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PROPHYLACTIC REST AFTER SPIN ANESTHESIA IN WOMEN UNDERGOING CESAREAN SECTION

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Abstract: With the rise of medical technologies, childbirth has become a hospital event, which has increased cesarean section rates around the world and especially in Brazil in recent decades. Knowing that cesarean section carries much more risks for postpartum women compared to natural birth, the main obstetric complication associated with spinal anesthesia is highlighted, post-dural puncture headache (PDPH). Although there is no scientific evidence about the benefits of prophylactic rest in the immediate post-operative period of a cesarean section, many professionals working in maternity wards continue to routinely recommend this practice. In this sense, the objective of this study was to analyze the nursing team's guidance to postpartum women in the immediate postoperative period of a cesarean section, in relation to prolonged prophylactic rest. This is applied research, with a qualitative approach, exploratory and field research in nature. The study included 49 women who underwent a cesarean section and 15 nursing technicians who work or have worked in maternity wards. Data collection was carried out from February to April 2021, using an electronic form. The research highlighted the lack of preparation of the nursing team in assisting postpartum women undergoing cesarean section, with guidelines based on common sense, such as resting in the supine position on a zero-degree headboard in the immediate postoperative period, without pillows and without the possibility of locomotion, the prohibition of fluid and food intake, as well as the difficulty of promoting breastfeeding and care for the newborn in this position, thus characterizing obstetric violence. Therefore, it is urgent and necessary to update and train these professionals in the mother and child binomial, especially the nurse who is responsible for managing their team, so that they can promote humanized, safe, quality care based on scientific evidence.
Keywords: Caesarean section; Spinal anesthesia; Post-dural puncture headache; Nursing.

INTRODUCTION

Spinal anesthesia was developed at the end of the 19th century by researchers who aimed to apply various anesthetics to the subdural space. It is one of the most widespread techniques throughout the world, as it is simple to perform, low cost and low toxicity. The technique has been improved for years to reduce its adverse effects, gaining much popularity (Oliveira, Louzada, Jorge, 2015; Magalhães, et al., 2019).

One of the determining factors for the expansion of spinal anesthesia was the manufacture of minimally traumatic needles and the production of pharmacological drugs with effective and safe action on inhibitory and neuromodulatory synapses (Benitez, et al., 2016).

Although spinal anesthesia is a safe, widely used technique with a low incidence of serious complications, several adverse effects have been associated with it, including: post-puncture headache, low back pain, urination disorders, cardiovascular complications, coagulation disorders, meningitis and complications. neurological (Magalhães, et al., 2019).

Post-dural puncture headache (PDPH) is one of the most common complications of spinal anesthesia. It is caused by CSF hypotension, that is, by low intracranial pressure. A complete anamnesis and detailed physical examination are necessary before completing the diagnosis for post-dural puncture headache (Dornelles, Pereira, 2018; Rodriguez, et al., 2016; Santos, Almeida, 2015).

There are some risk factors for PDPH, including age, sex, body mass index (BMI), needle gauge, type of needle, needle orientation at the time of puncture and the

skill of the operator (Gyanesh, et al., 2015).

With the rise of biomedicine and technological interventions, childbirth care practices underwent several changes throughout the 20th century, where the increased use of cesarean section surgery is part of this entire process (Riscado, Jannotti, Barbosa, 2016).

According to Santos and Almeida (2015), post-dural puncture headache is a very common complication in obstetric patients undergoing spinal anesthesia, accompanied by other symptoms, such as stiffness of the shoulder and cervical region, photophobia and nausea.

For Gyanesh (2015), the higher incidence of headache in pregnant women undergoing cesarean section under spinal anesthesia is due to the increased elasticity of the dural fibers, as well as the incidence of accidental dural puncture (PDA) is 76 to 85% in these patients.

Contrary to the recommendation of the WHO (World Health Organization), which recommends a cesarean section rate of between 10 and 15%, Brazil continues to have high rates of cesarean births, accounting for more than half of newborns in the country (WHO, 2015; Rodrigues et al., 2016).

Taking into consideration, the growing number of cesarean sections in Brazil, and changes in childbirth care, we are faced with mass guidance on prolonged prophylactic rest after spinal anesthesia, a practice that creates discomfort for the mother and newborn (Gyanesh, 2015).

Prolonged bed rest in the supine position in the immediate postoperative period after cesarean section has been recommended to prevent the onset of PDPH, as it is known that the upright position is used in its treatment, however, studies show that prolonged prophylactic rest it is not effective in preventing PDPH and does not prevent its occurrence (Rodriguez, et al., 2016; Santos, Almeida, 2015).

Therefore, the objective of this study is to analyze the nursing team's guidance to postpartum women in the immediate postoperative period of a cesarean section regarding prolonged prophylactic rest. As well as describing the nursing team's guidelines, identifying the main difficulties of women undergoing cesarean sections and correlating these reports and guidelines with current literature.

METHODOLOGY

This is an applied research, with a qualitative, exploratory, survey and field approach, covering the area of Health Sciences, in the area of Nursing, with a focus on nursing performance in obstetrics. Being carried out using an electronic form, through Google Forms, from February to April 2021.

49 (forty-nine) women over the age of 18, who underwent cesarean section surgery, participated in the research, with the average age of participants being 32 years old. 63.3% of participants underwent a cesarean section, 24.5% underwent two cesarean sections and 12.2% underwent three cesarean sections.

15 (fifteen) nursing technicians who work or have worked in maternity wards also participated, two of which were excluded from the research because they did not meet the study's inclusion criteria, which would be working or having already worked in maternity wards.

For data collection, the electronic form link was sent via social networks (WhatsApp, Instagram and Facebook) to the participants. The form used to collect data from women contained 14 questions, 12 closed and 02 open, and the form used with nursing technicians contained 13 questions, 12 closed and 01 open.

Participants had access to the Free and

Informed Consent Form at the beginning of the form, where they were informed about the objectives of the research, and could withdraw at any time without causing harm or loss, maintaining the privacy and psychological aspects of the participants.

The results were organized and divided into categories, subsequently analyzed and discussed respecting ethical and legal precepts, in accordance with Resolution 466/12 of the National Council for Ethics and Research involving Human Beings, having been approved by the Research Ethics Committee of the Campos Gerais Higher Education Center – CESCAGE, with opinion number 43523321.9.0000.5215.

RESULTS AND DISCUSSION

Over the past 20 years, cesarean section rates have increased significantly in many parts of the world. In Brazil, between 1996 and 2011, rates rose from 40 to 55% of total births in the country (Negrini, et al., 2020).

According to the World Health Organization (2015), more than half of births in Brazil are through surgical procedures. These data are alarming and do not comply with WHO recommendations, where cesarean section rates must be 10 to 15% of total births.

The increase in cesarean section rates has become a public health problem, as it carries a greater risk of maternal and neonatal morbidity and mortality. Concomitant to this, there is the incidence of post-dural puncture headache (PDPH), which is one of the most common complications of lumbar punctures and in postpartum women undergoing cesarean section (Rodrigues, et al., 2016).

According to Rodriguez, et al. (2016) post-dural puncture headache (PDPH) is defined as any headache that occurs after a lumbar puncture that worsens 15 minutes after sitting or standing and is relieved 15 minutes after lying down. Patients affected by PDPH experience frontal or occipital headaches between 6 and 72 hours after the anesthetic procedure.

Prolonged bed rest is one of the forms of treatment for post-dural puncture headache, however, it has been widely aimed at preventing it even though there is no scientific evidence that it is beneficial for the prevention or onset of PDPH (Rodriguez, et al, 2016).

In this research, 84.6% of Nursing Technicians believe that not resting after a cesarean section can cause PDPH in the postpartum woman. A study carried out in 2016 shows that there is a greater risk of PDPH occurring if the patient is not mobilized immediately after surgery (Rodriguez, et al., 2016).

There are some risk factors for PDPH, including age, sex, previous history of PDPH, needle gauge, type of needle, needle orientation at the time of puncture, number of punctures and operator skill (Gyanesh, et al., 2015).

Evidence shows that non-traumatic needles reduce the risk of PDPH without increasing adverse effects, such as paresthesia or back pain (Rodriguez, et al., 2015)

The needle with a pencil-shaped tip provides faster exit of cerebrospinal fluid (CSF) and easier injection of the anesthetic at the site, as the tissue is separated and not cut, the incision is less painful and with less loss of CSF, this It requires skill from the operator, as thin needles tend to bend more easily and requires a longer period of time to confirm CSF exit (Oliveira, Grachten, Vinhas Filho, 2015).

Although there is no evidence of the benefits of prophylactic rest after cesarean section, many professionals who work in maternity wards continue to recommend it routinely. All professionals participating in this research responded that they advise the postpartum woman to remain on bed rest

after the cesarean section.

In the survey, 87.8% of women remained on absolute bed rest after the cesarean section, 40.8% for approximately 12 hours and 38.8% for approximately 6 hours.

According to Gyanesh et al. (2015) in some maternity hospitals, the use of pillows or at least lateral movement is not allowed, which causes pain, stress and anguish in the mother who cannot breastfeed the newborn or care for him in this position.

Regarding guidance during rest, 76.9% of professionals advise the postpartum woman to remain without a pillow during this period, 84.6% advise her not to drink water, 92.3% advise her not to eat food, 84.6% advise her not to eat advise that the postpartum woman takes a shower approximately 6 hours after the cesarean section and 100% of professionals advise the postpartum woman to breastfeed during the rest period.

In a systematic review, evidence was found that prophylactic rest does not prevent the onset of PDPH, regardless of the duration of rest or the position of the head assumed by the patient (Rodriguez, et al., 2016).

The immediate postpartum period is characterized by important physical and emotional changes and numerous discomforts, which delay early walking, make it difficult to position in bed for breastfeeding, contact with the newborn and perform other tasks (Borges, 2019).

Assistance must be provided to relieve pain, reduce constipation, encourage early walking, ensuring comfort, improving the physical condition of the postpartum woman to provide general care for the newborn (Borges, 2019).

In Brazil, one in every four women suffers some type of violence during childbirth, this includes all types of aggression suffered during labor, postpartum and abortion. The deprivation of movement, and food and liquid intake, is classified as obstetric violence (Brandt, et al., 2018).

In the research, 69.4% of participants were without a pillow and 49% were unable to drink water during the rest period. Regarding bathing, 57.2% only showered 6 hours or more after surgery.

Obstetric violence represents a loss of autonomy on the part of women; this violence, in any instance, impacts women's health and well-being. Some situations of obstetric violence: lack of access to maternal care services that are respectful, competent and understanding, lack of a companion, immobility, prohibition of eating food and liquids, lack of confidentiality and privacy and lack of information about the interventions that will be provided practiced (Mastropaolo, 2017).

This period is essential for the mother and baby to get to know each other, create bonds and learn the breastfeeding process, which is extremely important for the baby's development (Gyanesh, et al., 2015).

Of the professionals who participated in the survey, 53.8% believe that this period of rest interferes with breastfeeding. Only 28.6% of those interviewed were able to breastfeed the baby while resting and 55.1% breastfed with difficulty.

According to the Ministry of Health (2016), breastfeeding is the natural strategy for bonding, affection, protection and nutrition, being the most sensitive, economical and effective way to reduce child morbidity and mortality.

More than half of those interviewed breastfed with difficulty. The first hour of a newborn's life, known as golden hour, is essential for the success of breastfeeding later on, however, due to postpartum complaints, the limiting position and team interventions, postpartum women are unable to breastfeed during this period. period.

Golden hour is a recommended practice

in good obstetric practice protocols, being the time of greatest identification of maternal and neonatal risk, as well as the implementation of evidence-based practices for skin-to-skin contact, this practice has been ignored or fragmented by complications of the mother or baby and institutional routines in maternity wards (Monteiro, 2019).

A study carried out in 2017, on discomforts in the immediate postpartum period, observed that women undergoing cesarean sections are more vulnerable to greater morbidity compared to vaginal birth (Monteseano, et al., 2017).

The table below describes the greatest difficulties and discomforts reported by postpartum women in the immediate post-operative period of a cesarean section.

Main difficulties	Answers (%)
Resting without being able to get up	28 (57,1%)
Not being able to drink water	10 (20,4%)
Not being able to eat	12 (24,55)
Difficulty breathing	5 (10,2%)
Nausea and/or vomiting	10 (20,4%)
Uncomfortable position	21 (42,9%)
I was distressed and/or stressed	11 (22,4%)
I couldn't hold the baby	15 (30,6%)
Difficulty breastfeeding the baby	18 (36,7%)
I had no help from the team	8 (16,3%)
It wasn't how I imagined or planned	9 (18,4%)

Table 1: The biggest difficulties after cesarean section

During the immediate postpartum period, the woman goes through physical, psychological and social changes, in the hospital environment, some complaints such as pain, insecurity and fear may arise, this directly affects the quality of life and health status of the postpartum woman and the newborn. -born (Tomasoni, et al., 2020).

The nursing care provided to women during the birth process, here mainly in the post-operative period of the cesarean section, brings important changes in the postpartum period and in the woman's life. The perpetuation of obstetric violence and actions without scientific basis continues in maternity wards.

The lack of women's protagonism throughout the gestational process has major impacts on childbirth care. It is extremely important that there is health education, a group of pregnant women and pregnant couples to contribute and strengthen women's potential to make decisions in conducting the birth process. childbirth (Copelli, et al., 2015).

Participating health professionals reported that 69.2% received training on this model of care from the maternity nurse and 15.4% on the technical course, where the majority of professional nurse's work as teachers.

On the other hand, the participating women reported that they received this guidance from these same professionals.

The results presented show that it is urgent to train nursing professionals, especially those working in maternity wards, to respect women's desires and needs, promoting humanized assistance, physical and mental comfort and their satisfaction.

According to Sandler (2018), when a woman does not actively participate in decisions regarding her birth process, the physical and psychological outcomes can leave consequences for the life of the woman, the newborn and the family.

As important as knowing the techniques and decisions that must be made in risk situations, it is understanding women's expectations, doubts and desires, aiming at women's leading role in the birth scene.

The guidance received from professionals since the prenatal consultation and family influence have a significant impact on women's decision-making. Therefore, the inclusion of the family, especially the companion and/or partner in care during the birth process is

fundamental (Copelli, et al., 2015).

Nursing training centers have a duty to assume this leading role in breaking the paradigm to promote action based on autonomy and respect, based on evidence, with multidisciplinary teams working organically together with women (Sandler, 2018).

CONCLUSION

With the advancement of medical technologies in recent decades, birth care practices have undergone major changes. This is confirmed by the alarming increase in cesarean section rates around the world and especially in Brazil.

According to the WHO, more than half of births in the country are through cesarean section, the majority of which are elective, which contrasts with the rates considered acceptable by the World Health Organization.

The large increase in cesarean section rates is considered a public health problem, as it leads to greater maternal and neonatal morbidity and mortality, in addition to being harmful to the breastfeeding process.

A cesarean section must be an option whenever the risk of vaginal birth is greater than that of a cesarean section. This may occur in clinical or obstetric situations that increase the risk for the mother and baby.

Compared to vaginal birth, cesarean section causes numerous complaints in the immediate postpartum and postpartum period. The lack of preparation of professionals working in maternity wards to promote quality care is observed in the research results, which show numerous violations of these women's rights.

Childbirth has become a medical and surgical event, increasing beliefs that a cesarean section would be the safest option, which culminated in the lack of ability of health professionals to attend vaginal births and promote humanized care for patients.

As the research results show, professionals continue to help in accordance with popular beliefs and common sense, advising postpartum women to remain in the same position for hours to prevent the onset of post-dural puncture headache.

Evidence shows that the risk factors for the onset of PDPH are the gauge of the needles used, the type of needle, the number of punctures, the skill of the operator, as well as factors such as age, sex and patient history.

In addition to spending hours resting in the supine position, headboard at zero degrees, without a pillow, and without the possibility of moving sideways, many women are advised not to drink food or liquids and are unable to breastfeed or care for their baby in this position.

The act of prohibiting food, drinking liquids and making it difficult for women who have recently given birth to move around is characterized as Obstetric Violence. This directly interferes with the bond between mother and child, making the breastfeeding process and the right to golden hour difficult.

Reports from women undergoing cesarean surgery show that they felt stressed, frustrated, distressed, that they had difficulties and were not helped by the team.

The entire process of pregnancy, childbirth and postpartum brings physical and emotional changes to women, the lack of women's role in this entire process, making childbirth a medical event, taking away women's total autonomy, their basic rights, such as mobility. and feeding, thus being a violent birth, will have lifelong consequences.

The lack of preparation of these professionals is notable, as evidenced in this research, by the nursing team and the professional nurse who is responsible for training his team in assisting postpartum women after a cesarean section. It is urgent to train them to promote safe, humanized, quality care based on scientific evidence.

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