QUESTIONS FROM THE ZAMBIAN ANAESTHESIA REFRESHER COURSE, KITWE 2005

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Are husbands allowed in the operating room during Caesarean Section; if yes, what are the advantages?

Husbands are encouraged to come into the operating room during Caesarean section in Britain, as long as the section is under epidural or spinal anaesthesia. Theatre clothes are worn and a screen is erected to hide the view of the wound. Practice varies whether he comes in before insertion of the block or after the block has been confirmed as satisfactory but before surgery commences. If, at any stage, a general anaesthetic becomes necessary, the husband or partner is usually asked to leave. A debate last year at an Obstetric Association of Anaesthetists' Controversies meeting on whether partners should be allowed if Caesarean section were to be under general anaesthesia showed only a minority of anaesthetists in favour, with little change after debate[1].

The perceived advantages are

- Emotional support for the mother. An early audit study[2] of maternal concerns in the theatre environment and satisfaction during this event showed that mothers talked to family more than to staff about their worries. In theatre, husbands / partners scored more highly than all others in the provision of moral support.
- Sharing of a life event. The involvement of the husband / partner in decision making and in the birth process was emphasised in an Audit Commission report[3].
- Paternal bonding with the baby. When appropriate after delivery, the baby is brought over to be held by the parents. One could argue that the mother should have first call, having carried the baby for 9 months!

In the event of a husband or partner not being able or unwilling to come into theatre, another person who is emotionally close to the mother (patient's mother, sister or close friend) may be allowed instead.

Some disadvantages are that there could be pressure on the husband / partner to conform though he may be reluctant for some reason. It could be awkward persuading the husband to leave if difficulties arise, though this should be agreed in advance. In U.K., the anaesthetist is rarely required to look after the baby. In an environment where looking after the baby is the norm, the anaesthetist may have three potential patients to attend as it is not unknown for husbands to feel queasy or to faint.

1) Robinson N and Smiley R. Controversies: Partners should be allowed to stay in the operating theatre during Caesarean section. International Journal of Obstetric Anesthesia 2004; 4: 251-6

2) Kennedy BW, Thorp JM, Fitch W and Millar K. The theatre environment and the awake patient. Journal of Obstetrics and Gynaecology 1992; 12:407-11

3) Audit Commission. First Class Delivery; improving maternity services in England and Wales. Abingdon: Audit Commission Publications; 1997.

Can the Glasgow Coma Score be used in a patient with head injury intoxicated with alcohol?

Yes, the Glasgow Coma Score (GCS) can be used in any patient as an assessment of "conscious level". In a case where alcohol and pathology may co-exist e.g. possible head injury in a patient who has been drinking alcohol, it would be expected that the scores would improve with falling alcohol levels and that non-improvement would suggest underlying pathology.

There are several important points to note about the Glasgow Coma Scale:-

- The worst possible score is 3 not zero.
- The best response is noted.
- GCS 8/15 provides less information than the three components of the Scale E2 V3 M3.
- If impossible to assess the best response, e.g. the patient is sedated and / or intubated, this is documented - not scored as "1" for no response.

1) Teasdale GM, Jennett B. Assessment of coma and impaired consciousness. Lancet 1974;2:81-4.

2) Teasdale GM, Murray L. Revisiting the Glasgow Coma Scale and Coma Score. Intensive Care Medicine 2000;26:153-4.

Is there a different Glasgow Coma Score for Paediatric Patients?

The assessment tool below is the one used at the Institute of Neurological Sciences in Glasgow, the home of the Glasgow Coma Scale. A modification of the adult scale was suggested by Australian workers[1,2] to take account of normal developmental milestones and after discussion with Glasgow.

The age column indicates the best that can be expected for that age range, e.g. 12 months to 2 years

- Verbal scale - recognizable words are expected - so best is 4.
- Motor scale - the infant will usually locate pain but not obeys commands - best is 4.

"Orientation" for children is defined as awareness of being in hospital

	Age		Coma scale
Eyes open		Spontaneously	4
		To speech	3
		To pain	2
		None	1
Best verbal response	> 5yrs	Orientated to place	5
	1-2yrs	Words	4
	6-12 mths	Vocal sounds	3
	6 mths	Cries	2
		None	1
Best motor response	>2 years	Obeys commands	5
	6mths- 2 yr	Localises pain	4
	6mths	Flexion to pain	3
		Extension to pain	2
		None	1

Normal aggregate score for children	
0-6 months:	9
> 6 - 12 months:	11
> 1 - 2 years :	12
>2 - 5 years:	13
> 5 years:	14

1. Simpson D, Reilly P. Paediatric Coma Scale. Lancet 1982; 2:450.

2. Reilly P, Simpson D and al. Assessing the conscious level in infants and young children: a paediatric version of the Glasgow Coma Scale. Child's Nerv Syst 1988; 4:30-3.