A.M.

My most Memorable Anesthetic Experience

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After my graduation from school of Anesthesia 1979, I started working with the John F Kennedy Medical Center in the OT Department as a nurse anesthetist. Few years later I was transferred to Maternity hospital within the same complex and the supervisor of Anesthesia Dept. put me on the 3rd shift without a helper.

Obstetric Anesthesia has problems and requires special consideration. You are dealing with two persons, the mother and the baby. Obstetric patients have always a full stomach and may have pulmonary aspiration.

I received a 32 years old female multipara who was in active labour with a diagnosis of multiple pregnancy and prolong labour. Because of the emergency situation of all OB cases, proper pre-operative anaesthetic assessment was done. I did not know the Hb which was not done but clinical assessment of the conjuntiva allows me to go ahead.

In this case, I decided to give spinal anesthesia because I know that it is the safest and easiest to maintain in OB. It is associated with low maternal mortality. Before I performed the procedure, I make sure that 18G cannula is in place and blood specimen sent to lab for cross match and Hb. Stat. 500ml-1000ml Ringer Lactate solution is in progress. BP and heart rates taken and Ephedrine, Atropine and Oxytocin prepared. One litre N/Saline ready to put under the right hip of patient to displace the gravid uterus to the left and make blood return to the heart to prevent hypotensive syndrome because more sympathetic nerves are blocked.

I put patient in sitting position and started the procedure. Surgery started few minutes later twins were extracted alive. The result from the Lab. Came in, the Hb was 6.5g. I also forgot to tilt the right hip of the patient to the left to prevent hypotensive syndrome. This what I thought of at first, but to my surprise before 5 minutes after babies extracted, patient went into irreversible shock and I did not know whether this was spinal shock or hypovolaemic shock. I informed the surgeon but he didn't do much for the patient because he had no experience of shock or anesthesia. Patient started with yawning and restless, much attention was given to this patient at all. I intubated and give necessary drugs like Ephedrine, Atropine, but to no avail. Resuscitation exercise continue until all vital signs ceased completely.

Now I thought of two things may be responsible for this terrible accident – 1) the O_2 carrying capacity was low, that is Hb 6.5. I failed to tilt the table to the left side to prevent gravid uterus from compressing the inferior vena cava. To permit cardiac blood return.

From this conjunction I came to know that it is always good, regardless the urgency of the situation, one should know the Lab results before surgery. Based on this result,

you make your anesthetic choice. This patient in question was a good candidate for general anesthesia because the Oxygen carrying capacity was low. Therefore, this is a bitter experience for me to remember thru-out my practice as a nurse Anesthetist.

thanks