

A Local Survey of Current practice and opinions of obstetric anaesthetists in regards to guidelines and recommendations for fasting during labour in a tertiary hospital

D. Seddon and N. Desai

Introduction

For many years, the advice given to patients in regard to the oral intake allowed during labour has remained an area of controversy. Individual opinion differs and institutional practice varies, particularly in light of the non-uniform guidelines from the national and international organisations and societies. It is more important than ever to understand the current practices and opinions in relation to oral intake in labour among healthcare professionals and institutions in the UK. Only then can we reach consensus on the optimal recommendations which balance maternal safety and wellbeing.

Methods

We designed a short ten question electronic survey via the Google form platform to gather opinions and current practices relating to fasting recommendations given to patients during labour. The survey was distributed in person to consultants and residents that regularly populate the obstetric on-call rota of St Thomas's Hospital Birth Centre.

Results

Overall, 24 obstetric anaesthetists completed the survey, indicative of a departmental response rate of 80%. Six (25%) were consultants. Most anaesthetists (72%) were not aware of any national or international organisational guidelines. The current practice of anaesthetists in relation to the fasting guidance they give to patients in labour has been illustrated in Figure 1. Just under half of respondents (48%) recommended that women follow a more restrictive fasting recommendation subsequent to the placement of an epidural. The most common clinical situations in which respondents recommended more restricted intake in labour included: concern about the cardiotocography (68%); previous difficult mask ventilation and/or tracheal intubation (64%); previous difficult or failed neuraxial anaesthesia (64%); obesity with a body mass index greater than 40 kg/m²; and antepartum haemorrhage (56%).

In which of these clinical situations would you advise a restricted intake during labour?

1. Concern about the cardiotocography **(68%)**
2. Previous difficult mask ventilation and/or tracheal intubation **(64%)**
3. Previous difficult or failed neuraxial anaesthesia **(64%)**
4. Obesity with a body mass index greater than 40 kg/m² **(56%)**
5. Antepartum haemorrhage **(56%)**

What are the BENEFITS of permitting eating during labour?

1. Increases patient comfort (96%)
2. Increases patient satisfaction (96%)
3. Prevention of patient stress (84%)
4. Facilitates patient autonomy, choice and control (80%)

What are the RISKS of permitting eating during labour?

1. Risk of gastric content regurgitation and aspiration with general anaesthesia (100%)
2. Delayed gastric emptying in labour (77%)
3. Risk of gastric content regurgitation and aspiration with high neuroaxial block (65%)

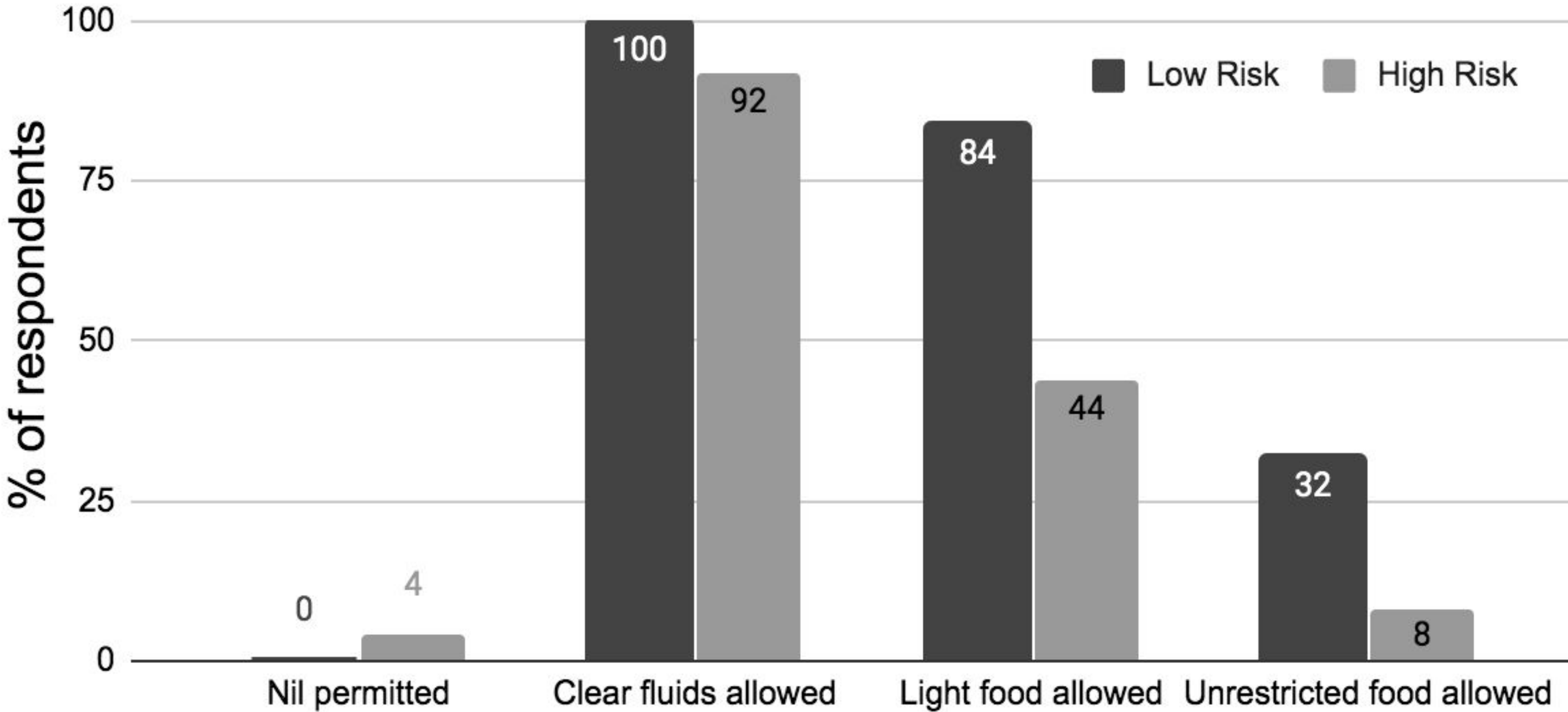


Figure 1. Current practice of anaesthetists in regard to the recommendations they provide to women with respect to fasting in labour

Discussion

Our survey reveals significant local variation in the recommendations provided to women in labour with respect to fasting within our institution. They do not always align with the evidence base to date.¹ The placement of epidural analgesia in labour represents such an example as they have been shown to increase gastric emptying.² There is a lack of widespread awareness in relation to national and international guidelines. The next step of this project is to present a revised survey nationally to gain better understanding of current practices.

References

1. Lawson J, Howle R, Popivanov P, et al. Gastric emptying in pregnancy and its clinical implications: a narrative review. *Br J Anaesth* 2025;**134**(1):124–67.
2. Bouvet L, Schulz T, Piana F, Desgranges FP, Chassard D. Pregnancy and labor epidural effects on gastric emptying: a prospective comparative study. *Anesthesiology* 2022;**136**(4):542–50.