Obstetric Anesthesia Subcommittee Minutes
December 3rd, 2025
1:00-2:00 pm EST - Zoom

Attendees:

Kate Buehler, MPOG	Mary McKinney, Corewell Health
Meilou Calabio, MPOG	Kam Mirizzi, MPOG
Arthur Calimaran, Cleveland Clinic	Melinda Mitchell, Henry Ford Health
Ruth Cassidy, MPOG	Allison Mootz, UT Southwestern
Johanna Cobb, Dartmouth	Katie O'Conor, Johns Hopkins
Laura Cohen, UMass Memorial	Jillian Printz, Cleveland Clinic
Rob Coleman, MPOG	Sharon Reale, Brigham & Women's
Heather Dobbs, Bronson Health	Nirav Shah, MPOG
Jackie Goatley, University of Michigan	Shashank Shettar, University of Oklahoma
Josh Goldblatt, Henry Ford Health	Sahar Siddik-Sayyid, American University of Beirut
Ashraf Habib, Duke	Rachel Stumpf, MPOG
Jerri Heiter, Trinity Health	Brian Taussig, NYU Langone
Patrick Henson, Vanderbilt University	Brandon Togioka, OHSU
Michelle Huntington, Corewell Health	Lawrence Tsen, Brigham & Women's
Zachary Janik, Walter Reed	Pam Tyler, Corewell Health
Wandana Joshi, Dartmouth	Meridith Wade, MPOG
Teshi Kaushik, UAB	Christine Warrick, University of Utah
John Kowalczyk, Brigham & Women's	Nathan Woody, University of North Carolina
Heather Lalonde, Trinity Health	Amy Zheng, University of Maryland
Allison Lee, UPENN	Andrew Zittleman, MPOG
Kristyn Lewandowski, Corewell Health	Graciela Mentz, MPOG
Tiffany Malenfant, MPOG	Michael Furdyna, Brigham and Women's
Michael McDonald, UPENN	Anjana Sekaran, Johns Hopkins
Christine McKenzie, UNC	Rachel Kacmar, University of Colorado

Obstetric-Anesthesia Quality Subcommittee — Meeting Summary
Date/Time: 12/3/2025 1-2pm EST via *Zoom*
Chair: Dr. Brandon Togioka (OHSU) **Vice Chair:** Dr. Wandana Joshi (Dartmouth)
Facilitator: Kate Buehler (MPOG)

1. Announcements

- 2026 Meeting Dates:
  - February 11th, 2026 1-2pm EST
  - June 3rd, 2026 1-2pm EST
  - September 16th, 2026 1-2pm EST
- Welcome to new OB Subcommittee members!
  - OB Subcommittee is open to anyone, if interested in attending, please email Kate Buehler (kjbucrek@med.umich.edu)
- Thank you to Dr. Joshi for her service over the last 2 years! She will be stepping down as of December 2025 from her vice chair position.
- Seeking an OB Subcommittee Vice Chair:
  - Obstetric Subcommittee Vice Chair Description: here
  - Actively practicing OB anesthesiologist at current MPOG site
  - Guide and support the work of the Obstetric Subcommittee
  - Lead measure performance review, new measure development, measure revision discussions
  - Identify and participate in research opportunities
  - Monthly meetings with Chair (Brandon Togioka) and the MPOG team
  - Be able to devote 2 - 4 hours per month to this role for a 2 year term
  - Interested faculty should submit their interest to MPOG QI Director (Nirav Shah) at nirshah@med.umich.edu and MPOG Obstetric Subcommittee Chair (Brandon Togioka) at Togioka@ohsu.edu

2. Literature Spotlight (In-the-News)

- The Multicenter Perioperative Outcomes Group (MPOG) learning health system: a model for promoting evidence-based peripartum care (Togioka, Reale, Klumpner, Aziz, and Mathis, 2025)
- Highlights implications for using MPOG data for obstetric research and QI
- Excellent article to reference for future OB research

3. September Meeting Recap

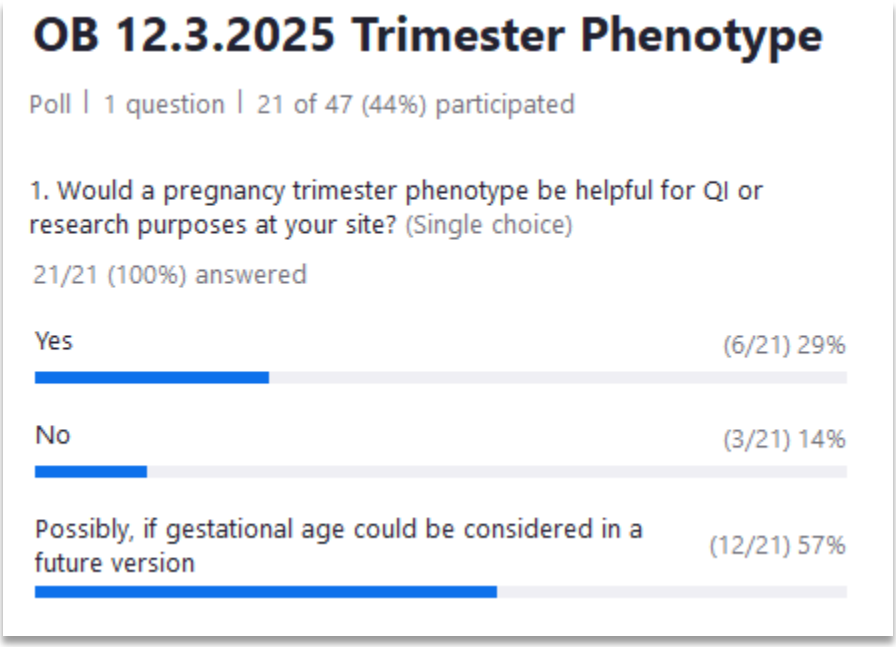
- Reviewed Clinical Practice Guidelines for PDPH
- Voted to define pregnancy phenotype based on a threshold of 42 weeks prior to delivery date/time as found in MPOG database.
- Reviewed updates to obstetric antibiotic administration measure time frames for ABX-01-OB and ABX-06-OB.
- Voted to no longer consider nitrous oxide administration (alone) as general anesthesia.
- Reviewed proposed specifications and preliminary data for two new measures:
  - Unintended dural puncture
  - Epidural replacement

4. Obstetric Phenotypes Update

- Obstetrics Delivery – Date/Time phenotype recently revised! Now returns a delivery date/time for 100% of all obstetric cases in MPOG
- 'Obstetric – Is Pregnant' phenotype published December 1st
    - Preliminary data (January – December 2024) shared with the committee:
    - ~2.7% of cases in the MPOG registry during this time period were performed on patients who were likely pregnant (102,250 cases)
    - 1574 cases were definitively not pregnant during their procedure
    - 2078 (0.1%) were postpartum at the time of surgery
    - Unable to determine pregnancy status for 97.2% of patients undergoing a procedure in this time frame (no delivery found in MPOG)
- Obstetrics – Pregnancy Trimester phenotype in development
    - **Proposed return values:**
        - -999: Unable to determine trimester (no delivery found in MPOG)
        - 0: Not pregnant
        - 1: First Trimester (pregnant)
        - 2: Second Trimester (pregnant)
        - 3: Third Trimester (pregnant)
        - 4: Fourth Trimester (postpartum)
    - **Discussion: Would a pregnancy trimester phenotype be helpful for QI or research purposes?**
    - ***Ashraf Habib (Duke):*** I'm hesitant about creating a trimester phenotype. I think it would be better to limit to pregnant vs. non-pregnant. If there is any possibility to have gestational age at the time of delivery. If you have this data in the delivery encounter that would help sort this out.
    - ***Patrick Henson (Vanderbilt):*** Potentially helpful but seems challenging to do correctly
    - ***Richard Wissler (University of Rochester):*** I would rather have it as a continuous variable rather than categories
    - ***Michael Furdyna (Mass General Brigham):*** There are ICD codes also for an encounter for gestational age basically maternal care particularly towards the end so I know when reviewing cases for deliveries and trying to estimate gestational age at least to the week, that would give some of a ballpark. It may be off by one week off but at least if they stop being reported that might indicate that they delivered already
        - ***Brandon Togioka (OHSU):*** That's a really good point. We looked at this too with the current study we're working on. Rich: to your point, I like the descriptive variable as it allows the individual investigator to make an inference themselves versus relying on a phenotype that we create which has a lot of inaccuracy variable
        - ***Kate Buehler (MPOG):*** using billing codes eliminates a fair number of cases because a lot of times we don't get billing reliably or quickly.
    - ***Daniel Berenson (Mass General Brigham) [chat]:*** I'm sure this has been discussed before, but out of curiosity: There is definitely no way to extract the mom's gestational age from anywhere in the records?

- ***Patrick Henson (Vanderbilt):*** Did you mention whether EGA and date of conception could be extracted? Day of conception and EGA and things are really a fundamental part of obstetric coding and documenting but there's no way without putting that in some anesthetic documentation. I know that our obstetricians put that in their notes, but I guess that would have to be seen here. For that purpose as I think out loud about this. If they came in and were not seen here, that would be information that couldn't be reliable.
  - ***Kate Buehler (MPOG):*** You can always add it manually to your extract but it's not part of the standard MPOG extract.
  - ***Nirav Shah (MPOG QI Director):*** Yea, it's kind of exposing a weakness of the MPOG extract, especially for EPIC sites. One of the strengths is that there's a standard EPIC extract umbrella it's a relatively limited amount of work we can get it up and running compared to having to build your own but the weakness of that is boundaries and so if we want to extend it, for example, to include historic data or OB data or floor/ICU data then either we have to rely on Epic to modify the extract or sites will have to pull that manually. To do that at scale across every site and ask them to do that has been challenging. That's kind of the work that MPOG is trying to figure out over the next few years: how do we reduce that dependency so that when we want to get this additional important information, we're able to .
    - ***Patrick Henson (Vanderbilt):*** I guess it seems like a lot to ask to have this for what is a seemingly small change but if you think about this on a broader population like I can think of fewer maybe more meaningful groups to actually look at data in then early gestation surgical procedure; this is a really potentially meaningful. Maybe I'm overestimating that, but I wonder if there is some sort of solution to actually getting this as opposed to just saying like 'we don't know'. I don't know what that answer is and I certainly don't think it's worth making a dramatic change but at least worth exploring further.
  - ***Daniel Berenson (Mass General Brigham):*** I agree, exploring possibilities for including this data more widely would definitely be very helpful. We're already needing to exclude like 98% of patients because they just don't have a delivery documented which could be because they're not pregnant or could be, because their delivery was outside MPOG or whatever so we're already kind of narrowing the patients we really are confident into a small subset and I think it would be better to further narrow it to patients where we can more confidently say what their gestational age is. If there is some fraction of patients where the data is obtainable through the current system and really know what's going on with them rather than having the guesswork.
  - ***Josh Goldblatt (Henry Ford) [chat]:*** Back to previous conversation, Henry Ford is collecting pregnancy as gestational age as a discrete field in the pre-op evaluation. This is fairly new, and I don't know about its actual use.

Vote:



5. PONV-05 Updates

- Dr. Shashank Shettar (OU Health – University of Oklahoma) presented recent updates to the PONV guidelines (5th Consensus Guidelines for the Management of Postoperative Nausea and Vomiting: Executive Summary) and posed questions to the subcommittee regarding modifications to the existing MPOG PONV prophylaxis measure (PONV-05) for cesarean delivery patients
- **Discussion:**
    - ***Richard Wissler (University of Rochester) [via chat]:*** Very nice presentation on anticholinergics. My question to MPOG: Why are we only giving credit for certain anti-emetics. Isn't there room for differing clinical approaches, as long as N/V prophylaxis is being addressed?
        - ***Kate Buehler (MPOG):*** Scopolamine patch is included in the success criteria for PONV05 for cesarean delivery as an acceptable antiemetic for prophylaxis, but you're correct that atropine and glycopyrrolate are not included currently
        - ***Ashraf Habib (Duke):*** My understanding is that ondansetron between what the recommendation first practice but it is not, I think all antiemetics should be included is that correct?
        - ***Kate Buehler (MPOG)****:* That's correct. In the specification we list the recommended antiemetics to align with the SOAP-specific recommendations but we do include all of them for consideration when determining if a case passes.

- ***Wandana Joshi (Dartmouth)****:* Dr. Shettar, if you are giving glycopyrrolate and scopolamine? What is the rate of patients complaining about a dry mouth?
    - ***Shashank Shettar (OU Health)****:* It's not much to be honest. For some reason, at least for cesarean surgery, we've not seen much. I do not know the exact mechanism but they do not complain so much. Maybe it's multifactorial the baby being born, but there have been some academic literature in terms of one of the textbooks they also mentioned the use of anticholinergic like glycopyrrolate and atropine specifically helps decrease, at least, the intraoperative nausea and vomiting.
    - ***Ashraf Habib (Duke):*** There are two or three studies out there about glycopyrrolate and cesareans. One is an older study from a group in Glasgow that showed that it reduced instances of intraoperative nausea and vomiting but this was at the time when vasopressors were given as rescue boluses before the time of phenylephrine infusion. There was another study that looked at phenylephrine infusions and examined the ways to address the bradycardia that happens with phenylephrine infusion. In one study, they did give all patients glycopyrrolate in the setting of phenylephrine infusion and what they found that those patients who got glycopyrrolate did have higher cardiac output but there was more variability in blood pressure, more reactive hypertension and more dry mouth in the glycopyrrolate group. As a result, they found that this was not a clinically beneficial intervention. They did not recommend its routine measure in the setting of phenylephrine infusion which is very commonly in practice currently.
- ***Josh Younger (Northwell):*** One of our sites introduced scopolamine as part of the ERAS process and there was some objection from the lactation consultants because of mixed evidence in terms of it affecting the lactation. So the compromise that we came to was that it could be used for 24 hours opposed to the 3 days that you can usually apply the scopolamine patch. The other objection was that some obstetricians had patients that experienced hallucination for some form of negative secondary effect from it. Those are two experiences that we had with it.
    - ***Shashank Shettar (OU Health)****:* Yes, we also as part of our ERAS protocol, do just apply scopolamine for 24 hours, we did have a similar objection basically from lactation consultants and MFM also and most of them went home on day 2 or 3 and they just didn't want that patch to be gone home so we take out within 24 hours after delivery. As far as hallucinations, I don't think it has been reported but it's a known side effect that's worth considering.

- **Vote:**

MPOG
MULTICENTER PERIOPERATIVE OUTCOMES GROUP

1. Should glycopyrrolate be considered an acceptable medication for PONV prophylaxis for cesarean delivery? (Single choice)

26/27 (96%) answered

Yes	(16/26) 62%
No	(10/26) 38%

2. Should atropine be considered an acceptable medication for PONV prophylaxis for cesarean delivery? (Single choice)

26/27 (96%) answered

Yes	(10/26) 38%
No	(16/26) 62%

3. Should MPOG develop a new PONV prophylaxis measure to assess cesarean deliveries independent of the existing PONV-05 measure? (Single choice)

27/27 (100%) answered

Yes	(17/27) 63%
No	(10/27) 37%

4. Should MPOG develop a new IONV prophylaxis measure specific to cesarean delivery surgery? (Single choice)

25/27 (92%) answered

Yes	(18/25) 72%
No	(7/25) 28%

- ***Ashraf Habib (Duke):*** I have a few thoughts. There is a bit of complexity in deciding in a database setting what is given for intraoperative and what's given postoperative NV and most commonly they do overlap significantly. I can think of probably one antiemetic that is helpful for intraop and not postop NV is metoclopramide but other than that people will give ondansetron to help for both intraoperative and postoperative nausea and vomiting. Maybe dexamethasone is for postop and then there is the complexity of patients receiving antiemetics intraop. You don't really know if this was because of prophylaxis or whether this is because they actually did have symptoms and they were treated. So there is significant complexities of looking at this in a database setting without somebody collecting this data prospectively for cesarean population determining what was given for intraop vs. what was given for postop. That's why I actually voted no for those. Also because I think there's significant complexity to it. Also voted 'no' for adding glycopyrrolate for this reason- too much complexity.
    - ***Wandana Joshi (Dartmouth):*** I also see that it wasn't mentioned in the 5th Consensus guidelines either. I tend to use glycopyrrolate intraoperatively, just if the patient gets bradycardic from the phenylephrine infusion, but I don't consider it an antiemetic in my practice.
    - ***Josh Younger (Northwell):*** Ashraf – I have a question for you. I mean, it seems that your objection is that the primary reason that it's given should be considered, not the secondary effects but couldn't a medication serve two functions? Let's say benzodiazepines. Most people aren't going to be getting a benzo for PONV, we'll be giving it for some degree of anxiety. But if it aids in PONV, do we want to rule that out?
    - ***Nirav Shah (MPOG):*** I'd just chime in here to say that I don't know that we want to incentivize providers to give something like midazolam as a prophylactic antiemetic as the primary purpose. We want the measure to support administration of medications that work best for PONV, not happen to have a side effect of PONV prophylaxis.
    - ***Ashraf Habib (Duke):*** Yes, giving a benzodiazepine, specifically for cesarean delivery is controversial in that it can impact the patients memory of the event. I still remain concerned about that. It would not be my first choice for PONV prophylaxis in the obstetric population.
    - ***Josh Younger (Northwell):*** My only last comment is, that's why I like the idea of not listing these meds as recommended in the measure but also not excluding them from the success criteria.
- ***John J. Kowalczyk (Mass General Brigham) [chat]:*** Does the measure include antiemetics given by nursing in the "pre-op" period on labor and delivery? I can imagine that the scopolamine patch may be given early by nurses prior to the case.
    - ***Brandon Togioka (OHSU) [chat]:*** As long as it is administered within the 4 hour period before preop start, anti-emetics administered would count *[**Note:** Documentation from the L&D nursing record may not be included in your site's MPOG extract as this varies from site to site. MPOG recommends confirming your extract time period of obstetric cases specifically, as the standard MPOG extract includes 4 hours before anesthesia start through 6 hours after anesthesia end for cases performed in the operating room and diagnostic imaging suites. Data extracts for NORA and L&D areas may differ.]*

- ***Johanna G. Cobb (Dartmouth) [chat]:*** I agree with Dr. Younger regarding preferred medications and acceptable medications. You may have a very good reason for using lorazepam as an antiemetic - perhaps an anxious patient with long QT

6. New Measure Discussion – Postponed to the February meeting due to time

Meeting Adjourned: 1407

Action Items

1. Hold on further development of the pregnancy trimester phenotype as currently specified and investigate alternative options for capturing gestational age at time of delivery, potentially using ICD-10 codes.
2. MPOG Coordinating Center with support from OB Subcommittee leadership will develop an initial measure specification to assess IONV/PONV prophylaxis for cesarean delivery patients.
    a. Will include glycopyrrolate in the list of acceptable antiemetics for prophylaxis in the new measure.
    b. Will **exclude** atropine & midazolam as acceptable antiemetics.
3. Will move forward with excluding cesarean delivery patients from PONV-05.
4. MPOG Coordinating Center to release neuraxial catheter replacement (NCR-01-OB) as a departmental measure (not available for provider feedback emails) once validated. Will post to forum when available for Obstetric Champions to review.
5. Contact Brandon Togioka or Nirav Shah if interested in the OB Subcommittee Vice Chair Position.

Next meeting: ***Wednesday, February 11, 2026 — 1 p.m. ET / 10 a.m. PT***