مستشفى كينغز كوليدج لندن
King's College Hospital London

FAQ's Labour Epidural

FAQs Labour Epidural

We understand that Labour can be a daunting time and you may have a lot of unanswered questions, which is why we have compiled a list of the most common questions asked about Labour Epidural.

1) What are Epidurals?

Epidurals are the most complicated method of pain relief and are put in by an anaesthetist. An anaesthetist is a doctor who is specially trained to provide pain relief and drugs that make you go to sleep. Pain relief during operations can be provided using general anaesthesia, epidurals or spinals.

Formore information on these types of anaesthesia for a Caesarean section, see here .

A few facts about epidurals:

- Epidurals are the most effective method of pain relief.
- For an epidural, the anaesthetist inserts a needle into the lower part of your back and uses it to place an epidural catheter (a very thin tube) near the nerves in your spine. The epidural catheter is left in place when the needle is taken out so you can be given painkillers during your labour. The painkillers may be a local anaesthetic to numb your nerves, small doses of opioids, or a mixture of both.
- An epidural may take 40 minutes to give pain relief (including the time it takes to put in the epidural catheter and for the painkillers to start working).
- An epidural should not make you feel drowsy or sick.
- Having an epidural increases the chance that your obstetrician will need to use a ventouse (a suction cap on your baby's head) or forceps to deliver your baby.
- An epidural can usually be topped up to provide pain relief if you need a ventouse, forceps or a Caesarean section.
- An epidural will have hardly any effect on your baby.

2) What are spinals and combined spinal epidurals?

Epidurals are rather slow to act, especially if you have one late in labour. If the painkillers are given direct into the bag of fluid surrounding the nerves in your back, they work much faster. This is called a spinal. Unlike an epidural, it is given as a one-off injection without a catheter. If an epidural catheter is put in at the same time, this is called a combined spinal-epidural.

3) Can everyone have Epidural?

Most people can have an epidural, but certain medical problems (such as spina bifida, a previous operation on your back or problems with blood clotting) may mean that it is not suitable for you. The besttime to find out about this is before you are in labour. If you have a complicated or long labour, your midwife or obstetrician may suggest that you have an epidural as it may help you or your baby.

If you are overweight, an epidural may be more difficult and take longer to put in place. Once it is in andworking, you can have all the benefits.

4) What is the procedure for putting in an epidural?

First, a cannula (a fine plastic tube) will be put in a vein in your hand or arm, and you will usually have adrip (intravenous fluid) running as well (you may also need a drip in labour for other reasons, such as to give you medication to speed up your labour or if you are being sick).

Your midwife will ask you to curl up on your side or sit bending forwards, and your anaesthetist will clean your back with an antiseptic. Your anaesthetist will

inject local anaesthetic into your skin, so that putting in the epidural does not usually hurt much.

The epidural catheter is put into your back near your nerves in the spine. Your anaesthetist has to be careful to avoid puncturing the bag of fluid that surrounds your spinal cord, as this may give you a headache afterwards. It is important to keep still while the anaesthetist is putting in the epidural, but after the epidural catheter is fixed in place with tape you will be free to move. Once the epidural catheter is in place, you will be given painkillers through it.

5) How long does an epidural take to work?

It usually takes about 20 minutes to set up the epidural and 20 minutes for it to give pain relief. While the epidural is starting to work, your midwife will take your blood pressure regularly. Your anaesthetist will usually check that the epidural painkillers are working on the right nerves by putting an ice cube or cold spray on your tummy and legs and asking you how cold it feels. Sometimes, the epidural doesn't work well at first and your anaesthetist needs to adjust it, or even take the epidural catheter out and put it in again

6) What can be done to keep the epidural working after it has been put in?

During labour, you can have extra doses of painkillers through the epidural catheter either as a quickinjection (a top-up), a slow, steady flow using a pump, or with a patient-controlled epidural analgesia (PCEA) pump. With patient-controlled epidural analgesia, you can give yourself doses of the painkiller when you need them by pressing a button attached to the pump.

In each hospital there will usually only be one, or possibly two, of these methods for keeping the epidural pain relief going.

After each epidural top-up, the midwife will take your blood pressure regularly in the same way as when the epidural was started.

7) What is a Mobile epidural?

A mobile epidural is where the pain of labour is reduced without making the lower part of your body very numb or making your legs feel weak. The epidural cannot be adjusted exactly, so if you want to havesome feeling when your baby is delivered, there is more chance that you may have an uncomfortable sensation during labour as well.

8) How will having an epidural affect my baby?

Having an epidural should not affect the condition of your baby when it is born, in fact newborns are less likely to have acid in their blood. Having an epidural does not make it any harder to breastfeed.

9) How could an epidural be used for keeping me comfortable during an operation?

If you need a Caesarean section, the epidural is often used instead of a general anaesthetic. A strong local anaesthetic is injected into your epidural catheter to make the lower half of your body very numb for the operation. This is safer than a general anaesthetic for you and your baby. Occasionally the epidural may not work well enough to be used for a Caesarean section. This can happen in 1 in 20 people. If this happens to you, you may also need another anaesthetic such as a spinal or general anaesthetic.

10) Will having an Epidural make it more likely for me to need a caesarean section or to have back ache afterwards?

With an epidural, you do not have a higher chance of needing a Caesarean section.

There is no greater chance of long-term backache. Backache is common during pregnancy and often continues afterwards. You may have a tender spot in your back after an epidural which, rarely, may last for months, there is no increased chance of long-term backache.

11) What are the risks of having an epidural?

- Between one in a hundred and one in two hundred women who have an epidural may get a headache.
- Permanent nerve damage is very rare with an epidural about 1:24,000.
- The epidural might not work well enough to reduce labour pain so you need to use other ways of reducing the pain, about 1 in 8.
- Strong solutions of local anaesthetic in your epidural can increase the risk of instrumental delivery but thereis no evidence that this is the case for most commonly used "low dose" epidurals.
- With an epidural, the second stage of labour (when your cervix is fully dilated) is longer and you are morelikely to need medication (oxytocin) to make your contractions stronger.
- You have more chance of having low blood pressure.
- Your legs may feel weak while the epidural is working.
- You will find it difficult to urinate. You will probably need to have a tube passed into your bladder (a bladdercatheter) to drain the urine.
- You may feel itchy.

12) How can having an epidural give me a headache?

In about one in every 100 women who have an epidural the bag of fluid which surrounds their spinal cord is punctured by the epidural needle (this is called a 'dural puncture'). If this happens to you, you couldget a severe headache that could last for days or weeks if it is not treated. If you do develop a severe headache, your anaesthetist should talk to you and give you advice about the treatment you could have.

Reference lists for the FAQs:

1) Intrapartum care. Care of healthy women and their babies during childbirth. National Collaborating Centre for Women's and Children's Health. Commissioned by the National Institute for Health and Clinical Excellence. 2007 RCOG Press, London.

2) Waldenstrom U, Nilsson CA. Experience of childbirth in birth center care. A randomised controlled study. Acta Obstetricia et Gynecologica Scandinavica 1994; 73: 547 -554.

3) Hodnett ED, Gates S, Hofmeyr GJ, Sakala C. Continuous support for women during childbirth. Cochrane Database of Systematic Reviews 2003, Issue 3. Article number: CD003766. Date of issue: 10.1002/14651858.CD003766.

4) Cluett ER, Burns E. Immersion in water in labour and birth. Cochrane Database of Systematic Reviews 2009, Issue 2. [DOI:10.1002/14651858.CD000111.pub3]

5) Smith CA, Collins CT, Cyna AM, Crowther CA. Complementary and alternative therapies for pain management in labour. Cochrane Database of Systematic Reviews 2006, Issue 4. Article number: CD003521. Date of issue: 10.1002/14651858.CD003521.pub2.

6) Olofsson C, Ekblom A, Ekman -Ordeberg G, Hjelm A, Irestedt L. Lack of analgesic effect of systemically administered morphine or pethidine on labour pain. British Journal of Obstetrics and Gynaecology 1996;103:968972.

7) Tuckey JP1, Prout RE, Wee MY Prescribing intramuscular opioids for labour analgesia in consultant-led maternity units: a survey of UK practice. Int J Obstet Anesth. 2008 Jan;17(1):38. Epub 2007 Nov 5.

8) Wee MYK, Tuckley JP, Thomas P, Bernard S and Jackson D. The IDvIP trial: A two centre double blind randomised controlled tril comparing i.m. diamorphine and i.m. pethidine for labour. International Journal ofObstetric Anaesthesia. 2012;21(S1) S15.

9) Volmanen P, Akural E, Raudaskoski T, Ohtonen P, Alahuhta S. Comparison of remifentanil and nitrous oxide in labour analgesia. Acta Anaesthesiologica Scandinavica 2005; 49: 453 -458.

10) Volikas I, Butwick A. Maternal and neonatal side effects of remifentanil PCA. British Journal of Anaesthesia2005; 95: 504-509.

11) Lavand'homme P, Roelants F. Patient-controlled intravenous analgesia as an alternative to epidural analgesia during labor: questioning the use of the short-acting opioid remifentanil. Survey in the French partof Belgium (Wallonia and Brussels). Acta Anaesthesiologica Belgica 2009; 60: 75 –82

12) Muchatuta NA, Kinsella M. Remifentanil for labour analgesia: time to draw breath? Anaesthesia 2013; 68: 231–235.

13) Anim-Somuah M, Smyth R, Howell C. Epidural versus non -epidural or no analgesia in labour. Cochrane Database of Systematic Reviews 2005, Issue 4. Article number: CD000331. Date of issue: 10.1002/14651858.CD000331.pub2.

14) Reynolds F, Sharma S, Seed PT. Analgesia in labour and funic acid -base balance: a meta-analysis comparing epidural with systemic opioid analgesia. British Journal of Obstetrics and Gynaecology 2002;109: 1344-135310A.

15) Wilson MJA, MacArthur C, Cooper, GM, Bick D, Moore PAS, Shennan A. Epidural Analgesia and breastfeeding: a randomised controlled trial of epidural techniques with and without fentanyl and a non-epidural comparison group. Anaesthesia 2010 65: 145 -153.

16) Russell R, Dundas R, Reynolds F. Long term backache after childbirth: prospective search for causative factors. British Medical Journal 1996; 312: 1384 -1388.

17)Holdcroft A, Gibberd FB, Hargrove RL, Hawkins DF, Dellaportas CI. Neurological complications associatedwith pregnancy. British Journal of Anaesthesia 1995; 75: 522 -526.

18) Jenkins K, Baker AB. Consent and anaesthetic risk. Anaesthesia 2003; 58: 962-984.

19) Jenkins JG, Khan MM. Anaesthesia for Caesarean section: a survey in a UK region from 1992 to 2002. Anaesthesia 2003; 58: 1114 -1118.

20) Jenkins JG. Some immediate serious complications of obstetric epidural analgesia and anaesthesia: a prospective study of 145,550 epidurals. International Journal of Obstetric Anesthesia 2005; 14: 37 -42.

21) Reynolds F. Infection a complication of neuraxial blockade. International Journal of Obstetric Anesthesia 2005; 14: 183-188.

22) Ruppen W, Derry S, McQuay H, Moore RA. Incidence of epidural hematoma, infection, and neurologic injury in obstetric patients with epidural analgesia/anesthesia. Anesthesiology 2006; 105: 394 -399.

23) Rice I, Wee MYK, Thomson K. Obstetric epidurals and chronic adhesive arachnoiditis. British Journal of Anaesthesia 2004; 92: 109 -120.

24) Major complications of central neuraxial block: Report on the 3rd National Audit project of the Royal Collegeof anaesthetist. 2009. RCOA

25) Anim-Somuah M, Smyth RMD, Cyna AM, Cuthbert A. Epidural versus non-epidural or no analgesia for pain management in labour. Cochrane Database of Systematic Reviews 2018, Issue 5. Art. No.: CD000331. DOI: 10.1002/14651858. CD000331.pu.

Keep this information document. Use it to help you if you need to talk to the healthcare team.

Some information, such as risk and complication statistics, is taken from global studies and/or databases. Please ask your surgeon or doctor for more information about the risks that are specific to you.

This document is intended for information purposes only and should not replace advice that your relevant healthcare team would give you.