

## Postersession V

### Abstract K

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<b>Medforfattere</b>	Anette R. Jensen, Anne Sofie B. Pedersen, Lisbeth T. Jensen
<b>Titel</b>	SIMULATION BASED TEAM TRAINING IN THE OPERATING ROOM. -WITH A FOCUS ON COMMUNICATION AND TEAMWORK

#### Background & Objectives

This study aimed to improve communication and teamwork in the operating room (OR) and to stimulate the simulation based training. Prior to this study a team consisting of scrub practitioners, anaesthetic nurses and doctors were educated to do team training.

Simulation training is inspired by flight simulation, where pilots and cabin crew are trained in critical situations. Anaesthetic nurses and anaesthesiologists have used this technique to train critical situations for years. Scrub nurses haven't been used to this way of learning, and as far as we know the setting has never been used with both scrub nurses, anaesthetic nurses and doctors. The scrub nurses were included both as instructors and in making the scenarios. The objective of the project was to increase and improve communication and team work in the OR through systematic simulator training.

#### Materiel & Methods

To prepare our colleagues, two staff meetings were held. They included introduction from the Danish Institute for Medical Simulation. Our colleagues were informed about principles of simulation and communication including introduction to the Anaesthetist Non-Technical Skills, ANTS-principles. 50 people participated. The instructors prepared 4 cases: 1. Circulatory arrest during laparoscopic procedure. 2. A patient who refuses to have gastroscopy performed without anaesthesia, meanwhile interruptions occur. 3. The bariatric patient with sudden leak of cuff and need for re-positioning. 4. Post partum bleeding including problems with positioning. 13 times we completed full scale simulation training in a period of 4 months. Each training with 5-6 participants and 2-3 instructors. Surgeons were also invited, and able to join 5-6 times. The project was evaluated through questionnaires before and after project implementation and a subsequent interview in a focus group.

#### Results

Before implementation 40 % of participants agree (37 %) and strongly agree (3%) that closed loops are used. After implementation 66 % of participants agree (59%) or strongly agree (7%). Before implementation 59% of participants agree (48%) and strongly agree (11%) that the the team communicate clearly about distribution of tasks. After implementation 71% of participants agree (67%) or strongly agree (4%). See table. 90% of participants agrees that the project increases their skills to communicate in acute situations. 73% agrees that the project has improved their skills for teamwork during acute situations.

#### Conclusions

The results show that the project has improved our common language including closed loops and clear communication. The staff has gained an increased knowledge of factors affecting team work. The simulation training continues in our ward, now during working hours. 4 times a year, for all doctors and nurses.

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### Abstract Q

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<b>Medforfattere</b>	Eske Kvanner Aasvang, dr.med.; Jonas Peter Eiberg, ph.d.
<b>Titel</b>	Post-anaesthesia care unit challenges after infra-inguinal arterial revascularisation surgery

#### Background

Patients with peripheral arterial disease (PAD) scheduled for infra-inguinal arterial revascularisation, often suffer from multiple severe cardio-pulmonary comorbidities making them high-risk patients to surgery and anaesthesia including complications in the acute postoperative anaesthesia care unit (PACU). However, details on the PACU-course are undescribed in the literature, hinde-

ring evidence based interventional trials. Thus, we aimed to explore the challenges in PACU after infra-inguinal revascularisation surgery, to identify relevant factors for subsequent improvement of rehabilitation.

## Methods

A prospective observational cohort study on the reasons for stay in PACU after infra-inguinal vascular surgery during a 3 month period was performed. Procedures included: femoral artery- bypass, cross-over, thrombectomy, embolectomy and thrombus endarterectomy (TEA). Pre- and intraoperative data included co-morbidities and severity (ASA), medications, pain, surgery- and anaesthesia technique. PACU data were collected every 15 minutes with assessment of patients' dischargeability to the surgical ward based upon the modified Aldrete discharge criteria as recommended by DASAIM. Primary outcome was time-related incidence of single item discharge score > 1, except saturation required a score > 2 due to local standards.

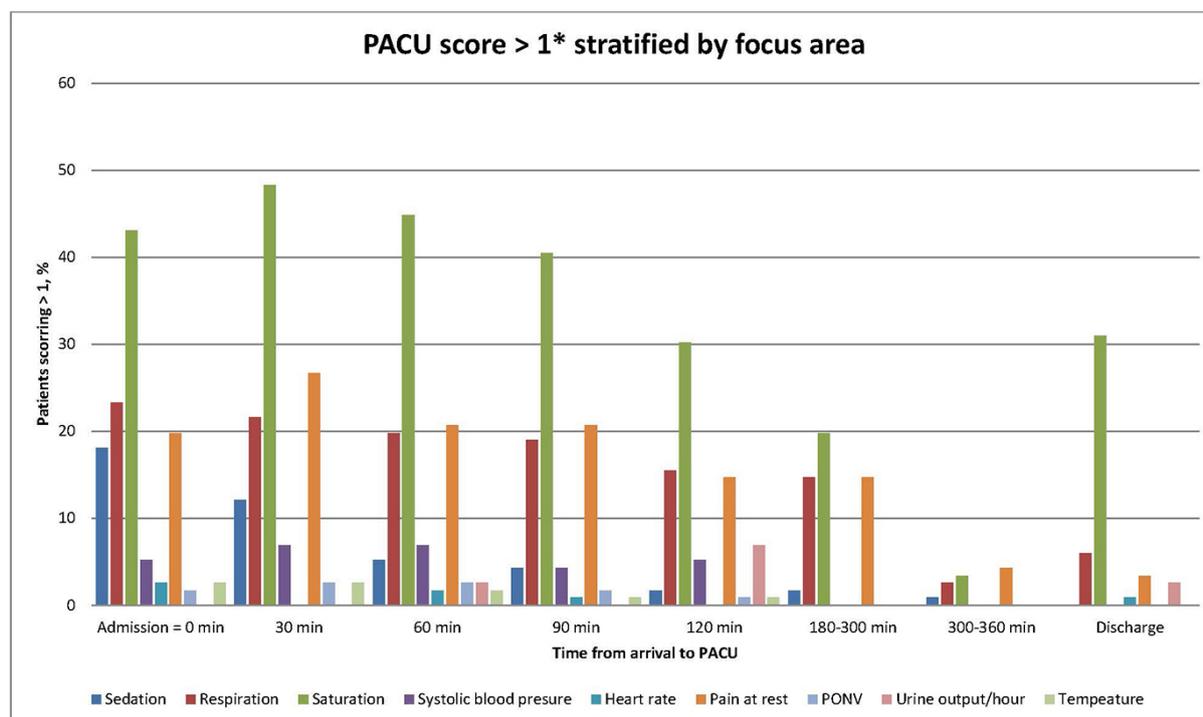
## Results

116 patients were included involving 61 (53%) bypasses/cross-overs, 33 (28%) TEAs and 22 (19%) thrombectomies/embolectomies. 99% of procedures were performed under general anaesthesia. During the PACU stay, low saturation was found in 50 patients (43%) having a SpO<sub>2</sub> < 85 % or required ≥ 3 litres oxygen upon PACU arrival and in 35 (30%) after 120 min. Sedation, respiration and pain at rest were other causes for not fulfilling discharge criteria (figure 1). Pain score > 1 (i.e. VAS > 3) at rest was found 23 patients (20%) and in 17 patients (15%) after 120 min. Supplemental opioid in PACU was given to 55% of patients. We found no differences in PACU complications between the different procedures or between elective and acute surgery.

## Discussion and conclusion

Our study found that patients undergoing infra-inguinal revascularisation often have respiratory insufficiency, low SpO<sub>2</sub>, sedation and moderate-severe pain at rest with need for supplemental opioids in the PACU, across procedure types. However, circulatory problems (hypotension, tachycardia/bradycardia) or urine output was not a frequent problem in PACU, despite significant cardiovascular co-morbidities. Similar to international standards, general anaesthesia is the preferred anaesthetic technique but with potential side-effects especially from opioid use in this frail population. Based upon our findings of PACU challenges primarily related to saturation, respiration, sedation and pain we suggest that epidural analgesia could be optimal due to the expected reduced opioid use, but the ideal perioperative regime must be confirmed in a prospective randomised trial.

Figure 1



\*Saturation score > 2, except at discharge.

## Abstract U

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**Titel** Medical students' technical and non-technical performance is positively correlated in simulated cardiac arrest scenarios

**Introduction**

Junior doctors' effect on patient mortality and morbidity has been debated for decades. Some research does suggest an increased risk for patients during periods with high turnover of medical graduates in hospitals, especially for high risk medical emergencies. Previous studies also indicate that many medical graduates feel unprepared for the job as a junior doctor. In particular, the diagnosis and treatment of acutely ill patients is identified as a challenge. Underperformance among junior doctors is most frequently seen in emergency medicine. The challenges seem mainly related to insufficient NTS. However, literature regarding NTS in medical students is lacking.

Consequently, it remains unclear to which extent medical students' NTS is affected by TS and when and how these skills should be trained during medical school to prepare medical graduates for internship and improve patient safety.

The aim of this study was to explore the relationship between medical students' technical skills (TS) and NTS and identify and describe the presence of NTS among medical students.

**Methods**

A convenience sample of medical students from University of Copenhagen were invited to participate in this study. The medical students were randomly assigned into groups of four and tested in four different standardised cardiac arrest simulation test scenarios (CASTS). Each medical student was individually assessed in one CASTS as team leader and participated in the remaining three CASTS as team member. To minimize team- and setting familiarity, two alternating participants from each simulation room rotated to the next simulation room after each CASTS. All CASTS were video-recorded and saved for later assessment of performance.

Technical performance was assessed using an earlier validated checklist to assess performance in a similar setting. Non-technical performance was assessed using Anaesthesiologists' Non-Technical Skills in Denmark behaviour rating system (ANTSdk). All video-recorded CASTS were rated independently by two experienced raters.

**Results**

A total of 21 medical students were included in this study. The medical students displayed an overall acceptable level of NTS compared to the expected level of a newly qualified anaesthetist, median ANTSdk overall global rating = 3. No significant difference in medical students' non-technical performance across ANTSdk categories was found. A moderate, positive correlation between TS and NTS was found ( $r_s = 0,591, p = 0,005$ ), see Fig. 1. The correlation was strongest between TS and non-technical performance on Decision Making and Leadership category level ( $r_s = 0,671, p = 0,001$  vs.  $r_s = 0,650, p = 0,001$ ), see Table 1.

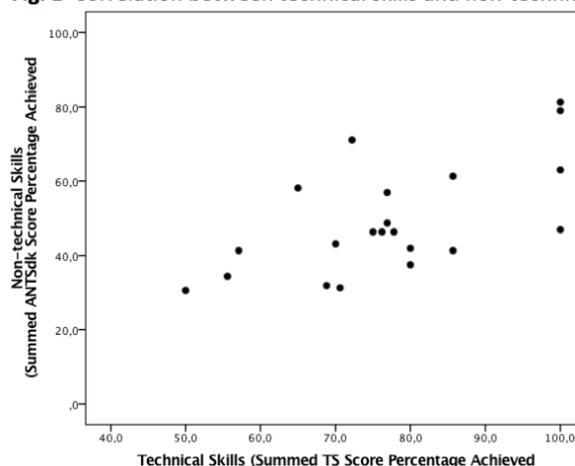
**Conclusion**

This study revealed a moderate to strong correlation between TS and NTS among medical students managing CASTS. An acceptable baseline level in all categories of NTS in medical students was found.

**Table 1** Spearman's correlation between TS and ANTSdk categories. \* $p < 0,05$ ; \*\* $p < 0,01$

	Situation Awareness	Decision Making	Team Working	Leadership	ANTSdk <sub>summed</sub>
TS Score	0,498*	0,671**	0,446*	0,650**	0,591**

**Fig. 1** Correlation between technical skills and non-technical skills



## Abstract R

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**Overskrift**

Analgesi til den fødende kvinde. Hvilken smertelindring tilbydes? – en spørgeskemaundersøgelse af skandinaviske jordemødre

### Introduktion

Mere end 200.000 kvinder føder hvert år i Danmark, Norge og Sverige. Trods at fødsel er en ikke-patologisk tilstand, accepteres ofte betydelige smerter. Flere smertelindrende metoder kan benytte under fødslen for at lindre kvinden. Begrænset viden om opioider og neuraxial analgesi er tilgængelig, men aktuelt findes ingen samlet opgørelse over hvilke smertelindrende metoder der reelt tilbydes fødende.

Undersøgelsens formål er derfor at skabe et overblik over de forskellige smertelindrende metoder som benyttes til fødende kvinder i de tre skandinaviske lande.

### Metoder

Via et elektronisk spørgeskema, indhentede vi svar fra klinisk aktive jordemødre. Spørgeskemaet blev, ved en iterativ proces, indholds- og forståelses valideret i mindre grupper af jordemødre. Alle besvarelser var anonyme. E-mails på klinisk aktive jordemødre var udleveret af lederen af fødegangen. Sygehuse med obstetrisk aktivitet blev identificeret via sundhedsstyrelsens offentlige årlige opgørelser fra de tre lande. Studiet krævede kun tilladelse fra Datatilsynet (REG-133-2014).

### Resultater

125 klinisk aktive jordemødre fra i alt 76 afdelinger besvarede spørgeskemaet. Non-farmakologisk analgesi kan ses på fig. 1. Morfin var det hyppigst rapporterede opioid (82%) og da oftest til intramuskulær injektion (92%). Kun otte (6%) jordemødre rapporterede at afdelingen tilbød remifentanyl infusion.

N2O blev rapporteret som mulig analgetisk behandling af 77% af jordemødrene. 48% i Danmark, 80% i Norge og 100% i Sverige ( $p < 0.001$ ). N2O var den analgetiske behandling som flest jordemødre fandt manglede i deres afdeling.

98% alle jordemødre rapporterede at en anæstesi-læge var tilgængelig døgnet rundt og 97% rapporterede at epidural analgesi kunne tilbydes. 30% af jordemødrene ( $n=38$ ) mente at der var en tidsgrænse i afd. for anlæggelse af epidural. Danske jordemødre rapporterede 79% af tidsgrænserne. Ti rapporterede en deadline for anlæggelse af epidural analgesi på 30 minutter og tyve jordemødre en grænse på 60 minutter.

### Diskussion

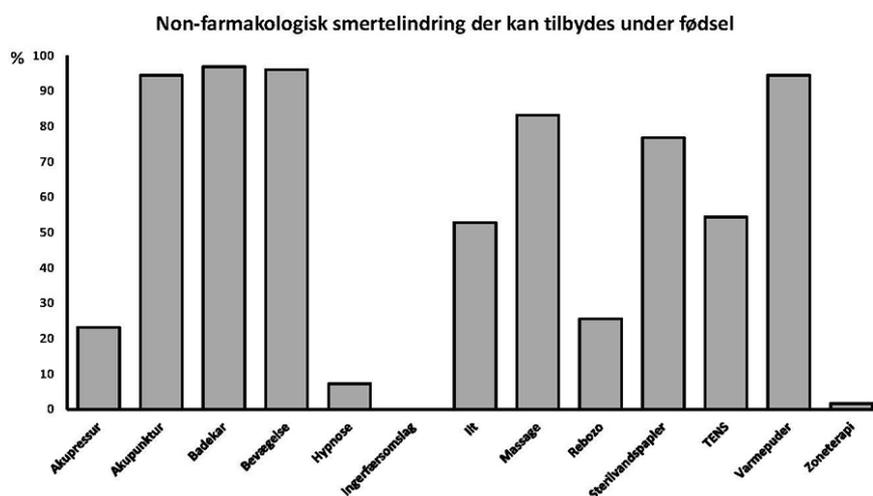
Jordemoderen er gate-keeper for smertelindring til den fødende. Vores undersøgelse viser at en række metoder administreret af jordemoderen er hyppigt tilgængelig om end der er betydelig varians.

For visse behandlinger er det andre forhold end effektiviteten der bestemmer hvor ofte en behandling er tilgængelig. Brugen af N2O viser stor spredning, antagelig pga. fokus på personalets arbejdsmiljø.

Danske anæstesiologer der anlægge fødeepiduraler er bekendt med at anlæggelsen er forbundet med et kvalitetsmål, procedurerestart inden for en time. Lignende kvalitetsindikatorer virker ikke til at blive benyttet som standard i Norge og Sverige.

### Konklusion

Store nationale forskelle på tilbudt smertebehandling til fødende eksisterer mellem Danmark, Norge og Sverige. Trods tilbud om mange andre smerte lindrende behandlinger, rapporteres epidural analgesi som en meget udbredt behandling, hvor tidsgrænser for anlæggelse dog kun virker implementeret i Danmark.



## Abstract Z

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Hvor lang tid er vi om at forløse, hvor dårligt er barnet og hvor ondt får mor? En retrospektiv undersøgelse af grad 1 og grad 2 sectio'er på Roskilde Sygehus.

### Introduktion

På Sjællands Universitetshospital Roskilde (SUHR) fødes ca. 2300 børn om året. Af disse forløses omkring 500 ved kejsersnit (CS) herunder ca. 180 som grad 1 eller 2. Målet er at overholde de nationalt vedtagne tider for forløsning; 15 minutter for grad 1 CS, 20 minutter for STAN events og 30 minutter for grad 2.

Baggrunden for denne poster er, at skabe et overblik over forløbet på de mest akutte kejsersnit på SUHR. Dels ved at undersøge, om forløsningstiderne overholdes og hvordan barnets tilstand er efter forløsningen. Dels ved at undersøge behovet for smertestillende postoperativt.

### Metode

Studiet er udført ved en retrospektiv indsamling af data fra samtlige grad 1 og 2 CS på SUHR i perioden 1/6-31/7 2016. Sectioets grad, valgte anæstesimode, forløsningstid, navlesnors pH samt det postoperative behov for smertestillende hos moderen noteredes. Data blev indsamlet fra anæstesiskemaet og den elektroniske patientjournal.

Data, beregnet ved SigmaPlot 11.0, er præsenteret med gennemsnit (+/- SD) hvis det er normalfordelt og median (øvre og nedre kvartil) såfremt det ikke er tilfældet.

### Resultater

29 akutte CS blev registreret i perioden. Der blev registreret 4 grad 1 kejsersnit, der alle blev forløst indenfor tidsfristen i generel anæstesi (GA). Der var 6 Grad 2 CS med STAN events. 5 blev udført i spinal og 1 i epidural, og ingen overholdt de foreskrevne 20 minutter. Der blev registreret 19 grad 2 kejsersnit. Heraf 12 i spinal, 6 i epidural og 1 i GA. 15 af disse blev forløst til tiden (Fig. 1). Navlesnors-pH viste en tendens til korrelation med sectio-grad, dog ikke signifikant. Grad 1: 7,17 (+/- 0,10), Stan 7,18 (+/- 0,07) og grad 2 7,25 (+/- 0,07);  $p=0,054$  (One-way Anova)

Det samlede opioid forbrug under indlæggelse var 30 (20;50) mg orale morfinækvivalenter, hvoraf 20 (10; 36) mg blev givet indenfor de første 12 timer. Der var ikke nogen signifikant forskel mellem grad eller anæstesimode (Fig 2).

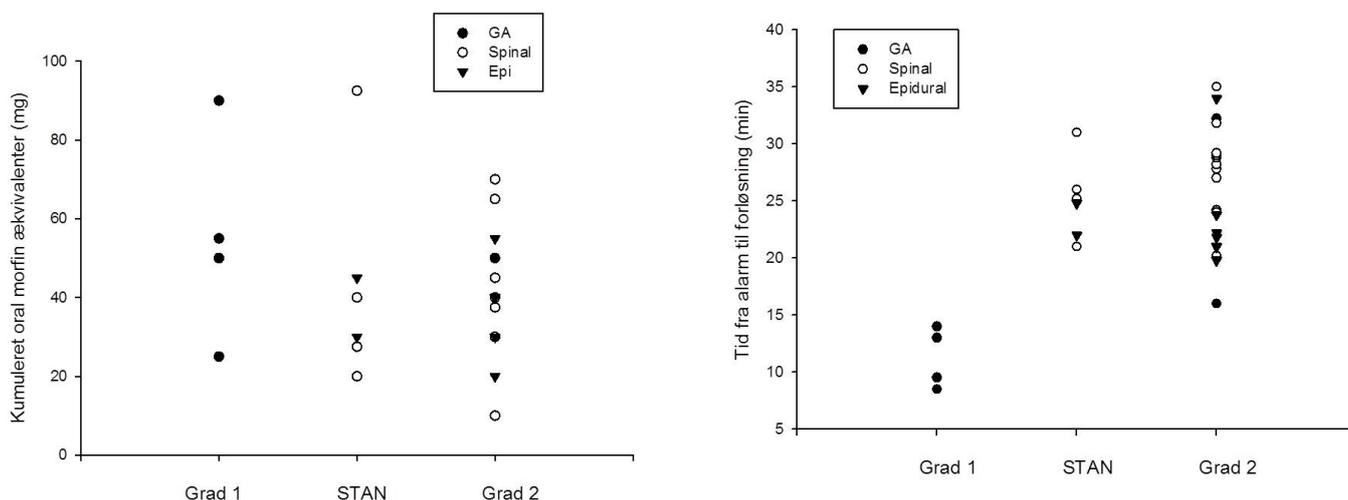
### Diskussion

Samtlige grad 1 kejsersnit forløst indenfor 15 min, hvor man fandt de mest påvirkede børn. Herimod blev ingen på STAN indikation forløst til tiden, og kun 80 procent af grad 2 CS blev forløst til tiden. Der ligger en udfordring for afdelingen i at overholde forløsningstiderne. For CS med Stan-events kunne det muligvis forbedres ved at ændre alarmkald, så det fremgår specifikt, at det er grad 2 med STAN.

Indtrykket af den postoperative smertebehandling var at behovet for smertestillende overvejende lå indenfor de første tolv timer og var jævnt fordelt uafhængigt af grad og anæstesimode. Det virker sandsynligt at kunne nedbringe opioid-forbruget ved at tilbyde en perifer nerveblokada efter operationen.

### Konklusion

Tidsfristen for grad 2 med og uden STAN-event blev ikke overholdt, hvilket er særlig kritisk for CS med STAN-events. I forhold til det den postoperative smertebehandling observeredes det overvejende behov indenfor de første tolv timer og var uafhængigt anæstesimode og grad.



## Abstract H

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**Titel** Characteristics of children undergoing anaesthesia in Danish hospitals 2005-2015.

### Introduction

Thorough knowledge of patient populations undergoing clinical procedures is needed for quality assurance and continuous improvement. We aimed to describe the population of children who received anaesthesia in Denmark during 2005-2015.

### Methods

Population-based observational cohort study. Children <18 years of age who received anaesthesia at a Danish hospital from January 1st 2005 to December 31st 2015 were identified in the Danish Anaesthesia Database (DAD). Adults  $\geq 18$  years identified in DAD were used as for comparison. DAD is a clinical quality insurance database, covering approximately 75 % of all anaesthesia episodes in Denmark. Age, sex, comorbidity measured by ASA score, frequency of anaesthesia per child, and indications for anaesthesia were tabulated for the whole child population as well as in annual strata. Indications for anaesthesia were tabulated for adults as well. The study is approved by the Danish Data Protection agency (2015-41-4498).

### Results

A total of 138,397 children (57 % male) received 221,074 episodes of anaesthesia during the 11-year study period. Among all children, including repeated anaesthesia episodes, 18 % were 0-2 years old; 18 % were 3-5 years old; 19 % were 6-9 years old, 19 % were 10-13 years old; and 26 % were 14-17 years old. Seventy-three percent had an ASA score of 1; 19 % had a score of 2; 5 % had a score of 3; and 3 % had a score of 4 or higher. The distribution of age, sex, and ASA score did not change over time. Seventy-two percent (99,180/138,397) underwent anaesthesia only once; 18 % twice; 5 % three times; and 5 % four times or more. Hence, 55 % (121,894/221,074) of all anaesthesia episodes were conducted on children with anaesthesia experience. The indications for anaesthesia were the following for children (n=221,074) and adults (n=1,969,309): 85 % vs. 92 % due to surgery; 7 % vs. 1 % due to diagnostic non-surgical procedures; 6 % vs. 6 % due to non-surgical care; and 2 % vs. 1 % due to other reasons. In children, the three most common indications for anaesthesia were tonsillectomy (15,349; 7 %), operation for antebrachium fracture (11,194; 5 %) and appendectomy (7,137, 3 %), and the most common non-surgical indication for anaesthesia was magnetic resonance imaging scan (7,184; 3 %).

### Discussion

The population of children undergoing anaesthesia in Danish hospitals has been stable during the last decade with regard to sex, age, and comorbidity. About half of the anaesthesia episodes were in children with anaesthesia experience. A large proportion of anaesthesia episodes were for non-surgical reasons, a pattern that was different in adults.

About half of the anaesthesia episodes were in children with anaesthesia experience. A large proportion of anaesthesia episodes were for non-surgical reasons, a pattern that was different in adults.

### Conclusion

This study provided important information on the composition of children undergoing anaesthesia in Denmark during the past 11 years.

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## Abstract 14

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**Titel** Anaesthetic management of children in Danish hospitals

### Introduction

Detailed knowledge of current practice for provision of anaesthesia is important for quality assurance and continuous improvement. We aimed to describe anaesthesia practice for children in Denmark during 2005-2015, compared to adults.

### Methods

Population-based observational cohort study. Children <18 years of age who received anaesthesia at a Danish hospital from January 1st 2005 to December 31st 2015 were identified in the Danish Anaesthesia Database (DAD). Adults ≥18 years identified in DAD were used for comparison. Anaesthesia methods were tabulated and compared between children and adults. The study was approved by the Danish Data Protection Agency (2015-41-4498).

## Results

A total of 138,397 children (57 % male) received 221,074 episodes of anaesthesia during the 11-year study period. Anaesthesia methods used for children and adults (n=1,928,419) are shown in Table 1. For anaesthetic episodes where general anaesthesia or sedation were provided, methods used for administration of anaesthetic agents in children (n=218,742) and adults (n=1,717,847) are shown in Table 2. In 17,479 episodes of regional anaesthesia in children, methods used were neuraxial blocks, 16%, with sacral and epidural being most frequently applied blocks; peripheral nerve blocks, 32%, with the femoral, popliteal, and infra clavicle blocks being the most frequent; local infiltration analgesia, 20%; intravenous regional anaesthesia, <1 %; and 32 % of the episodes were unclassified.

## Discussion

Although national DAD coverage is less than 75%, the proportions presented in this study are assumed to be representative of current national practice. The differences observed between children and adults reflect some of the clinical considerations that need to be taken into account when providing anaesthesia to children. Children may not be able to comply with being awake during regional anaesthesia alone, or with the peripheral venous puncture required for total intravenous anaesthesia. This may explain our observations of general anaesthesia being more frequent in children, and inhalation anaesthesia being more common in children either alone or in combination with intravenous anaesthesia. Unfortunately, available data did not allow us to detail the use of intravenous and inhalation anaesthesia in combination. In children, anaesthesia is often induced by inhalation followed by intravenous maintenance. In adults, an opposite pattern would often apply, thus reflecting different practices according to age.

## Conclusion

General anaesthesia alone or in combination with regional anaesthesia was by far the most common method of anaesthesia in children in Danish hospitals, with regional anaesthesia alone being rarer compared to adults. Although total intravenous anaesthesia was the predominant method for general anaesthesia, inhalation anaesthesia either alone or in combination with intravenous anaesthesia was used more frequently in children than in adults.

**Table 1**

Anaesthetic methods in children and adults	Patient group			
	Children		Adults	
	n	%	n	%
Total anaesthesia episodes	221,074		1,928,419	
GA alone	196,761	89	1,423,461	74
GA + RA	16,683	8	136,055	7
Sedation alone	5,003	2	85,212	4
Sedation + RA	295	<1	73,119	4
RA alone	501	<1	189,304	10
Monitoring under anaesthesia preparedness	558	<1	9,417	<1
Not classified	1,273	1	11,851	1

Legend: general anaesthesia (GA), regional anaesthesia (RA)

**Table 2**

Administration of anaesthetic agent where general anaesthesia and/or sedation was part of the strategy	Patient group			
	Children		Adults	
	n	%	n	%
Total anaesthesia episodes	218,742		1,717,847	
Total intravenous anaesthesia	142,403	65	1,333,703	78
Intravenous + inhalation anaesthesia	56,974	26	215,208	13
Inhalation anaesthesia	14,088	6	10,539	1
Rectal or intramuscular administered agent	53	<1	370	<1
Not classified	5,224	2	158,027	9

## Abstract 17

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<b>Medforfattere</b>	Fredrik Hetmann, Kim Wildgaard
<b>Titel</b>	Management of acute caesarean section and intrauterine resuscitation – a survey of Scandinavian practice

### Introduction

Acute caesarean section (CS) is a common procedure in the obstetric ward. As the urgency of acute CS increases the risk for the mother, clear communication, effective teamwork and optimal logistics is warranted for reducing errors and safely perform the procedure. Lucas et al [1] therefore proposed a four-point classification system in order to facilitate communication and set an auditable standard for the most urgent CS. This classification system has been endorsed by the Danish society of anaesthesia but neither the Swedish nor the Norwegian counterpart have clear guidelines regarding classification and decision-to-delivery interval (DDI) for acute CS. Contrary to the United Kingdom[2][3], little is known about actual organisational factors, anaesthetic practise, alarm chain and use of intrauterine resuscitation (IUR) for acute CS in the Scandinavian countries. The aim for this survey was therefore to describe actual practise of classification, organisation and anaesthetic care for the most acute CS in Denmark, Norway and Sweden.

### Method

Using publicly available data from the National Board of Health obstetric anaesthetic departments were identified. An electronic questionnaire was sent to two specialists from each participating department in the three countries. Mandatory electronic registration of data was approved by the Danish Data Protection Agency (no. 2007-58-0015).

### Results

Response rate was 80% (n = 145), in total 82% of all departments participated. Urgency of acute CS was most commonly classified in to three grades (60.7%) followed by two grades (31.7%). Nomenclature for urgency classification fell in to one of five groups; Colours, Enumerative, Time, Urgency descriptors and Others (table 1). For the most urgent CS, 90% of specialist reported DDI <15min (figure 1) and both anaesthetist and theatre staff are most commonly informed by pager or similar device. General anaesthesia is the dominant anaesthetic used in Sweden and Norway (97%, 93%), however in Denmark 42% of specialist report use of neuraxial anaesthesia as default for the most urgent CS. 20 out of 145 specialists confirmed existence of local guidelines for IUR.

### Discussion

In the three Scandinavian countries there seems to be a non-unanimous classification for acute CS. However, the vast majority of Scandinavian specialists report a DDI for the most urgent CS to be shorter than UK standards, which may in turn explain the high rate use of general anaesthesia as default. IUR is poorly described in Scandinavian local guidelines for anaesthetists

### Conclusion

Our survey of Scandinavian anaesthetist show variances within classification, nomenclature and anaesthetic care of acute CS in the three countries, with some international congruence.

The data presented should be used as an inspiration for the development of local or national consensus guidelines, particularly for Norway and Sweden.

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2. Kinsella SM, Walton B, Sashidharan R, Draycott T. Category-1 caesarean section: a survey of anaesthetic and peri-operative management in the UK. *Anaesthesia* 2010;65:362-8.
3. Thurlow JA, Kinsella SM. Intrauterine resuscitation: active management of fetal distress. *Int J Obstet Anesth* 2002;11:105-16.

Table 1. Grading and classification for acute caesarean section in Scandinavia 2014.

	Denmark (n=43)	Norway (n=43)	Sweden (n=59)	Total (n=145)
<b>Number of acute CS gradings</b>				
1	0	0	8 (14%)	8 (5.5%)
2	0	17 (40%)	29 (49%)	46 (31.7%)
3	42 (98%)	25 (58%)	21 (36%)	88 (60.7%)
4	0	1 (2%)	1 (2%)	2 (1.4%)
5	1 (2%)	0	0	1 (0.7%)
<b>Acute CS classifications named using:</b>				
Colour system	2 (5%)	4 (9%)	0	6 (4.1%)
Enumerative (numbered category)	41 (95%)	17 (40%)	7 (12%)	65 (44.8%)
Time (in minutes)	0	1 (2%)	10 (17%)	11 (7.6%)
Urgency (emergency, urgent, etc.)	0	19 (44%)	42 (71%)	61 (42.1%)
Other	0	2 (5%)	0	2 (1.4%)

CS = caesarean section

Figure 1. Decision to delivery interval (DDI) for the most urgent degree of caesarean section in Denmark, Norway and Sweden 2014.

