Abstract

Background: An effective relief of labour pain has become an important part of obstetric medicine. Therefore regional nerve blocks, systemic analgesic and non-pharmacologic techniques are commonly used. This review article gives a summary of pathophysiology and anatomy of labour pain as well as advantages, disadvantages, risks and adverse reactions of analgesic techniques in newborns and parturients.

Methods: We performed a selective literature search in Medline via PubMed using the search-terms "Analgesia" and "Obstetrics". We also included the current guidelines of the German Society for Anesthesiology and Intensive Care Medicine.

Results: PDA and CSE are safe techniques for the relief of labour pain if contraindications are excluded. The risk for instrumental delivery but not for caesarean section is increased under neuraxial analgesia. PDA and CSE should be performed in an early stage of labour using low doses of local anaesthetics if possible. It is not necessary to wait for a defined cervical dilatation before starting neuraxial analgesia. Anesthesiologists and obstetricians should inform patients as soon as possible before the situation of stress during labour. Systemic opioid analgesia is a possible alternative for neuraxial techniques. Because of possible side effects systemic remifentanil analgesia should only be performed under continuous monitoring. Several nonpharmacologic methods can also relieve labour pain, but results of studies about their effectiveness are inconsistent.

Zusammenfassung


Analgesia in Obstetrics

Effective pain relief has become an important part of obstetric medicine. The history of modern analgesia during childbirth can be traced back to 1847 with the application of ether and, later, chloroform. At the beginning of the twentieth century morphine and scopolamine were used to induce a “twilight sleep” [1] and between 1900 and 1930 the first epidural block and pudendal nerve anaesthesia were performed [2]. Further developments in continuous spinal analgesia took place in 1943 [3]. In addition to the long known non-pharmacological methods, today effective regional anaesthesia and systemic analgesic procedures are available for alleviating labour pains. The following review provides a summary of the anatomical and pathophysiological principles involved in labour pain, as well as the analgesic procedures available, including their advantages, effects on mother and child, risks and potential complications.

The pathophysiology of labour pain

Pain impulses from the cervix and lower uterine segment during the first stage of labour are transmitted via the visceral afferent nerve fibres to the spinal cord at the level of T10–L1. Frequently pain is localised in the dermatomes T10–L1. During late first stage and early expulsion stage pain sensations are also caused by pressure on the pelvis and parts of the lumbosacral plexus, often experienced as pain in the thighs, back and legs. Pain during the expulsion phase is mainly somatic, transmitted via the pudendal nerves to spinal segments S2–S4. Particularly strong pain is often experienced in the case of abnormal positioning of the foetus, e.g. occiput posterior position, macrosomic foetus or narrow pelvis.

During the first stage of labour pain is determined mainly by the elongation of the cervix and lower uterine segment. Subsequently, during the expulsion phase, pain is caused by the foetus engaging in the birth canal with increasing pressure on the vaginal and perineal structures. The pain intensity varies greatly from person to person and is higher in first pregnancies than in subsequent pregnancies. The reason for this is that in subsequent pregnancies the cervix is already softened before the start of the labour pains and uterus contractions are less intense at the onset of labour. First pregnancies in older women frequently also result in greater pain than in younger nulliparous. Other factors associated with stronger pain intensity are, for instance, dysmenorrhoea and maternal exhaustion [4].

Psychological factors which can influence the perception of pain during childbirth include anxiety sensitivity [5], the presence of a trusted person [6,7], cultural factors and preparedness through, for instance, prenatal classes [8].

Besides the subjectively negative experience of pain, labour also has several pathophysiological effects on the mother and child. Pain during labour strongly stimulates breathing, resulting in an increase in breathing minute volume and oxygen during contractions, compensated by hyperventilation between contractions. This can even lead to temporary hypoxia in both mother and child. A respiratory alkalosis caused by hyperventilation can also result from a left shift in the maternal oxygen binding curve leading to reduced O2 delivery to the foetus and consecutive hypoxia. Stress and pain during labour have been known to cause increased blood pressure, cardiac output and catecholamine concentrations [9] in the plasma. The latter in turn reduces uterine perfusion [10]. Epinephrine is known for its tocolytic effect in this case [11]. Changes in the uteroplacental blood flow are normally tolerated well by healthy foetuses. However, in the case of a pre-existing uteroplacental insufficiency, for instance preeclampsia [12], intrauterine growth retardation or diabetes mellitus may present a risk for the foetus.

A traumatic, excessively painful childbirth may cause serious mental health disorders, possibly resulting in post-natal depression [4] or even post-traumatic stress disorder [13], as well as causing difficulties related to sexuality and mother-child bonding.

Spinal analgesia procedures

Advantages

The advantage of obstetric spinal procedures is good analgesia with no maternal and foetal sedation, allowing the mother to participate actively in the birth and remain conscious. Unfavourable pathophysiological changes and reflexes caused by pain can be reduced. Full anaesthesia via an epidural catheter can be achieved in the event that a Caesarean section is necessary.

Disadvantages, risks and side effects

Results of previous studies, such as the meta-analysis by Liu et al. 2004 [14], suggest a link between obstetric spinal analgesia, in particular in the case of high local anaesthetic concentrations (e.g. Bupivacaine 0.25%), and a prolongation of the second stage of labour (weighted mean difference 15.2 min), as well as a statistically significant, slightly higher instrumental delivery rate (odds ratio 1.63%; 95% confidence interval 1.12–2.37). Excluding induced and elective forceps deliveries, statistical figures indicate an increased but not more significant risk of an instrumental birth in PDA cases (odds ratio 2.11; 95% confidence interval 0.95–4.65). These results may be attributed to the fact that foetal malpositioning or macrosomia, which are more frequent causes for an instrumental birth, lead to increased pain during labour and, therefore, to an increased need for analgesia. The risk of requiring a secondary Caesarean section is not increased with PDA. Furthermore, a sympathetic block can lead to maternal vasodilation, in particular in the arterial system with consecutive hypotension, reduced cardiac preload and decreased cardiac time volume [12,15]. Due to failure of the self-regulating mechanism of the blood supply to the uterus, a drop in blood pressure leads to reduced uteroplacental perfusion [16]. Vasoressurs, such as ephedrine or phenylephrine, are used to treat hypotensive phases. In literature, the definitions of maternal hypotension requiring intervention differ considerably [17]. Meta-analyses comparing the vasoressurs ephedrine and phenylephrine used in spinal anaesthesia for Caesarean sections indicate increased risks of foetal acidosis with the use of ephedrine [18], concluding that phenylephrine is favoured over ephedrine for the treatment of maternal hypotension [19]. Professional bodies (German Society of Anaesthesiology and Intensive Care Medicine, Association of German Anaesthetists, German Society of Gynaecology and Obstetrics) also recommend cafedrine/theodrenaline (Akrinor®) for treating hypotensive phases. A meta-analysis carried out by Mardirosoff et al. [20] indicated that foetal bradycardia was more common after intrathecal opioid administration. Foetal bradycardia can occasionally occur independently of maternal hypotension during the first 15–45 minutes after PDA or CSE, and is possibly associated with a drop in the maternal plasma catecholamine concentrations [10].

One of the most common but harmless and mostly well-tolerated side effects of PDA/CSE is pruritus due to opioid application. The exact mechanism for its occurrence is as yet unknown; however,
it is histamine-independent [21]. In literature, intravenous application of opioid antagonists, such as naloxone or nalmefene, as well as the administration of diphenhydramine, are indicated as therapeutic interventions for opioid-associated pruritus [22].

Maternal hyperthermia is a further side effect indicated in several studies with a frequency of 1–46% [23]. This has occurred predominantly in extended use of epidural analgesia exceeding six hours [23–25]. Similarly, the mechanism for this occurrence is not yet known; inflammatory causes are suspected. However, studies have shown that neonates of women treated with PDA were more likely to be examined for sepsis and treated with antibiotics [26].

The frequency of nausea and vomiting, provided hypotensive phases can be avoided, appears not to be increased with epidural anaesthesia. However, the frequency of shivering is somewhat increased [27]. The risk of intra- and post-partum urinary retention was shown by certain studies to be higher with PDA [28,29].

Complications such as inadvertent dural punctures with the insertion of peridural catheters were recorded in about 1.5% of cases [30]. In 50% of these cases, post-puncture headaches were reported [30]. Conservative therapies, such as increased fluid intake and bed rest, were not effective [31]. Treating post-puncture headaches with an epidural blood patch can potentially be successful. Following inadvertent dura puncture, an intrathecal catheter insertion instead of further epidural puncture attempts can be used as a prophylaxis against headaches related to the dura puncture. The intrathecal catheter should remain in position for 24 hours if possible [32]. Severe unexpected effects such as total spinal anaesthesia, inadvertent intravascular injection with systemic toxicity through local anaesthetics, spinal infections or breathing complications, are rare occurrences. Due to increased congestion of the epidural venous plexus during pregnancy, an intravascular catheter malpositioning occurs relatively often; although this is harmless, a removal of the peridural catheter and a further puncture is necessary.

In literature, the failure rate of spinal analgesia is estimated to be about 12% [33]. In the majority of these cases, good analgesia could still be achieved after one or more catheter re-insertions. However, spinal procedures are contraindicated for patients with blood coagulation disorders or undergoing anti-coagulation therapy (see below).

The results of early, low-dose spinal analgesia (with a cervix dilation of < 4–5 cm) with regard to delivery time, Caesarean section rate and outcomes, have been comparable with those of systemic opioid analgesia [33]. By contrast, patients who received peridural anaesthesia at a later stage (cervix dilation > 5 cm), were more likely to experience vaginal surgical deliveries, poor analgesia and poorer neonate status [34]. This is probably due to an already protracted delivery, as well as maternal issues.

**Drugs (bupivacaine/ropivacaine/opioids)**

At present spinal analgesia in childbirth is most frequently being used in combination with a low dose of long-lasting local anaesthetics (bupivacaine or ropivacaine) and a lipid-soluble opioid. The opioid component is capable of effectively alleviating visceral pain during the first stage of labour. In combination, the two substances function synergistically [35,36], allowing for the use of lower doses than would be the case in single applications. This contributes to reduced undesirable responses such as a severe motor block through the use of local anaesthetics or significant systemic opioid absorption and effect. Bupivacaine and ropivacaine are the most commonly used drugs in PDAs during labour. One disadvantage of bupivacaine is a high cardiotoxic potency. Ropivacaine is less cardiotoxic and appears to be less likely to cause motor blocks [37,38]. Clinical studies have found the efficacy of ropivacaine to be comparable with that of bupivacaine [37]. In Germany, the opioid sufentanil is approved for epidural anaesthesia, but not fentanyl.

Internationally, fentanyl and sufentanil are used in conjunction with local anaesthetics during PDA procedures due to their rapid effectiveness of only 5–10 minutes [39,40]. The effects last for 60–90 minutes, thus both opioids are suitable for repeat applications during labour.

**Methods (CEI, PCEA, CSE)**

The most common spinal analgesia methods used during labour are lumbar peridural anaesthesia (PDA) and combined spinal-epidural analgesia (CSE).

Lumbar PDA can be performed as continuous epidural infusion (CEI) or intermittently as patient-controlled epidural analgesia (PCEA). The PDA catheter is inserted with the patient in sitting position or lying on one side. Once the catheter is fitted, a test dose of a local anaesthetic is applied in order to check for an inadvertent spinal malpositioning. After an initial bolus injection, the analgesia can be controlled by CEI or PCEA, or a combination of these two methods [16].

In the case of CSE, the epidural space is first identified through a puncture with an epidural needle inserted in accordance with standard procedures. An epidural cannula is then used as introducer for a spinal needle. After intrathecal injection, the spinal needle is removed and an epidural catheter inserted [16]. Advantages of the CSE method include the clearly faster analgesic effect of only 2–5 minutes with opioid application, as opposed to 15–20 minutes in the case of a PDA [41]. One disadvantage is a higher incidence of pruritus in comparison with PDA [42,43]. If only one opioid is initially injected intrathecally during CSE, it is possible, as in PDA procedures, to check for a malpositioned intrathecal epidural catheter through the application of a test dose, and thereby avoid an inadvertent intrathecal infusion. Testing is useful only after the intrathecal opioid effect has worn off and immediately before the first delivery via the peridural catheter.

During the first stage of labour, an intrathecal opioid injection without local anaesthetic is sufficient to achieve analgesia. Due to the lack of motor block, the patient can still walk around [16]. There are no significant indications that lower umbilical cord pH values and a higher probability of pruritus are more likely with CSE than with low-dosage PDA [42]. With regard to maternal mobility during analgesia, as well as hypotension, maternal outcome (analgesic onset time and kind of delivery) and certain foetal outcome parameters (Apgar scores after 5 min, umbilical venous pH, umbilical pH and need for transfer to paediatric clinic), CSE is comparable with the low-dosage PDA [42].

In both procedures, analgesia can be controlled by continuous epidural infusion or PCEA. PCEA is preferred by professional associations since it yields greater patient satisfaction and reduces the average amount of local anaesthetic used and, therefore, the occurrence of motor blocks [19,44].

**Preliminary investigations and prerequisites**

The 2009 recommendations of the German Society of Anaesthesiology and Intensive Care Medicine (DGAI), in conjunction with the Association of German Anaesthetists (BDA) and the German Society of Gynaecology and Obstetrics (DGGG), stated that...
no routine laboratory investigations were necessary prior to re-

gional anaesthesia in the case of women with unremarkable

medical histories of pregnancy and haemorrhaging [19]. The

thrombocyte count should be determined in the presence of pre-

eclampsia. In the case of pathological values, a positive medical

history of haemorrhaging or HELLP syndrome, thorough coagula-
tion tests should be conducted. However, no definite minimum
value has been determined for the thrombocyte count, below

which a spinal puncture can no longer be performed. The acute
change in thrombocyte count during the hours prior to puncture,

as well as a careful risk-benefit assessment by the anaesthetist,

are of more crucial importance. A slightly decreased thrombocyte

count of 80000–100 000/µl is not abnormal even in healthy

women and increases during pregnancy. An increased coagula-
cion capacity is indicated during the peripartum period.

Optimal application time

A meta-analysis conducted by Marucci et al. in 2007 [34], com-
paring early (cervix dilation < 4–5 cm) and late (cervix dilation

> 4–5 cm) PDA, indicated that early PDA presented no increased

risk of a Caesarean section or instrumental delivery. In contrast,

an increased risk of an instrumental vaginal delivery, poor quality

analgesia and poor neonate outcomes with regard to umbilical

arterial pH and the need to administer naloxone, was found in

the case of late spinal analgesia and early systemic opioid anal-
gesa. However, significant differences in Apgar scores were not

found. According to the current recommendations of the DGAJ
[19], the American Society of Anesthesiologists and the American

college of Obstetricians and Gynecologists [45], waiting for a de-

finite minimum cervix dilation is not necessary for PDA applica-
tions.

Non-pharmacological pain therapy, peripheral blocks and systemic analgesia

For the sake of completeness, the following non-pharmacological
therapies for intrapartum pain relief should be mentioned: mas-
sage, therapeutic hot and cold applications, prenatal classes, aro-

matherapy, audio therapy, emotional support from, for instance,
a specifically trained person (doula), biofeedback, transcutane-
ous electrical nerve stimulation (TENS), acupuncture, acupres-
sure, hydrotherapy, hypnosis and intradermal water injections
[46–55]. In the case of contraindications for PDA/CSE, other re-
geonal analgesia methods are available. Bilateral, paracervical

Frankenhäuser ganglion block and bilateral, paravertebral symp-
athetic block are suitable for achieving analgesia during the first
stage of labour. In both cases only visceral pain affections are
blocked in the absence of motor block. Possible complications of
both methods are foetal bradycardia or inadvertent injection into
the head of the foetus with systemic local anaesthetic toxicity
[56], as well as systemic toxic effects on the mother in the case of
inadvertent intravascular injection.

In order to block somatic pain caused by extension and compres-
sion of the vaginal and perineal structures, bilateral pudendus
anaesthesia can be applied for transvaginal or transperineal ac-

to the pudendal nerve.

Perineal infiltration anaesthesia can be used in the case of episi-
omies or suturing of the perineum.

Opioid analgesia offers a systemic alternative to regional analge-
sia procedures. Since the early 1940s the most commonly used
systemic analgesic has been meperidine (pethidine). Controlled
studies indicated better analgesia with PDA than meperidine
[57]. The Caesarean section rate with meperidine is comparable
to that of PDA [57]. As with all opioids, meperidine crosses the
placenta and presents a dose-dependent risk of neonatal respira-
tory depression and reduction of foetal heart frequency. The
mother may suffer from nausea, vomiting, respiratory depres-
sion, dysphoria and delayed gastric emptying. In addition to
pethidine and piritramide, meptazinol (Meptid) is also one of
the most commonly i.v. or i.m. administered opioids in Germany
for analgesia during labour [58]. Meptazinol is a partial µ-opioid
receptor agonist, with additional central cholinergic properties.
In comparison with pethidine, respiratory depression when us-
ing Meptazinol is less common in neonates [59]. A new alterna-
tive is patient-controlled analgesia with remifentanil, which indi-
cates a substantially shorter half-life compared to meperidine.
Remifentanil crosses the placenta but is rapidly eliminated by
neonates through metabolic and redistribution processes. A meta-
analysis conducted by Leong et al. [60] indicated the supe-
rior analgesic effect of remifentanil compared with pethidine
within the first hour of administration. Procedures followed by
German clinics in the application of remifentanil PCA varied sub-
stantially. The doses used for a single bolus varied between 0.25
and 0.7 µg/kg body mass. The lock out time ranged between 1
and 5 minutes [58]. Patients should be informed that remifenta-
nil takes effect only within 30–60 s. A bolus administered at the
start of a contraction may take effect when the contraction has
already reached its peak. Pain reduction with remifentanil is
good within the first hour of administration; however, from the
second hour high pain levels can once again be reached [61]. The
procedure is currently still the subject of controversy [62]. Ad-
ministration of remifentanil may result in a drop in oxygen satu-
ration in the blood of the mother, which should be continuously
monitored. Effects on the neonate require further investigations
[63].

Nitrous gas has been used to relieve pain during childbirth for
over 100 years. However, this method has not been as common
in Germany as in certain other European countries such as Great
Britain. In Germany, nitrous gas is a 50% N2O und 50% O2 mix-
ture, marketed under the name of Livopan, while in English-
speaking countries it is sold under the brand name Entonox. A
meta-analysis conducted in 2002 [64] of the use of nitrous gas
during labour indicated that the studies on the analgesic effect
of nitrous gas within this context were very inconsistent. Never-
theless, some women benefitted from its use during childbirth.
The results obtained with nitrous gas inhalation are not compa-
rable with those of intravenous opioid analgesia using remifen-
tanil [65]. While remifentanil PCA was found to achieve a pain
reduction of 1.5 points on the visual analogue scale, nitrous gas
only indicated a reduction of 0.5 points. In comparison with this
result, PDA reduced pain by 5 points [66]. However, the sedative
effect of Remifentanil PCA was also higher than nitrous gas. The
maximum analgesic effect of nitrous gas is reached after 50 sec-
onds from start of inhalation. However, a contraction with a du-
ration of 30 seconds would have already reached its peak at that
stage.

A review led by the ASA [67] reported on possible undesirable ef-
effcts of nitrous gas such as respiratory depression, which in com-
bination with maternal hypcapnia during contractions may lead
to a drop in oxygen saturation of the blood. This is particularly
applicable during the simultaneous use of opioids. The mother
may experience drowsiness and occasional loss of consciousness,
as well as nausea, vomiting, dizziness, mouth dryness and ringing
in the ears [64]. Nitrous gas causes an irreversible oxidation of co-
balt atoms in Vitamin B12, which, in the case of long-term use,
can lead to reduced methionine and folic acid synthesis. Since folic acid is needed for DNA synthesis and in particular, in tissues with high cell division functions, bone marrow depression may result [68]. Potential negative effects on the neonate, in particular, on the neuronal development of the child, are still unclear [67].

The inhalation of subanaesthetic concentrations of sevoflurane have also been used in relieving pain during childbirth. A study by Yeo et al. comparing the analgesic quality and side effects of sevoflurane and nitrous gas indicated a better analgesic quality and less nausea with sevoflurane. However, a noticeable sedation effect was reported [69].

**Conclusion**

With due consideration of possible contraindications, PDA and CSE are safe methods of pain reduction during childbirth. The rate of Caesarean sections for these two procedures is lower than the rate of instrumental deliveries. PDA and CSE should be applied as soon as possible during the first stage of labour and in low doses. A definite minimum cervix dilation is not required for PDA application. It is recommended that the use of PDA be discussed in advance with the patient and not during the stressful process of labour.

**Conflict of Interest**

None.

**References**

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