J Anesth (2013) 27:320–321
DOI 10.1007/s00540-012-1514-3

LETTER TO THE EDITOR

Analgesic treatment of vaginal delivery for late termination and intrauterine fetal demise during the second or third trimester of pregnancy

Rui Matsumine · Hiroyuki Sumikura

Received: 27 August 2012 / Accepted: 22 October 2012 / Published online: 22 November 2012

Keywords Analgesic treatment · Labor epidural analgesia · Late termination · Intrauterine fetal demise · Vaginal delivery

To the Editor:

Vaginal delivery in cases of late termination (LT) and intrauterine fetal demise (IUFD) must cause immeasurable emotional distress to the parturient, and often she must also endure painful interventions such as cervical pretreatment and induced labor. Thus, the parturient needs emotional support and adequate pain management during delivery. However, in Japan, where labor analgesia is unpopular, analgesic treatment has not been fully provided in such cases. Contrary to this general approach, our hospital provides the option of labor analgesia for normal childbirth on a round-the-clock basis as well as for cases of LT and IUFD, as follows. Just before cervical treatment, spinal anesthesia with 7.5 mg of bupivacaine is performed and an indwelling epidural catheter is placed. After labor induction, patient-controlled epidural analgesia (PCEA) using 2 μg/ml fentanyl combined with 0.1 % ropivacaine is started (5-ml bolus dose, 15-min lockout time, no background infusion). Although there are few reports and no recommendations regarding analgesic methods for these patients, epidural analgesia and systemic opioid analgesia have both been used clinically [1, 2], and we believe PCEA can provide better pain relief than intravenous patient-controlled analgesia. We report here our experiences using this method of analgesia.

R. Matsumine (✉) · H. Sumikura
Department of Anesthesiology, National Center for Child Health and Development, 2-10-1 Okura Setagaya-ku, Tokyo 157-8535, Japan
e-mail: rui_yajima@yahoo.co.jp

We reviewed the cases of parturients who required vaginal delivery for LT due to fetal abnormalities or for IUFD over the 2-year period from January 2009 to December 2010. Ninety-one cases were identified (46 for IUFD, 45 for LT), and analgesic treatment was provided in 64 % (58/91) of all cases and 76 % (35/46) and 51 % (23/45) of IUFD and LT cases, respectively. The rate of analgesic treatment after IUFD was much higher than the overall rate of epidural analgesia for vaginal delivery at our hospital (60 %), suggesting there is latent demand for analgesic treatment for these parturients, reaching the demand seen in other countries [2–4]. In regard to the less frequent use of LT, it should be noted that LT is strictly limited until 22 weeks' gestation in Japan, so parturients might have hesitated to choose analgesic treatment because of feelings of guilt.

An increasing number of parturients are opting for labor analgesia in Japan, and an increasing number of anesthesiologists are trying to meet their needs. However, it is still difficult to establish a system whereby anesthesiologists are always available to perform it due to a lack of staff and other problems. Nonetheless, as many cases of vaginal delivery for LT and IUFD are performed in a planned manner, labor analgesia can be done relatively easily, even in a hospital with limited anesthesiologist resources. Furthermore, anesthesiologists do not need to consider fetal well-being and appropriate interventions according to the progress of labor for labor analgesia in these cases, as they must in cases of normal vaginal childbirth.

In conclusion, we believe that analgesic treatment of vaginal delivery in cases of LT and IUFD in the second or third trimester of pregnancy is in demand in Japan, and it can be performed relatively easily. Therefore, hospitals should attempt to introduce labor analgesia services in such cases.

References

1. Dubar G, Benhamou D. Anesthesiologists' practices for late termination of pregnancy: a French national survey. Int J Obstet Anesth. 2010;19(4):395–400.
2. Benhamou Dan. Pain, epidural analgesia and late termination of pregnancy: a new challenge for obstetric anaesthesiologists. Int J Obstet Anesth. 2007;16:307–9.
3. Lo TK, Lau WL, Lai FK, Lam HS, Tse HY, Leung WC, Chin RK. Effect of fetal diagnosis on the outcomes of second-trimester pregnancy termination for fetal abnormalities: a pilot study. J Maternal-Fetal Neonatal Med. 2008;21(8):523–7.
4. Dickinson JE, Brownell P, McGinnis K, Nathan EA. Mifepristone and second trimester pregnancy termination for fetal abnormality in Western Australia: worth the effort. Australian and Newzealand. J Obstet Gynaecol. 2010;50(1):60–4.