**Appendix 2**

International Obstetric Anesthesia Experts Survey of Post-Cesarean Delivery Analgesia Practices and Respiratory Monitoring Following Neuraxial Opioid Use in Their Institution

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| Question/ Number of Member Responses | Response |
| Country Represented: Australia; Austria; Belgium; Brazil; Canada; Chile; Colombia; Egypt; France; Germany; Iceland; Indonesia; Israel; Panama; Singapore; South Africa; Spain; Switzerland; United Kingdom | N=28 |
| Are regional techniques (such as spinals and epidurals) the primary anesthetic used for cesarean delivery in your country?  Yes  No  Don’t Know | N=28  26(92.3)  1(3.6)  1(3.6) |
| Is intrathecal morphine routinely added to local anesthetic solution when doing spinal anesthesia for cesarean delivery?  Yes  No | N=28  14 (42.9)  16 (57.1) |
| If no, why not?  Hospital Policy  Inability to Monitor  Drug Not Available  Other | N=16  3 (18.8)  6 (37.5)  3 (18.8)  4 (25) |
| What dose of intrathecal morphine is typically used in your country?  0.05 mg  0.1 mg  0.15 mg  0.2 mg  Don’t use intrathecal morphine | N=28  1 (3.6)  15 (53.6)  4 (14.3)  1 (3.6)  7 (25) |
| For healthy patients (without comorbidities or risk factors for respiratory depression) receiving intrathecal morphine for cesarean delivery, do you consider the ASA/ASRA guidelines for respiratory depression monitoring after neuraxial opioids (i.e., clinical assessments with or without oximetry/capnography intermittently every hour for 0-12 hours and then every 2 hours for 12-24 hours) to be:  Too stringent  Too lenient  Just right  Unaware of ASA Guidelines | N=28  15 (53.6)  4 (14.3)  8 (28.6)  1 (3.6) |
| Why too stringent? (Mark all that apply)  Too frequent assessments  Too long duration of monitoring | N=14  11 (78.6)  3 (21.4) |
| Why too lenient? Mark all that apply  More frequent assessments needed  Monitoring should be continuous  Capnography should be used | N=5  1 (20)  3 (60)  1 (20) |
| Please state your degree of agreement with the following recommendations: When using low-dose intrathecal morphine (0.05-0.15mg) or epidural morphine (1-3mg) in low-risk, healthy parturients: The Task Force members agree that monitoring using respiratory rate and sedation assessments should be every 3 hours for 12 hours, in addition to routine institutional postoperative monitoring.  Strongly agree  Agree  Neutral  Disagree  Strongly disagree | N=27  4 (14.8)  12 (44.44)  1 (3.7)  8 (30)  2 (7.4) |
| If disagree, why do you disagree?  Too stringent  Too lenient  Clinician judgement should be used | N=10  5 (50)  4 (40)  1 (10) |
| When using higher dose of intrathecal morphine (>0.15mg) or epidural morphine (>3mg): The Task Force members agree that monitoring should be based on ASA or ASRA Practice Guidelines for the Prevention, Detection, and Management of Respiratory Depression Associated with Neuraxial Opioid Administration. (i.e., clinical respiratory rate and sedation assessments with or without oximetry/capnography intermittently every hour for 0-12 hours and then every 2 hours for 12-24 hours)  Strongly agree  Agree  Neutral  Disagree  Strongly disagree | N=27  2 (7.4)  16 (59.3)  5 (18.5)  3 (11.1)  1 (3.7) |
| If disagree, why do you disagree?  Too stringent  Too lenient  Clinician judgement should be used | N=3  1 (33.3)  1 (33.3)  1 (33.3) |
| When using ultra low-dose ≤0.05mg of intrathecal morphine or ≤1mg of epidural morphine in low-risk, healthy parturients: The Task Force members agree that additional respiratory monitoring beyond routine institutional postoperative cesarean monitoring is not needed. Although ultra-low neuraxial doses do not provide as optimal analgesia compared to larger doses, when used in combination with a nonopioid multimodal analgesic regimen is a reasonable option in low resource settings with limitations for postoperative monitoring.  Strongly agree  Agree  Neutral  Disagree  Strongly disagree | N=26  7 (26.9)  12 (46.1)  2 (7.7)  3 (11.5)  2 (7.7) |
| If disagree, why do you disagree?  Dose too low  Clinical judgement should be used  Other problems arise with postoperative monitoring | N=5  3 (60)  1 (20)  1 (20) |
| The Task Force Members strongly agree or agree that in higher risk women with co-morbidities and other perioperative circumstances that place them at higher risk of respiratory depression, monitoring should align with the ASA and ASRA Practice Guidelines for the Prevention, Detection, and Management of Respiratory Depression Associated with Neuraxial Opioid Administration with ANY dose of neuraxial morphine. (i.e., clinical respiratory rate and sedation assessments with or without oximetry/capnography intermittently every hour for 0-12 hours and then every 2 hours for 12-24 hours)  Strongly Agree  Agree  Neutral  Disagree  Strongly Disagree | N=26  14 (53.9)  9 (34.6)  1 (3.9)  1 (3.9)  1 (3.9) |
| Do you think these SOAP recommendations have the potential to change practice in your country?  Yes  Maybe  No  Don’t know | N=26  11 (42.3)  7 (26.9)  6 (23)  2 (7.7) |
| If yes, why?  Increase safety with these recommendations  No current recommendations to follow (evidence based, expert opinion)  Recommendations will increase use of neuraxial morphine | N=11  2 (18.2)  5 (45.5)  4 (36.4) |
| If no, why?  Guidelines already exist (national or institutional)  Lack of Interest by anesthesiologists  Guidelines are not needed because neuraxial morphine is so safe  Not applicable | N=9  3 (33.3)  2 (22.2)  2 (22.2)  2 (22.2) |
| Are there national guidelines in your country for respiratory monitoring following neuraxial morphine administration?  Yes  No  Don’t know  I follow ASA Guidelines | N=26  4 (15.4)  17 (65.4)  1 (3.9)  4 (15.4) |