The following is a suggested guideline and does not replace ongoing clinical assessment and professional judgment.

1. **PRACTICE OUTCOME**

1.1 To provide clear directions for the safe care of a labouring patient with an intrathecal (spinal) catheter.

2. **BACKGROUND**

2.1 If a patient receives an accidental dural puncture (wet tap) during the placement of an epidural catheter for labour, the anesthesiologist has two choices:
   a. Repeat the procedure at a different interspace.
   b. Thread the epidural catheter into the intrathecal (spinal) space.

2.2 Inserting an intrathecal catheter limits the number of epidural attempts, can provide a very effective form of pain control, and mitigates the risk of high blocks that can occur with epidurals that are inserted following a wet tap.

2.3 There is some evidence that intrathecal catheter may reduce the need for an epidural blood patch (EBP), possibly by reducing the severity of post dural puncture headaches.

2.4 Intrathecal catheters may also be the preferred option for analgesia in the morbidly obese parturient.

3. **GUIDELINES**

3.1 Anesthesia will:

3.1.1 Affix the intrathecal (spinal) catheter with a green sticker labeled “spinal catheter.”

3.1.2 Follow suggested bolus dose of 0.5-1 mL bupivacaine 0.25% with fentanyl 10-20mcg.

3.1.3 Load the pharmacy pre-mixed 20 mL syringe of epidural solution (0.08% bupivacaine with 2 mcg/mL fentanyl) into the Medfusion 3500 syringe pump. Suggested infusion rate is 1-4 mL/hr. An Anesthesia MD and/or designate is responsible for infusion pump rate changes, bolus administration and change overs of pre-mixed syringes.

3.1.4 Lock the pump.

3.1.5 Complete Intrathecal Medication Continuous Infusion orders as applicable.

3.1.6 Leave clear directions regarding the timing of catheter removal, the timing of the catheter removal is at the discretion of the attending anesthesiologist. The intrathecal catheter may be left in for up to 24 hours. If the catheter remains in situ it must be capped and clearly labeled to prevent inadvertent injection in the catheter and an order left with specific instructions on when to remove the catheter.

**NOTE:** Patients with an intrathecal catheter in situ cannot be admitted to the postpartum unit.

3.1.7 Document if the catheter tip was intact on the Obstetrical Regional Anesthesia Form or in the Obstetrical (OB) Anesthesia follow-up binder after remove the intrathecal catheter. Place a sterile band aid over the site.

3.1.8 Follow all patients who had an intrathecal catheter daily while in hospital.

3.1.9 Give a “wet tap” letter to the patient prior to discharge. Ensure the patient’s demographic information is entered into the OB Anesthesia follow-up binder.

3.1.10 Insert the Regional Anesthesia Follow-up Sheet and the yellow copy of the Obstetrical Regional Anesthesia Form (marked anesthesia department) in the OB Anesthesia follow-up binder under spinal catheter (for St. Boniface site).

3.2 The patient remains on bed rest while the intrathecal (spinal) catheter is in use. If the infusion is not running and the catheter is properly capped and labeled, the patient may be allowed to mobilize.

3.3 Nursing will:

**NOTE:** Patients with an intrathecal catheter in situ cannot be admitted to the postpartum unit.
3.3.1 Follow the epidural procedure for vital signs and monitoring of sensory and motor block.
3.3.2 Examine the intrathecal catheter every hour to ensure there are no leaks and/or disconnections.
3.3.3 **An Anesthesia MD and/or delegate will be responsible for the infusion pump rate changes, bolus “top-up” administrations, and change overs of premixed syringes.**
3.3.4 Enter “spinal catheter” into NAPADEX (St. Boniface site).
3.3.5 Ensure this information is transferred with every break/shift change.
3.3.6 Remove the intrathecal catheter following the orders from Anesthesia on the timing of the catheter.
3.3.7 Document the removal of the intrathecal catheter on the Integrated Progress Note (IPN) indicating date and time of removal and if then catheter tip was intact.

4. **RESOURCES:**

4.1 Dr. Vasudha Mirsa, Site Medical Manager for Obstetrical Anesthesia, Women & Child Program, St. Boniface Hospital.
4.2 Dr. Leanne Docking, Site Medical Manager for Obstetrical Anesthesia, Women’s Health Program, Women’s Hospital.
4.3 Dr. Hema Begry, Consultant Anesthesiologist, St. Boniface Hospital
4.4 Dr. Chris Christodoulou, Site Leader, SBH Anesthesia and Perioperative Medicine
4.5 Continuing Education Instructor, Labour & Delivery, Women and Child Program, St. Boniface Hospital

5. **REFERENCES:**