

Management of Pain During Caesarean Section Clinical Guideline

V1.0

July 2026

Summary

This guideline has been developed to improve patient experience and psychological sequelae and to support clinicians and promote standardisation of practice in this area.

It outlines recommended practice in the following areas:

- Consent and expectations.
- Identification of risk factors.
- Block testing.
- Management of pain and timely conversion to general anaesthesia.
- Postoperative follow up.
- Documentation.

1. Aim/Purpose of this Guideline

- 1.1. This guideline aims to provide guidance to Anaesthetic doctors, Obstetricians and midwives looking after patients who are at risk of, or who have experienced pain during Caesarian Section. Its purpose is to improve patient experience and psychological sequelae and optimise/standardize practice and documentation.
- 1.2. This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women, but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman, please ask them their preferred pronouns, and then ensure this is clearly documented in their notes to inform all health care professionals.

Data Protection Legislation

The Trust must comply with the UK GDPR, Data Protection Act 2018, and Data (Use and Access) Act 2025 by ensuring all personal data is processed lawfully, fairly, transparently, and for a defined purpose.

Before processing personal data, an appropriate Article 6 UK GDPR lawful basis must be identified and recorded. Where special category data is involved, a relevant Article 9 condition must also be documented.

All staff, contractors, students, volunteers, agency workers, and third parties working on behalf of the Trust are responsible for complying with data protection legislation.

Further guidance is available in the Trust's Information Use Framework and Information Governance policies. Advice can also be obtained from the Information Governance Team.

2. The Guidance

2.1. Background

- 2.1.1. Neuraxial anaesthesia is the preferred mode of anaesthesia for 90% Lower Section Caesarean Section (LSCS) in the UK.
- 2.1.2. Although generally reliable, these techniques can fail wholly, partially or subsequently; and supplementation or conversion to general anaesthesia may become necessary.
- 2.1.3. Pain experienced during LSCS carries significant distress and psychological sequelae for patients, including risk of chronic pain, postpartum depression, post-traumatic stress disorder (PTSD) and anxiety in future pregnancies.

2.2. Incidence

Incidence	Epidural	Spinal
Pain requiring supplemental analgesia	1:7 (common)	1:20 (occasional)
Pain requiring conversion to general anaesthesia (GA)	1:20 (occasional)	1:50 (uncommon)

2.3. Risk Factors for Intra-operative failure

- Operative urgency.
- Inadequate pre-operative block.
 - Augmentation in labour >2 times.
 - Miscommunication when testing, including language barriers.
 - Lower epidural top up volume.
 - No augmentation with neuraxial opioids.
- Duration of surgery.
- Patient anxiety.
- High body mass index (BMI).
- Provision of care by non-obstetric anaesthetist.

2.4. Consent Process

2.4.1. Background

It is recognised that patient recall of consent process is poor following all types of surgery, so it is essential to document all the risks that have been discussed. Women in labour retain the capacity to consent in the eyes of the law, unless there is significant convincing evidence to the contrary.

2.4.2. Montgomery ruling

‘Whether a reasonable person in the patient’s position would be likely to attach significance to the risk’.

This demands that all risks/benefits of all management options be discussed, including GA as a primary alternative. ‘Best’ treatment in a professional opinion may be advised, but we may not pressurise patients into taking this advice. However, a patient cannot insist on treatment that a doctor does not believe to be in their best interest.

Many women regardless of urgency will be highly anxious and it is important to establish rapport to facilitate peri-operative communication.

2.4.3. What should be discussed and documented?

- Planned mode of anaesthesia and alternative.
- Planned level of block and how it will be tested.
- Expected sensation with effective block.
- Pain requiring analgesia - 1:7 epidural top up (common); 1:20 spinal (occasional).
- Failure of block requiring conversion to GA - 1:20 epidural (occasional) 1:50 spinal (uncommon).
- For non-elective LSCS potential fetal risk from time taken to ensure adequate block.

2.5. Time dependent deliveries

2.5.1. Consent process must be tailored to facilitate timely delivery.

2.5.2. Subsequent documentation should reflect that delivery was time critical and chosen technique performed in the mothers best interests with her verbal and/or implied consent.

2.6. Pre-operative Block Assessment

2.6.1. Background

- Uterine innervation.
 - Sympathetic - inferior hypogastric plexus T10-L1.
 - Parasympathetic – pelvic splanchnic nerves S2-4.
- Visceral organs send sympathetic afferent nerves to T4-L2.

2.6.2. A good rapport between woman and anaesthetist may improve accuracy of sensory assessment. Testing sensation depends on the woman understanding what the anaesthetist wants to know and being able to communicate what she is experiencing. Factors that might affect communication:

- Distress and distraction especially in time dependant deliveries.
- Previous trauma.
- Power of suggestion – questions should be open and neutral.
- Hierarchy – confidence and professionalism are reassuring but may also inhibit a woman from speaking her concerns.
- Confirmation bias – anaesthetist should make a conscious effort to look for signs of inadequate block.

2.6.3. Widely accepted standard is sensory block to T5.

- Light touch is suggested modality.
- Second confirmatory modality such as cold used.
- Lower level of block should be tested and documented, using back of leg if necessary.
- Motor block – absence of straight leg raising (SLR) adequate and should be documented.
- Documentation on a dermatome map for accuracy and reproducibility.
- Use non ambiguous language.
- Allow time for response.
- Avoid confirmation bias and power of suggestion – situational awareness and recognition that even a ‘perfect’ block can fail.

2.7. Intra-operative Failure and management of pain during LSCS

2.7.1. Background

In addition to the failure of the block that causing distress, the disregard, inadequate or delayed response of an anaesthetist to listen and act can exacerbate and further contribute to psychological trauma. It is important to acknowledge that pain is pain if the patient says it is and respond accordingly.

2.7.2. Recommendations for management of pain

- Ask the surgeon to stop for further assessment unless uterus open and baby not yet delivered or uncontrolled bleeding.
- Assess nature and degree of pain – further management will depend on this.
 - Acknowledge distress. Apology is not an admission of fault.
 - Reassure patient you will address this.
- Minimal pain/operation ending:
 - Analgesic options include N2O, boluses of short acting iv analgesics (alfentanil 250-500 mcg, fentanyl 25 to 50 mcg, ketamine 10mg) LA infiltration by surgeon.
 - Advise the woman this may make her feel a little drowsy.
 - Do not treat pain with anxiolytics.

2.7.3. Early failure of regional anaesthetic (RA)

- Consider second neuraxial technique or extension/augmentation of neuraxial technique if CSE/epidural.
- Do not allow surgery to restart until block rechecked.
- If this is not possible, acknowledge unfortunate outcome and advise conversion to GA.
 - Whatever the stage of surgery, a GA should be offered to any woman experiencing significant pain.
 - Documentation.
- Make a detailed record of events and timing on the anaesthetic chart, including testing methods, pain described, treatment offered/given, response to this and any offer of GA.

2.8. Follow up and debrief

2.8.1. Background

Lack of, insensitive or perceived to be unprofessional follow up can exacerbate long term psychological consequences and affect engagement and trust in future health interactions.

2.8.2. Guidance

- Prompt post-operative review by consultant is mandatory when patient has experienced pain during LSCS – ensure good handover for follow up – entry onto E3 and communications book.
- Debrief should be conducted after recovery from GA and should provide the patient opportunity to describe her experience and have any questions addressed as fully as possible.
- Patient's GP should be contacted if ongoing concerns.
- Further follow up should be arranged if appropriate. All women should be advised to contact the anaesthetic department if she has ongoing concerns, and be advised that she can ask for an appointment to see an anaesthetist to re-discuss events and/or plan anaesthetic management for any further delivery.
- Irrespective of seniority, the clinician should have the opportunity to discuss events with another clinician.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Incidence of, documentation of and management of the following areas – consent, documentation and methodology of block testing, management of and documentation of pain during LSCS and follow up of patients.
Lead	Obstetric Anaesthetist Lead Consultant.
Tool	Case notes and electronic records used for audit and data.
Frequency	This should be monitored every 2 years.
Reporting arrangements	The audit results will be received at the Departmental Obstetric Anaesthetic meeting and relevant results also taken to Maternity Patient Safety.
Acting on recommendations and Lead(s)	If deficiencies are identified, an action plan will be developed and monitored through the above groups.
Change in practice and lessons to be shared	As per the action plan.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the [Equality Diversity and Inclusion Policy](#) or the [Equality and Diversity website](#).

4.2. Quality and Equality Impact Assessment (QEIA)

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged. The Quality and Equality Impact Assessment (QEIA) Form is available via the link in [Appendix 2](#).

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Management of Pain During Caesarean Section Clinical Guideline V1.0
This document replaces (exact title of previous version):	New Document
Date Issued/Approved:	July 2026
Date Valid From:	July 2026
Date Valid To:	July 2029
Directorate/Department responsible (author/owner):	Dr Clare Moser, Associate Specialist Anaesthetist
Contact details:	01872 252361
Brief summary of contents:	To provide pre, peri and post operative standards and guidance to anaesthetists of all grades and other stakeholders as to how to manage pain during Caesarian section.
Suggested Keywords:	Pain, LSCS, Caesarian section, failure, conversion.
Target Audience:	RCHT: Yes CFT: No CIOS ICB: No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Maternity Guidelines Group
Manager confirming approval processes:	Caroline Chapman
Name of Governance Lead confirming consultation and ratification:	Michael Cross
Links to key external standards:	https://associationofanaesthetists-publications.onlinelibrary.wiley.com/doi/10.1111/anae.15717
Related Documents:	Prevention and management of intraoperative pain during Caesarian section S. Orbach-Zinger et al. BJA Education, 25(2) 50-56 (2025)

Information Category	Detailed Information
	Prevention and management of intra-operative pain during Caesarian section under neuraxial anaesthesia: a technical and interpersonal approach. F. Plaat, S.E.R Sranford, D.N. Lucas, et al Anaesthesia 2022, 77, 588-197 Learning from the Law: a review of 21 years of litigation for pain during caesarian section. K. McCombe, D. Bogod. Anaesthesia 2018, 73, 233-230
Training Need Identified?	Yes. Multidisciplinary training through PROMPT course, IACOA SIM training.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Midwifery and Obstetrics.

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
July 2026	V1.0	Initial issue	Clare Moser, Associate Specialist Anaesthetist

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus six years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust [The Policy on Policies \(Development and Management of Knowledge Procedural and Web Documents Policy\)](#). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Quality and Equality Impact Assessment (QEIA) Form

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged.

Please ensure you have completed a Quality and Equality Impact Assessment (QEIA) using this link to complete the form:

[E11 QEIA Policy](#)

For guidance, please see the [QEIA Essentials – Quick Reference Guide](#) or contact as required below:

Equality, Diversity and Inclusion guidance, please contact: rcht.inclusion@nhs.net

Quality Governance guidance, please contact Jillian Tozer: jillian.tozer3@nhs.net