Anesthesia Preferences

Obstetric and Gynecologic Surgery

Below are the surgeons’ preferences for anesthesia. We welcome any changes or suggestions. Please send them to Nadine Odo, nodo@gru.edu.

GYNECOLOGIC PROCEDURES

SURGEON: Emmi

Total Abdominal Hysterectomy, Laparoscopically Assisted Vaginal Hysterectomy, Myomectomy

- GETA.
- Type and screen all patients.
- Surgeon must be present before all inductions.

Hysteroscopy/D&C, Essure, NovaSure

- For hysteroscopy/D&C, LMA vs subarachnoid block.
- For Essure, Novasure, paracervical with sedation vs LMA.

Epidurals

- Prehydrate with 500 mL–1 L crystalloid.
- Check with OB service prior to hydration of pre-eclamptic patient.
- Platelet count prior to placement. If patient is being followed by OB Service at this institution and has labs in system during current pregnancy, may place catheter prior to current result returns if it is an uneventful pregnancy. Current result must be verified in system prior to removing catheter. If there are no labs from current pregnancy, should wait for current result prior to placement. This is, however, at the discretion of OB attending and should be discussed.

CERVICAL CERCLAGES

SURGEON: Browne, Devoe

Transabdominal Approach

- Procedure usually lasts 2.5–3 hours.
- Patients typed and screened. Can have significant blood loss.
- General anesthesia usually requested and required.
- Usually performed at 12–14 weeks gestational age. Can also be done in nonpregnant individual with previous fetal losses as preventive measure.
- Fetal heart tone (FHT) documented by ultrasound per surgeon.

Vaginal Approach

- Procedure lasts 30 minutes–1 hour.
- Patient typed and screened. Blood loss usually insignificant.
- Spinal anesthesia.
- Performed at 16–20 weeks' gestation.
- Document FHT before and after procedure.
- Discuss with Browne prior to administering hetastarch.