

## Original Research Article

### **Measurement (Of) The Outcome of Low Dose of 0.5% Bupivacaine (Mention heavy or in Dextrose solution instead of plain bupivacaine) in Spinal Anesthesia During Lower Segment Cesarean Section (LSCS)**

#### **Abstract:**

**Background:** Anesthesiologists still face difficulties while administering spinal anesthesia for a lower segment cesarean section, such as severe hypotension due to a large bupivacaine dosage or inadequate *proper (not required)* anesthesia level conditions due to a *little (lower)* bupivacaine dose.

**Objective:** In this study our main goal is to measure the efficacy of low dose of 0.5% Bupivacaine in spinal anesthesia during lower segment cesarean section.

**Method:** This cross-sectional comparative study was carried out at tertiary medical College from January 2020 to January 2021. Where a total of 100 pregnant women were included in the study.

Patients, who agreed to the study, were randomized (*and*) divided into two groups: Group A patients who received an intrathecal injection of 3 mL of bupivacaine 0.5%, n=50 and Group B patients who received an intrathecal injection of 2.5 mL of bupivacaine 0.5%, n=50. The method of randomization was by coin tossing.

Pre anesthetic pulse rate, blood pressure and oxygen saturation were recorded. After preloading with 800ml-1000ml of Isotonic I.V. fluid *SAB (explain abbreviation the first time used)* were *performed (was administered)* with 25-gauge Quincke spinal needle via midline approach in each patient. 20-30 seconds were taken to inject the Hyperbaric Bupivacaine, without barbotage. Bevel of the needle *were (was)* parallel to the dural fibres.

All collected data were *coding (coded?)* and input in SPSS-25 for further analysis. Both descriptive and inferential statistics done. Descriptive statistics included, percent, mean, standard deviation; graph, tables, figures and inferential statistics.

**Results:** During the study, majority were belonging to 26-33 years age group, 60% and 70% were multiparous. The satisfactory surgical sensory level was achieved in all cases in both groups with the following distribution. However, Only 19% cases in Group A *were indicated to have (required the use of) ephedrine*, whereas 89% in Group B were indicated to *(receive ephedrine in order to) support their blood pressure with ephedrine*. There were no differences between the two groups regarding the fluid intake ( $894 \pm 126\text{mL}$ ) in Group A versus  $720 \pm 212\text{ mL}$  in Group C with  $P > 0.05$ ). Neonatal Apgar score was 9 in the first 1 min and increased to 10 at 5 min. In addition, group A nausea and vomiting cases *(were) seen in 19% cases* whereas in group B it was 23%.

**Conclusion:** We can say that, unlike low dose, a *large (optimum) dose* of hyperbaric bupivacaine in the spinal anesthetic for a lower segment cesarean section will result in excellent surgical circumstances with little hypotension. Further study is needed for better outcome.

**Keywords:** Bupivacaine, spinal anesthesia, lower segment cesarean section (LSCS).

## **Introduction**

Common practice has shifted to include spinal anesthesia during cesarean sections. In a similar vein, Egypt's rapidly increasing C-section rate has prompted questions regarding the causes and potential solutions to this problem.

Hypotension after intrathecal bupivacaine injection has been shown to occur in 56–74% of patients in previous studies.<sup>1-3</sup>

To solve this problem, numerous study have been undertaken to minimize the amount of bupivacaine, based on the theory that spinal anesthetic promotes sympathectomy, which reduces blood pressure.

Unfortunately, all of these investigations discovered that reducing the dosage results in a lower block level, which leads to an unsatisfactory surgical situation as well as the patient's pain. Furthermore, it has no effect on the incidence of hypotension, suggesting that the reason of hypotension is multifactorial and may be strongly connected to uterine compression and increased intraabdominal pressure.<sup>4-6</sup>

Other researchers have investigated the effect of sitting position on hypotension using the second theory of great vascular compression by the gravid uterus.<sup>7</sup>

In this study our main goal is to compare the efficacy of low dose of 0.5% Bupivacaine in spinal anesthesia during lower segment cesarean section.

## Objective

To **compare (with what?)** the efficacy of low dose of 0.5% Bupivacaine in spinal anesthesia during lower segment cesarean section.

## Methodology

This cross-sectional comparative study was carried out at a Tertiary medical College from January 2020 to January 2021 where a total of 100 pregnant women were included in the study.

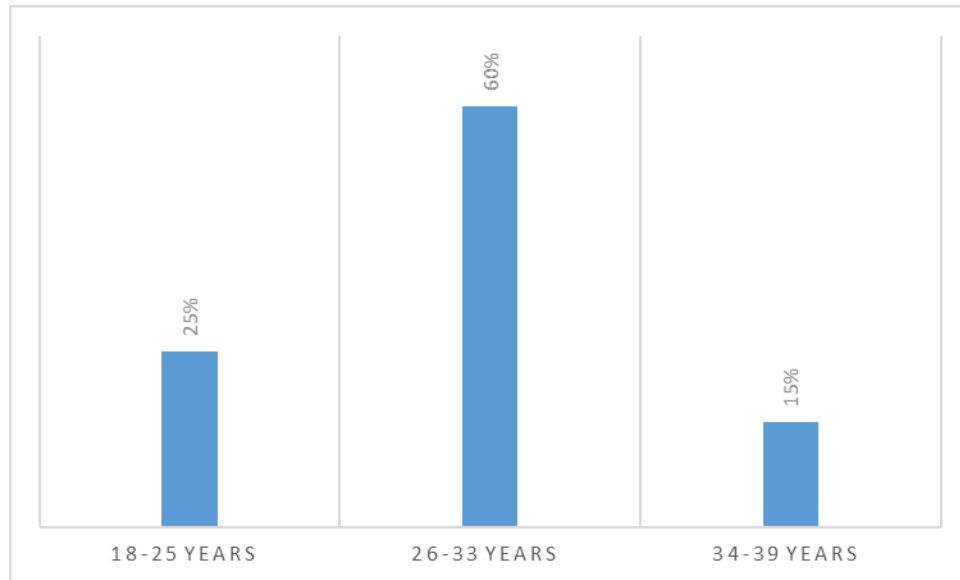
Patients, who agreed to the study, were randomized **(and)** divided into two groups: Group A patients who received an intrathecal injection of 3 mL of bupivacaine 0.5%, n=50 and Group B patients who received an intrathecal injection of 2.5 mL of bupivacaine 0.5%, n=50. The method of randomization was by coin tossing.

Pre anesthetic pulse rate, blood pressure and oxygen saturation were recorded. After preloading with 800ml-1000ml of Isotonic I.V. fluid SAB **were performed (was administered)** with 25 gauge Quincke spinal needle via midline approach in each patient. 20-30 seconds were taken to inject the Hyperbaric Bupivacaine, without barbotage. Bevel of the needle **were (was)** parallel to the dural fibres. Before injecting **L.A (Explain abbreviation in first use)** bevel rotated to direct cephalad. After injecting the LA, patients were kept supine with the wedge under right buttock. The level of sensory block **was** assessed bilaterally in anterior axillary line by pin prick method using a 25 gauge needle. Motor block **were (was)** assessed by the movement of lower limbs using modified Bromage scale, 0 = Able to rise extended legs, 1 = Inability to flex the knee, 2 = inability to flex the ankle, 3 = Complete block. Upto T6 and upward is taken as adequate block.

All collected data were **coding (coded?)** and input in SPSS-25 for further analysis. Both descriptive and inferential statistics done. Descriptive statistics included, percent, mean, standard deviation; graph, tables, figures and inferential statistics.

## Results

In (F)igure-1 shows age distribution of the study group where majority were belonging to 26-33 years age group, 60%. Followed by 25% belong to 18-25 years group and 15% belong to 34-39 years age group. The following figure is given below in detail:



**Figure-1: Age distribution of the patients**

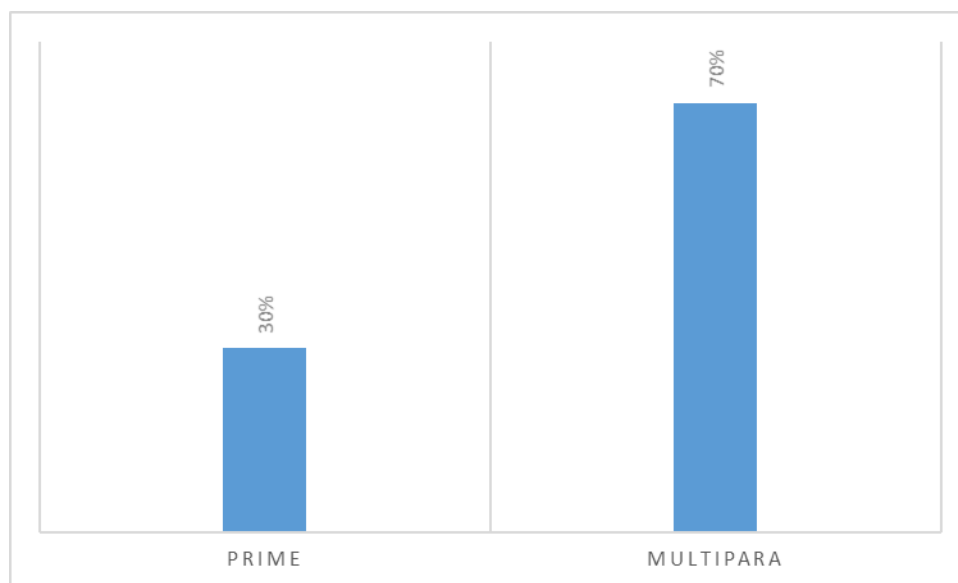
In table-1 shows demographic status of the patients where majority were literate, 70% and 72% were housewife. The following table is given below in detail:

**Table-1: Demographic status of the patients**

<b>Mean BMI</b>	<b>31.51±4.9</b>
<b>Educational status</b>	<b>%</b>
<b>Literate</b>	70%
<b>Illiterate</b>	30%
<b>Occupational status</b>	<b>%</b>
<b>Housewife</b>	72%
<b>Service holder</b>	18%
<b>Student</b>	10%
<b>Monthly family income (monthly)</b>	<b>%</b>
<b>&lt;10000 Tk</b>	20%

<b>10001-20000 Tk</b>	50%
<b>&gt;20000 Tk</b>	30%

In figure-2 shows parity distribution of the study group where the peak incidence was among the multiparous (70%). The following figure is given below in detail:



**Figure-2: Parity in patients with ectopic pregnancy.**

In table-2 shows Sensory level among two group where the satisfactory surgical sensory level was achieved in all cases in both groups with the following distribution. However, 90% cases were at T4 level, and only 10% cases were at T2 level in Group C (B) while all cases in Group B (A) were at the T4 level. The following table is given below in detail:

**Table-2: Sensory level among two group**

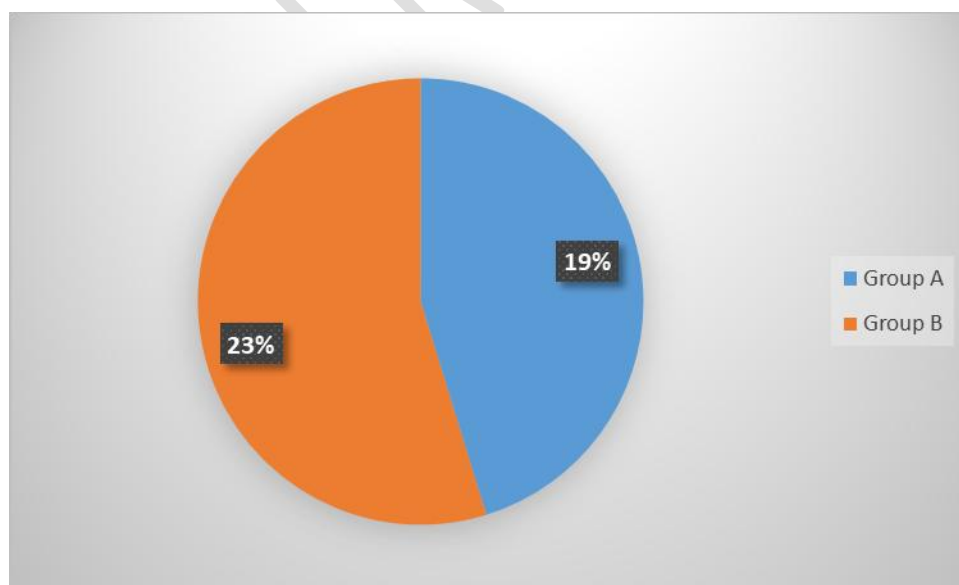
<b>Sensory level</b>	<b>Group A, %</b>	<b>Group B, %</b>
T2	0%	10%
T4	100%	90%

In (T)able-3 shows distribution of the groups according to clinical and Neurologic and Adaptive Capacity Score where only 19% cases in Group A were indicated to have (required the use of) ephedrine, whereas 89% in Group B were indicated to (receive ephedrine to) support their blood pressure with ephedrine. There were no differences between the two groups regarding the fluid intake ( $894 \pm 126$  mL) in Group A versus  $720 \pm 212$  mL in Group C with  $P > 0.05$ ). Neonatal Apgar score was 9 in the first 1 min and increased to 10 at 5 min. The following table is given below in detail:

**Table-3: Distribution of the groups according to clinical and Neurologic and Adaptive Capacity Score**

	Group A, %	Group B, %	P value
Ephedrine	19%	89%	0.001
Fluids (mL)	$894 \pm 126$	$720 \pm 212$	$>0.05$
Apgar at 1 min	(8-9)	(9-9)	$>0.05$
Apgar at 5 min 10	(10-10)	(9-10)	$>0.05$

In (F)igure-3 shows distribution of the study group according to clinical symptom where in group A nausea and vomiting cases were seen in 19 % cases whereas in group B it was 23%. The following table is given below in detail:



### Figure-3: Distribution of the study group according to clinical symptom

#### Discussion

Many studies were trying to reduce the volume or dose of bupivacaine claiming that the hypotension will be overcome.<sup>7-8</sup>

One study reported that, the ED 95 of bupivacaine and found that 11.2 mg is enough to achieve a satisfactory sensory level and a pain-free surgery. They also found that the ED50 was 7.6 mg using a logistic regression model.<sup>9</sup>

Most practitioners use doses between 7.5 and 15 mg of hyperbaric bupivacaine. Those who use the lower dose, aiming to decrease the incidence of side effects such as hypotension or nausea, have faced a cost of **patients' unsatisfaction (unsatisfied patients)** and visceral pain. The studies showed an increased incidence of patients with an inadequate surgical sensory block when using doses <10 mg up to 71%.<sup>10-11</sup>

Another report did a retrospective study on 1252 patients receiving either 8 mg or 10 mg and found that there was a higher rate of conversion to general anesthesia in a group who received 8 mg (the relative risk was 4.88 [95% CI 1.41–16.85]).<sup>12</sup>

In a review article done by two study done 15 reviewed articles concluded that doses <8 mg will result in more analgesic requirements such as a high rate of conversion to general anesthesia and less hypotension and nausea and vomiting.<sup>13-14</sup>

It is clear that a low dose is not a practical solution and that is why we used big doses in this study to overcome this limitation. However, someone can claim that a conventional dose or even a low dose in a large volume can be the solution.<sup>15</sup>

In our study showed only 19% cases in Group A were indicated to have ephedrine, whereas 89% in Group B were indicated to support their blood pressure with ephedrine. There were no differences between the two groups regarding the fluid intake ( $894 \pm 126$ ) in Group A versus  $720 \pm 212$  mL in Group **C (B)** with  $P > 0.05$ ). Neonatal Apgar score was 9 in the first 1 min and

increased to 10 at 5 min. The latter, who tried isobaric bupivacaine, found disappointing results as there were no differences between both medications (isobaric and hyperbaric) regarding hemodynamic and the incidence of hypotension. Which was supported by other studies.<sup>16</sup>

## Conclusion

We can say that, unlike low dose, a **large (optimum)** dose of hyperbaric bupivacaine in the spinal anesthetic for a cesarean section will result in excellent surgical circumstances with little hypotension. Further study is needed for better outcome.

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UNDER PEER REVIEW