initiation of analgesia are advocated under the current management of obstetric pain. Modern techniques using opioids alone^{15,16} or in combination with lower doses and concentrations of local anesthetic that are gradually increased as labor progresses prevent the delay of labor and secondary interruption of descent and dilatation.

Old ideas about the timing of analgesia in order to avoid interrupting labor, instrumentation and even C-section have to do in particular with obstetricians, but they are shared by many anesthesiologists who also reinforce them with the use of “standard” doses that do not cater to the unique needs of each patient, and do indeed interrupt or delay the progress of labor.

If analgesia were to be initiated early on, as should be the case, the “standard” dose of 12.5 mg of bupivacaine (10 ml at 0.125%), may actually be too high or, on the contrary, insufficient during the advanced stages or during transition. In the first instance, concentrations of 0.05% to 0.1%, or even the epidural administration of an opioid alone are useful, while during the advanced and transitional stages, there is a need for concentrations of 0.25% or 0.5%, respectively. Adequate analgesia is also possible with greater volumes of less concentrated solutions of local anesthetic.^{17–19}

Although in most cases the anesthetic choice is bupivacaine, there are many situations in which analgesia is given when cervical effacement is complete and dilatation is greater than 8 cm, or even upon impending birth, so it is convenient to use a short-latency anesthetic such as lidocaine. Otherwise, analgesia may occur after delivery has taken place.

There is little controversy regarding the volume of anesthetic solution that must be instilled. The required spinal segments are reached using 10–12 ml, but boost volumes as well as those required for birth are usually different. In the first case, it is important to titrate, while more than the conventional 10 ml volume is usually required at the time of birth.

Obstetric services should have an anesthesiologist available for the administration and monitoring of obstetric analgesia. If the method selected is epidural analgesia, the anesthesiologist may place the catheter, control the degree of analgesia, administer the required boost doses and the dose required during transition, and then give anesthesia for delivery instrumentation, uterine and birth canal check, and finally institute post-partum analgesia. On the other hand, if epidural analgesia is contraindicated, the anesthesiologist may decide on a different form of analgesia.

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Conflicts of interest

The authors have no conflicts of interest to declare

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