

## NEEDLE GUIDE FOR TRANSVAGINAL PUDENDAL BLOCK\*

ALONSO VELARDE

*Department of Obstetrics and Gynecology, Crawford W. Long Memorial Hospital of  
Emory University School of Medicine, Atlanta, Georgia, U. S. A.*

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The perennial shortage of anesthetists and anesthesiologists, together with the exigencies of the delivery room, have made conduction anesthesia increasingly popular in obstetrics. Of these, pudendal block has the advantage that it can be quickly administered by the obstetrician under almost any circumstances. For many years it has been used satisfactorily by members of the Visiting Staff as well as the Resident Staff of the Crawford W. Long Memorial Hospital. In 1956, 74 per cent of the 4924 deliveries in this hospital were conducted under local anesthesia, including pudendal block. This group included not only spontaneous normal deliveries, but low forceps, rotations of the head, midforceps, breech deliveries, including forceps to after-coming head, repair of lacerations, and elective perineoplasty.

The transvaginal technic for pudendal block, described by *Kobak, Euans, and Johnson*, has been used by several of our obstetricians who are very favorably impressed with it. To facilitate the transvaginal technic, the author has devised a needle guide which has proved quite satisfactory (Fig. 1). This instrument consists of a rigid metallic tube approximately 10cm. long with a lumen that permits the passage of a size 20 Luer needle. The shaft of the commonly used 13cm. (5 inch) needle is 3 cm. longer than the guide. A ring is welded to the shaft of the guide near the junction of its proximal and middle thirds.

This ring should fit loosely over the proximal phalanx of the obstetrician's middle finger. The distal portion of the shaft of the guide should be long enough to reach

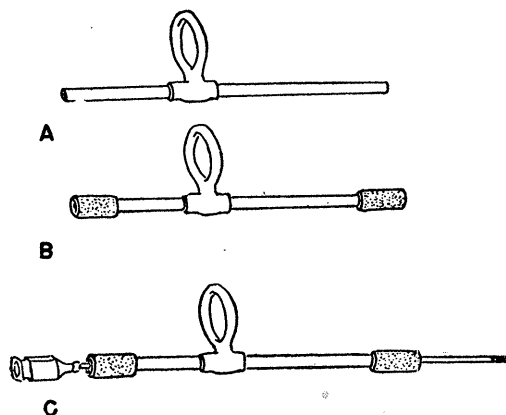


Fig.1. Needle Guide for transvaginal pudendal block. A, Without rubber tips: B, tipped with catheter rubber: C, showing relationship to 5-inch (13cm.) Luer needle.

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within 1 cm. of the tip of the palmar surface of the finger. The proximal or shorter end of the shaft should reach the center of the palm of the hand. Both ends of the shaft should be rubber tipped to prevent injury to the vaginal mucosa and the presenting part of the fetus, and to minimize damage to the operator's glove.

The technic of the procedure follows closely that of Kobak (Fig. 2). The tip of the ischial spine is identified, the left hand being used for the left side of the pelvis, and vice versa. The distal end of the guide is then placed against the ischial spine. The needle is then introduced through the guide and made to penetrate the mucose for injections of 3 to 4 cm. anterior to the spine, and 6 to 7 cm. posterior thereto (Fig. 2). The procedure is then repeated on the opposite side.

The use of the guide is obviously of value, especially with a rapidly descending presenting fetal part which tends to crowd the operator's fingers against the vaginal walls and interfere with insertion of the needle. Zylocaine, 2 per cent, has given excellent results in our hands as to extent and duration of anesthesia obtained.

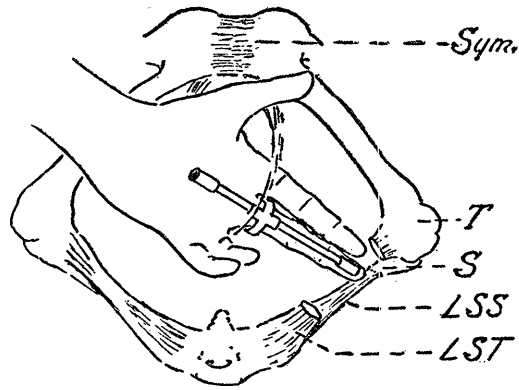


Fig. 2. Technic, Sym, symphysis pubis: T, tuberosity of ischium: S, ischial spine: LSS, sacrospinous ligament: LST, sacrotuberous ligament (cut).

#### REFERENCE

- 1). KOBAK, A. J., EVANS, E. F., and JOHNSON, G. R.: Transvaginal pudendal nerve block. *Am. J. Obst. & Gynec.*, 71: 981, 1956.