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Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.ijoa.2018.12.007>.

0959-289X/\$ - see front matter

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<https://doi.org/10.1016/j.ijoa.2018.12.007>

Intravenous dexmedetomidine



I was interested to read the editorial by Sng et al.¹ in which the use of intravenous (IV) dexmedetomidine in obstetric anesthesia is described. My anesthetic group has been using the drug for the last two years to relieve peri-operative shivering during cesarean delivery, this being a distressing symptom for most women, especially following labor. This decision was taken after reading the preliminary results of a study from Montreal² that were first reported at the Society of Obstetric Anesthesia and Perinatology meeting in 2016. The investigators described the benefit of a 30 µg dose of IV dexmedetomidine for the relief of shivering at cesarean delivery. Our experience is that dexmedetomidine, administered as a slow IV bolus of 15–30 µg in this setting, is as or more effective than 25 mg IV meperidine. It works within 45–90 s and it is rare that the patient requires a second dose. Since we are now trying to find ways to limit opioid exposure in our patients, it would seem prudent for IV dexmedetomidine to replace meperidine for shivering during cesarean delivery. Dexmedetomidine can cause a transient, moderate increase in systolic and diastolic blood pressures and a transient, manageable, fall in heart rate which, arguably, is useful after inducing spinal anesthesia. Blood pressure changes, however, are biphasic and there may be a period of hypotension after its use, but this has not been a clinically important finding in our practice. Patients may experience a brief period of sedation and anxiolysis, which has prompted some in our group to use dexmedetomidine for intra-operative anxiety instead of midazolam.

I am aware that other therapies for shivering during cesarean delivery, such as clonidine and tramadol, have been used and evaluated around the globe but our group has no experience with those drugs in this context.^{3–5}

Dexmedetomidine is an inexpensive drug (about US\$2 for a 200 µg vial) and I believe it should be considered as a first-line treatment for shivering, and as an option for the treatment of anxiety during cesarean delivery under neuraxial anesthesia. As such, dexmedetomidine is indeed a very useful “weapon in our armoury”.

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<https://doi.org/10.1016/j.ijoa.2019.02.004>

Knowledge and comfort with neonatal resuscitation among practising anesthesiologists



The Neonatal Resuscitation Program (NRP) was developed in 1987 by the American Heart Association and the American Academy of Pediatrics to teach an evidence-based approach to neonatal resuscitation.¹ When obstetric anesthesia became an accredited fellowship in 2011, NRP training became a requirement for graduation. However, most anesthesiologists do not have an obstetric anesthesia fellowship or formal NRP training and most of those who work on the labor and delivery unit do not have NRP training.² We conducted a pilot study, the purpose of which was to develop a reliable and valid survey that assesses anesthesiologists' knowledge and comfort with neonatal resuscitation. A demographics