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Opinion

Clinical Opinion: Epidural Analgesia for Labor and Delivery

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There are a myriad of articles specially from USA about epidural analgesia for labor and delivery assistance. Most of them talk about some side effects that we never have observed in our patients such as postpartum fever, punctuation place pain, and increase in the length of different phases of labor, in the number of instrumental delivery and in the cesarean section rate. To tell you the truth, this outcomes are very different from the outcomes observed for us.

The fact is that no any anaesthetist can help the obstetrician to handle a labor and delivery (L and D). Why?, because this anaesthetits should be an specialist in obstetrics assistance, should know very well the main characteristics surrounding L and D, the different phases of labor and modify the dose of the drug administrated according the different times of L and D.

First, we have to take in account that uterine cervix is prepared to keep the fetus into the uterus during at least 38 - 39 weeks and to allow delivery, it must have totally modified in its anatomical structure in hours. This process produce pain to achieve effacement and dilation besides the pain that produce the descent of presentation. Once the patient is into the active phase of delivery, is common that she asked pain relief. At this point of labor, the main target is to decrease the pain without decrease the frequency and intensity of uterine contractions. So, the epidural analgesia (EA) should be administrated with a determinate dose of anaesthetic drug plus an opioid (commonly fentanyl).

The administration of an excess of drug is going to produce a decrease of uterine contractions and as a consequence, this situation could be assumed for the obstetrician as a lack of progression of labor and finally decide to perform a cesarean section (CS) for arrest of labor. The amount of drug administrated should be enough to decrease the unnecessary pain and not to eliminate it. It is a very important point to avoid unnecessary CS by a busy obstetrician.

Second, once the fetal head take contact with the mother´s pelvic floor, is very important to take in account the anatomical and dynamic factors that are going to develop. The pelvic floor is a triangle shaped structure whose vertex is superior in a patient in a supine lying in position formed mainly by levator ani muscles.

The fetal head take close contact with this triangle whose main function is to obligate to the fetal head to rotate toward the antero posterior situation. To do that, this muscles have to have a determinate tone. If this muscles are relaxed because an excess of anesthetic drug, during the contraction the fetal head push against them but because of a lack of adequate tone, the fetal head push them and the muscles are not firm enough to obligate to the fetal head rotation. As a consequence, once again we observe a lack of progression of labor and the fetal head is not going to neither a rotate nor descent and the obstetrician could again choose to perform a CS for labor arrest when the problem is an excess of anesthetic drug. To avoid this problem, is necessary to explain to the patient that during this time is better to feel some pain but allow the fetal descent. If the pain is blocked, the patient will not feel pain but the fetus is not going to descent.

Under right conditions, once the fetus gave up this level of difficulty, the obstetrician could ask a little more of analgesic drug to proceed to assist the delivery including to apply instruments if it would be necessary and is enough drug to repair an episiotomy or perineal tears if it happen.

So, this is our point of view about the epidural analgesia for L and D. Not accomplish with this recommendations, of course is going to be associated with a lack of progression of labor, an inadequate length of the second phase of delivery and an increase in the rate of CS. Accomplishing with this recommendations, EA is the best method to decrease pain during L and D and will be not associated to any kind of side effects [1-5].

The good obstetrics team never should forget that the obstetrical times nothing have to do with the social times.

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