Few years ago a study was published dealing with a survey performed including North American academic institutions to obtain a more precise idea about the quality of anesthesia care during the perioperative period following cesarean section (1).

The survey mainly focused on the geographical location of such a post-anesthesia care unit (PACU) and the qualifications of nurses caring for these patients. The response rate was 54.8% while the cesarean section rate averaged 30% with a median of 2550 deliveries per year. In 97% of the institutions cesarean sections were performed in a separate obstetric surgery suite. Regardless of the type of anesthesia 81% of the hospitals recovered cesarean section patients on an obstetric PACU while the labor, delivery and recovery room were used in 16.2% and 14.9% for neuraxial and general anesthesia respectively. Less than 4% of the institutions recovered these patients elsewhere.

As a consequence in more than 85% of the institutions post-anesthesia care was staffed by perinatal labor and delivery nurses rather than dedicated peri-anesthesia care unit nurses. Although it should be avoided that one nurse would be responsible for two patients i.e. caring for both mother and neonate, the latter seemed the case in 65% of the responding institutions with a special obstetric recovery room.

Especially in patients recovering from neuraxial anesthesia (95% of the cesarean deliveries) continuous ECG and pulse oxymetry monitoring were not used in 20% and 12% of cases respectively. Specific training for the postoperative care of cesarean section patients was not organised in 45% of the hospitals while a similar incidence was noted for respondents rating the quality of post-cesarean section care to be lower as compared with general surgery patients. It is suggested that the quality of care for patients recovering from cesarean section does not meet the guidelines put forth by the ASA Task Force on Postanesthetic Care and the American Society of PeriAnesthesia Nurses.

This well conducted survey may raise significant concern. It is not a surprise that the quality of care for post-cesarean section patients may be of inferior quality as compared to our care given to other surgical patients. A variable degree of negligence may be explained by the high incidence of neuraxial techniques in patients not considered to be ill, the urge to care for their babies, to start breast feeding and skin-to-skin contact as soon as possible and to meet their families.

The survey was conducted in academic hospitals only although the pathology presented to (at times larger) non-academic obstetrical departments should not be ignored while these hospitals often do not have residents available or at least not around the clock.

When 30% of an average of 2550 deliveries are performed surgically then this signifies only one cesarean section per 12 hours.

As a consequence many (even newly built) hospitals, at least in Northern Belgium, prefer to perform cesarean deliveries in the central operating theatre (except for urgent procedures) where nurses are more familiar with asepsis, surgical procedures and instrumentation while it is considered safer to subsequently transfer these patients to the main surgical post-anesthesia care unit. Even those centers performing routine or only urgent C-sections in special obstetric operating rooms mostly send these patients to the main PACU in which dedicated nurses have more experience in post-anesthetic care, are available around the clock, are more likely to be BLS/ACLS certified and tend to leave their patients less as, in comparison with perinatal nurses, they have no other responsibilities than postoperative care. In most surgical recovery rooms an additional remote central monitoring is available and resuscitation equipment and prepared medication are more likely to be immediately available. The discussion in the survey whether continuous ECG monitoring is mandatory is not relevant because it does not signify a major effort while in case of problems the

Editorial

Do we need special recovery units for C-section patients?

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The evaluation of a surgeon called upon will be able to check the cardiac function immediately without further delay.

As no such studies have been performed up to date, it is unclear whether a decentralisation of surgical delivery and postoperative care is economically beneficial when considering manpower, equipment, transportation, ...

Although there may be an argument in favor of a quite separate recovery unit for C-section patients as skin-to-skin contact and breast feeding can start very soon after delivery as indicated by the Mother and Baby Friendly Hospital Initiative, perinatal nurses have to be aware that, despite this benefit, postsurgical maternal care prevails.

In conclusion, although obstetricians (for practical reasons) and midwives (for mother/neonatal care) prefer to a large extent that both cesarean procedures and immediate postoperative care should be performed and stay at the obstetrical and delivery suite, manpower and safety reasons may attenuate this policy to become routine practice in Northern Belgium. This is based upon actual practice and intentions suggested by interviewing anesthetists and information gathered from larger university (4), community (6) and private (5) hospitals.

The least we can expect is that our mothers receive excellent postoperative care and monitoring irrespective of the location where the recovery following regional or general anesthesia is done!

References