

A REVIEW OF REFERRALS AND OUTCOMES OF A TERTIARY MATERNITY CENTRE OBSTETRIC ANAESTHETIC CLINIC



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INTRODUCTION

In a busy tertiary obstetric and maternal medicine centre, we conducted a review of patient referrals to the weekly obstetric anaesthetic clinic to assess the case outcomes. This was prompted by a case where the proposed plan from clinic was not followed by the duty anaesthetist at time of delivery, resulting in patient dissatisfaction.

We also reviewed the case mix of referrals before and after consultant screening of referrals was introduced in February 2023 in an attempt to reduce unnecessary referrals and clinic overbooking.

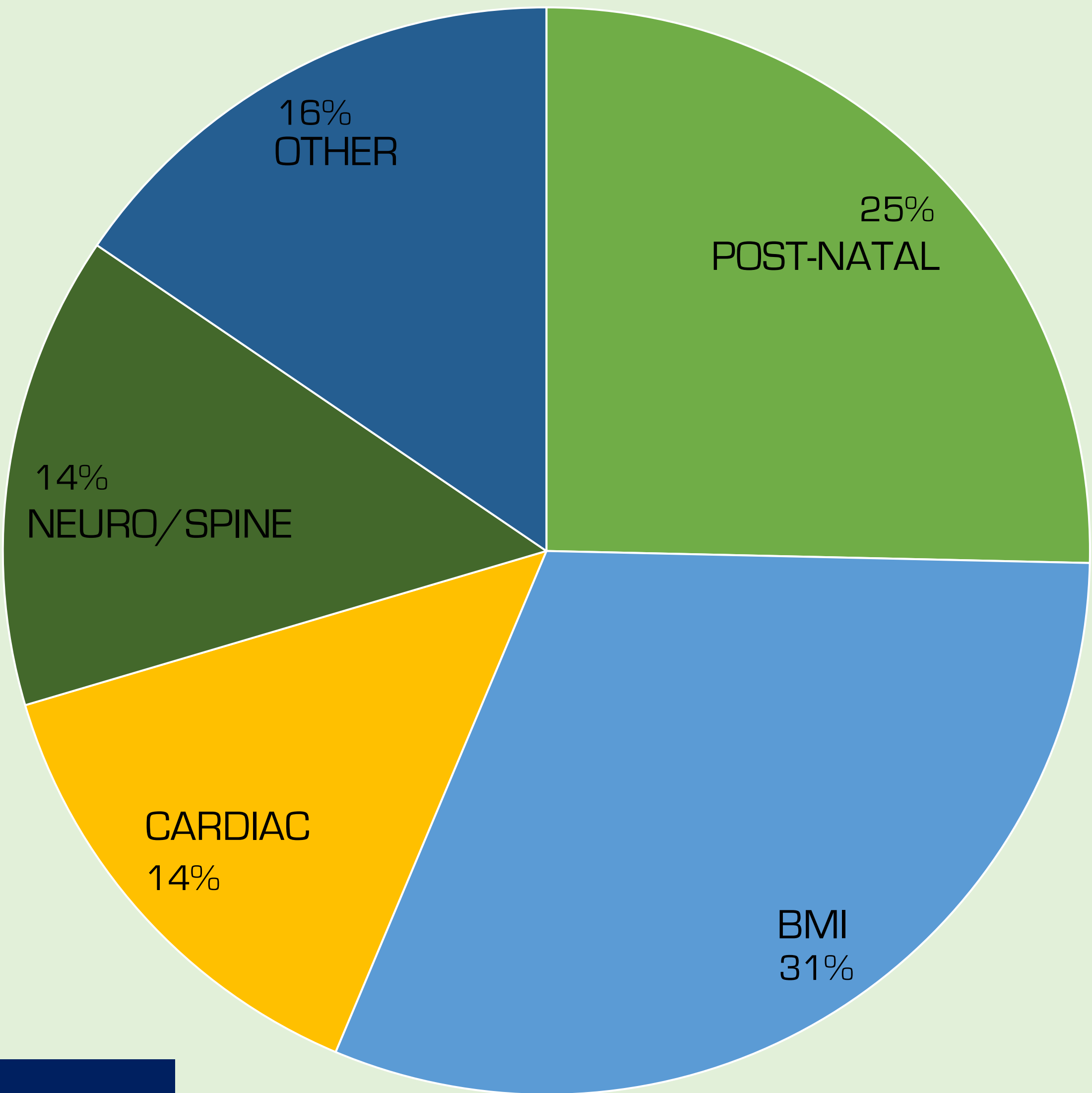
METHOD

A retrospective notes review was undertaken of all patients who had an appointment booked for obstetric anaesthetic clinic during the months of November 2022 and June 2024 [before and after consultant referral screening started]. The project was registered with the trust's clinical audit department.

WHO DO WE SEE IN CLINIC?



CHART: REASONS FOR REFERRAL TO OBSTETRIC ANAESTHETIC CLINIC



RESULTS

During the two months that were reviewed, there was no difference in unnecessary appointments with one each month (both Body Mass Index (BMI)<40) and so the two months' data were collated. A total of 77 patients were referred and 71 notes were reviewed (six patients were excluded; two repeat appointments, two unnecessary referrals and two did not attend). Eighteen appointments were for post-natal women who encountered an anaesthetic problem during delivery. Of the 53 antenatal cases, one patient did not receive the intended management plan (discussed further below). A BMI ≥ 40 was the most common referral reason, accounting for 42% (n=22), followed by cardiac disease and spinal disease with 19% of referrals each (n=10 x2). The remaining 11 patients were seen for a variety of reasons such as long COVID, coagulopathy or allergy.

DO WE FOLLOW THE PLAN?

DISCUSSION

One case did not receive the intended plan from obstetric anaesthetic clinic. This involved a patient with Idiopathic Intracranial Hypertension with a ventriculo-peritoneal shunt in-situ, who was booked for an elective caesarean section. In clinic, after discussion with neurosurgeons, it was agreed attempts at neuraxial blockade were acceptable at the level of L3/4 and below. However, on the day of delivery, the patient changed her mind and opted for a general anaesthetic. Therefore this does not reflect a deviation from the clinic recommendation but rather a change in patient preference.

The most common reason for referral to obstetric anaesthetic clinic was a BMI ≥ 40 with almost half of those [45% n=10] having a BMI ≥ 45 . This was followed by referral for post-natal review, accounting for 25% [n=18] . We anticipate these referral types to increase in future, due to increasing obesity[1] and Ockenden report recommendations[2]. The introduction of consultant referral screening has not reduced demand and so is now the time to increase the threshold BMI for clinic referral? And do we need a separate postnatal clinic to ensure we continue to provide women with this valuable resource as our understanding of the impact of birth trauma grows?

REFERENCES

1. Kim J, Ayabe A. Obesity in Pregnancy. [Updated 2023 Aug 8]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan-. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK572113/> [Accessed: 24th January 2025]
2. Ockenden, D. [2022] *Ockenden report - final: findings, conclusions and essential actions from the Independent Review of Maternity Services at The Shrewsbury and Telford Hospital NHS Trust.* (HC1219). Available at: <https://www.gov.uk/government/publications/final-report-of-the-ockenden-review/ockenden-review-summary-of-findings-conclusions-and-essential-actions> [Accessed: 24th January 2025].