

PROTOCOL #47 Maternal Fetal Medicine, University of New Mexico

Fetal Monitoring During Transfer to the OR

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Purpose: When there is the need for an urgent/emergent c-section for either maternal or fetal needs the speed in which the delivery can be done may be modified based on continuous fetal monitoring. Since a more rapid section requires general anesthesia with its associated risks and potential increase risk of infection or other injury to the mother, it is best not to rush if not necessary. Commonly once back in the OR the fetal strip will look better but there is a decision to proceed with the c-section. If it is possible to continue assessing fetal status, it may be possible to allow the anesthesia team to spend the time for a regional anesthesia modality which is safer for the mother.

Policy: To optimize the opportunity for use of regional anesthesia safely in the presence of a non-reassuring fetal strip the following will be policy.

1. The Fetal Scalp Electrode should not be removed when moving a patient from the LDR to the Operating room for an emergent cesarean delivery
2. Once in the OR the tracing will be re-established to determine current fetal status
3. If rapid sequence C/S is indicated proceed in a "Crash" procedure with rapid general anesthesia
4. If tracing allows more time to prepare mom and FSE is in place
 - a. **DO NOT REMOVE FSE** This will allow monitoring of the fetus in the OR while anesthesia is established.
 - b. The FSE cord should be cut as short as possible after anesthesia is induced and the baby should be delivered with the electrode attached to the scalp.
 - c. In emergency cesarean deliveries the Circulating nurse should reach under the drapes to cut the electrode
 - d. All laboring patients with nonreassuring fetal assessment should have internal monitoring (FSE) unless it is contraindicated (e.g. HIV, Hepatitis, Hemophilia)
5. If there is not an FSE in place, external monitoring should continue until anesthesia has established an adequate regional block and foley is placed. Then a rapid abdominal prepping with draping and surgery should occur.
6. If at any point the fetal tracing worsens abruptly then anesthesia may need to convert to a general anesthetic.