Epidural pain relief in labour

How much pain we can cope with is very personal, it varies between individuals and is affected by a number of physical and emotional factors.
This publication is designed to help you make the right choices for you and your baby.

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The contractions of the womb (uterus) that are part of labour are painful, which is why ‘labour pains’ are commonly referred to. This leaflet is about the use of ‘epidural’ pain relief, which is a method of blocking pain from your contracting womb to specific nerve endings; this means that you should no longer feel the pain from the contractions during your labour.
Epidurals are used as a method of pain relief in labour by approximately 20% of women. While it is the most effective method for ensuring a pain-free labour, it is also one of the most invasive methods and given the technical nature of epidurals, requires specialist services. It is therefore vital to understand the advantages and disadvantages of having an epidural so that you can make an informed choice about this option when you are in labour.

Information about non-epidural methods of pain relief in labour, including complementary and alternative therapies, can be found in the Informed Choice leaflet Non-epidural pain relief.

What is an epidural?

An epidural is where anaesthetic or pain relieving (or both) drugs are inserted into a space around your spinal cord, called the epidural space. A very fine tube is inserted into your lower back and the anaesthetic is injected through this which then numbs the nerve endings and stops you feeling the pain of the contractions, and sometimes back pain. It also affects how much you are able to move your legs, stand up and walk about and whether you can feel when you need to pass urine.

You should feel the benefit of the epidural within 10-20 minutes of having your epidural sited. You may be given a single dose (called a bolus dose) of the pain relieving drug/local anaesthetic, or receive the drugs via a drip (intravenous infusion). In some hospitals you might be offered the use of a hand-held device which means you can control your pain yourself by ‘topping up’ the dose when you start to feel pain (this is called patient-controlled analgesia (PCA)).

The dose and combination of drugs you are given and how they are used varies considerably between hospitals. The reason for this is that there is no clear evidence that one method is substantially better than others.

Recent guidance advises that analgesia should be made available to all women if the facilities can provide it. This means that if you request an epidural, it should be made available to you whether this is in very early labour or near to the point of the birth.

Most women enter pregnancy having had little experience of painful procedures, which is why it can be helpful to discuss your concerns about pain, and how you feel you will cope during labour in the antenatal period. You should be given access to the full range of resources available for support and pain relief in labour (see Informed Choice leaflets Support in labour, Non-epidural pain relief and Positions for labour and birth).

If you have strong feelings against having an epidural, you might find it helpful to talk to your midwife, GP or consultant so that any fears you might have about the procedure can be discussed with you. Ask your midwife or doctor to explain in straightforward language, what an epidural is and where the catheter (a very fine soft plastic tube) is inserted. This should help you to visualise what will happen and increase your understanding of the basic principles of how an epidural works.
You should also be informed before you go into labour about the availability of an epidural in your local hospital. This is because there are circumstances in which an epidural service is not always immediately available, and you should be prepared for this, although most hospitals give priority to their maternity services. However, even where there is usually prompt access to anaesthetic services, there might still be a delay in obtaining an epidural, which makes the need for information about alternative approaches to pain relief even more important. Disappointment and anxiety can arise if you request an epidural and are unable to have one (see Informed Choice leaflets Non-epidural pain relief, Support in labour and Positions for labour and birth).

**Having an epidural**

To have an epidural you will be asked to sit or lie on your side. It is usual for you to have an intravenous fluid ‘ drip’ started if you do not already have one. This will be placed in the back of your hand or your lower arm and your midwife should explain what it is and how it works.

To start the epidural an anaesthetist will come and see you to explain what is involved. The procedure requires insertion of a small hollow needle through the skin in your lower back. The skin is made numb first. As previously mentioned, a very fine plastic tube called a catheter is threaded through the hollow needle which is then taken out; this means that while the catheter stays in place, the needle is taken out. The catheter is long enough to reach your lower back to your shoulder and this is secured with tape onto your skin. The local anaesthetic and pain relieving drugs (if used) are then injected through the catheter.

Spinal anaesthesia gives the same pain relieving effects as an epidural, but works more rapidly. Again, a needle is inserted into the spinal fluid in your back. A local anaesthetic with or without added pain relief drug is then injected to provide the spinal anaesthesia and an epidural catheter is then used in the way described earlier. In labour, the spinal may be inserted first using a small dose of local anaesthetic to keep you pain-free. The epidural is then inserted a few minutes later as a separate procedure when you feel more comfortable. When small doses of local anaesthetic are used, you can walk normally (but with close supervision) and be free of pain from contractions during your labour. This technique is what’s known as the ‘mobile epidural’.
What are the advantages of an epidural?

- When an epidural (or spinal) is working effectively, you should be completely pain-free. This means it provides better labour pain relief than any other method.

- Although epidurals are associated with an increased risk of needing a forceps or ventouse delivery, they have not been found to increase the risk of having a caesarean delivery, long term backache, or your baby needing help with breathing (being born with a low Apgar score, which is an assessment of their well-being). For more information see Informed Choice leaflet How will your baby be born?

- Many women report being satisfied with their pain relief in labour and would have an epidural in their next labour.

- Once the epidural has taken effect (from 10 to 20 minutes on average), you should be free from contraction pains, as well as from other pain, which can be felt in the lower abdomen, in your back or at the top of your legs.

- There should be no change to your level of consciousness and you should not feel ‘drugged’ or drowsy outside the normal tiredness of labour.

- If you are given a low dose of local anaesthetic, you may still be able to stand and possibly walk (with assistance) despite having the epidural in place.

- Your birth partner can and should remain present throughout your epidural being inserted.

What are the disadvantages of an epidural?

Research has shown that use of an epidural in labour is associated with a number of factors. Some of these are more important than others with regard to the safety of an epidural, rather than some discomfort or side effect. The following list starts with the most important ones for you and your baby.

- The drugs used in epidurals can make your blood pressure drop; for this reason, your midwife will check your blood pressure regularly. If your blood pressure drops, you may feel sick or dizzy and you should tell your midwife if you start to feel this way. A few women will have a more severe drop in their blood pressure and will need to be given a specific drug that is injected through the ‘drip’ needle to bring their blood pressure up again.

- A longer labour: having an epidural has been found to increase the length of your labour by around an hour.

- You may need drugs to make your contractions stronger and more frequent (called ‘augmentation of labour’), although this can be for a number of reasons that are associated with, rather than caused by, the epidural.

- Not feeling the need to push which usually shows you are in the second stage. This means that your midwife will probably confirm that your cervix is fully dilated by doing a vaginal examination.
• Because the epidural makes you numb, it may be difficult to pass urine and you are more likely to need a small tube (catheter) put into your bladder to help with this as having a full bladder can delay the progress of your delivery.

• Incomplete (patchy) pain relief: although most epidurals are effective so that you will be pain-free from about 10 minutes after your epidural has been inserted, some women still feel pain on one side. Where this occurs the anaesthetist will come to see you and can check the position of the epidural and the drug dosage prescribed. Adjustments can be made until satisfactory pain relief is achieved.

• An effect on the baby: the pain relieving drugs used in epidurals can make your baby ‘sleepy’ at birth, so they may need some oxygen to give them a little help with their breathing shortly after they are born.
• The epidural drugs can make your skin itch and you should tell your midwife if this is the case. If the itchiness is uncomfortable, the anaesthetist can change the drugs used in your epidural or treat the itching.

• Heavy or numb legs (motor block): if this is how you are affected, you will be advised to stay on the bed during labour as it would be unsafe to walk about. Anaesthetists can use different combinations and doses of drugs to help this.

• Persistent headache after the birth. Many women get headaches after labour but, if this does not get better within a few hours of the birth or if it gets worse when you stand up and better when you lie down, this might be linked to the epidural. This can be treated, so it is important you tell your midwife or your doctor.

• Some women still have small patches of numbness on their legs after they have given birth. This is quite rare, only one in 550 women suffer this and although it can last for up to three months, it should get better on its own. It is extremely rare for there to be any long term permanent injury such as paralysis (complete loss of sensation and movement).

• Very rarely a woman has a life-threatening problem because of an epidural. The midwives and doctors on the labour ward are trained to deal with this.

What we don’t know

There is a high level of satisfaction for women when their epidural works well in labour. However, more research is needed into women’s overall views where they had not planned to have an epidural or where it was not effective.

To find out more about your options, please discuss this leaflet and any questions you may have with your midwife or doctor. More detailed information can be found in the professionals’ version of this leaflet.
Questions you may want to ask

After reading this leaflet there may be some things you are still not sure about. You can use this space to write down any questions you may have and any things you would like to discuss with your midwife or doctor

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