STATEMENT ON NONOBSTETRIC SURGERY DURING PREGNANCY

Committee of Origin: Obstetrical Anesthesia

(Approved by the ASA House of Delegates on October 21, 2009)

This is a joint statement from the American Society of Anesthesiologists (ASA) and the American College of Obstetricians and Gynecologists (ACOG). It has been designed to address issues of concern to both specialties.

1. NONOBSTETRIC SURGERY DURING PREGNANCY

The American College of Obstetricians and Gynecologists Committee on Obstetric Practice and the American Society of Anesthesiologists Committee on Obstetric Anesthesia acknowledge that the issue of nonobstetric surgery during pregnancy is an important concern for physicians who care for women. Due to the difficulty of conducting large-scale randomized clinical trials in this population, there are no data to allow for specific recommendations. It is important for physicians to obtain obstetric consultation before performing nonobstetric surgery and some invasive procedures (e.g., cardiac catheterization, colonoscopy) because obstetricians are uniquely qualified to discuss aspects of maternal physiology and anatomy that may affect intraoperative maternal-fetal well-being. The following generalizations may be helpful to guide decision-making:

1.1 No currently used anesthetic agents have been shown to have any teratogenic effects in humans when using standard concentrations at any gestational age.

1.2 Fetal heart rate monitoring may assist in maternal positioning and cardiorespiratory management, and may influence a decision to deliver the fetus.

2. CONSENSUS

The following recommendations represent the consensus of the two Committees:

2.2 A pregnant woman should never be denied indicated surgery, regardless of trimester.

2.3 Elective surgery should be postponed until after delivery.

2.4 If possible, non-urgent surgery should be performed in the second trimester when preterm contractions and spontaneous abortion are least likely.

3. FETAL MONITORING

When non-obstetric surgery is planned, the primary obstetric care provider should be notified. If that provider is not at the institution where surgery is to be performed, another obstetric care provider with privileges at that institution should be involved. If fetal monitoring is to be used:

3.1 Surgery should be done at an institution with neonatal and pediatric services.

3.2 An obstetric provider with cesarean delivery privileges should be readily available.

3.3 A qualified individual should be readily available to interpret the fetal heart rate.

3.4 General guidelines for fetal monitoring include –

3.4.1 If the fetus is considered previable, it is generally sufficient to ascertain the fetal heart rate by Doppler before and after the procedure.

3.4.2 At a minimum, if the fetus is considered to be viable, simultaneous electronic fetal heart rate and contraction monitoring should be performed before and after the procedure to assess fetal well-being and the absence of contractions.

3.4.3 Intraoperative electronic fetal monitoring may be appropriate when all of the following apply:

3.4.3.1 The fetus is viable;

3.4.3.2 It is physically possible to perform intraoperative electronic fetal monitoring;

3.4.3.3 A provider with obstetrical surgery privileges is available and willing to intervene during the surgical procedure for fetal indications.

3.4.3.4 When possible, the woman has given informed consent to emergency cesarean delivery.

In select circumstances, intraoperative fetal monitoring may be considered for previable fetuses to facilitate positioning or oxygenation interventions.

The decision to use fetal monitoring should be individualized, and, if used, should be based on gestational age, type of surgery, and facilities available. Ultimately, each case warrants a team approach (anesthesia, obstetric care providers, surgery, pediatrics, and nursing) for optimal safety of the woman and the fetus.