

# Radiofrequency ablation for fetal reduction

## L&D Nursing guidelines

**Purpose** – radiofrequency ablation of fetal vessel in complicated monochorionic twin pregnancy

**Staff:**

- Circulator nurse (scrub not necessary, but nice if available)
- Scrub available in setting of fetus > 23 weeks EGA and there is the potential for cesarean delivery in the setting of fetal bradycardia
- Faculty MFM; physician for sonography; physician as assistant
- Anesthesia

**Indications:**

- Monochorionic twin pregnancy with TRAP, discordant anomaly, TTTS
- Selective/elective multifetal pregnancy reduction in monochorionic twin pregnancy

**Equipment list in OR:**

- GE US machine from triage
- Probe cover and US sterile drape
- Amnioinfusion equipment may be required – review with MFM prior to procedure:
  - Sterile IV extension tubing (x 3)
  - Three way stop-cock
  - 20 cc syringe (luer lock tip) x 2
  - 1 L NS – to anesthesia (place in warmer line); pressure bag
  - 20 gauge spinal needle
- 11 blade
- cesarean drape
- 10 cc syringe x 3 if amniotic fluid is needed for analysis
- table cover
- raytec pack x 1
- steri-strips + mastisol
- suture scissors
- RITA Starburst SDE electrosurgical device (L = 12 cm; D = 2 cm)
- RFA generator
  - Bilateral return electrode leg pads
  - Folded towels
- Bandage

**Procedure:**

**Pre-op abx:** 2 gram cefazolin prior to procedure

**Anesthesia:** spinal vs local with sedation – OB anesthesia and MFM to confer

**Prep/positioning:**

- Supine position with left lateral tilt (bovie pad not needed)

- Place foley after spinal – confer with attending and may elect not to place foley if anticipate short case
- Cesarean prep and drape (cesarean instrument tray NOT needed)
- SCD's in place

**Procedure briefly:** MFM will perform US to confirm fetal position.

If amnioinfusion is necessary: IV tubing assembled with luer lock end at fetus end to attach to spinal needed, then 3 way stop-cock, then second and possibly third IV extension tubing to hand off to anesthesia. Tubing primed with NS via IV warmer. 20 g spinal needed placed and saline infused via syringe to confirm intra-amniotic placement. Transabdominal amnioinfusion done if needed via 20 gauge needle into amniotic cavity until adequate AF pocket present to allow shunt placement – usually ~ 500-600 ml. Needle removed.

**Specimen:**

- Usually no specimen
- May have amniotic fluid for karyotype, array, save cells, PCR for infection studies (review with MFM)

**Post procedure – recovery – discharge:**

- Meds: may give Indocin 50 mg po prior to discharge and then 25 mg po q 8 hours x 24-48 hours
- Keflex 500 mg po bid x 7 days
- If plan is for cesarean/delivery for abnormal fetal monitoring, place on fetal monitor post procedure. Review with MFM regarding fetal monitoring needed for individual case.
- Discharge in consultation with MFM when tolerating PO, void without comps, appropriate pain symptoms, spinal resolved.
- Will need follow up in US unit in 5-7 days.

*These algorithms are designed to assist the primary care provider in the clinical management of a variety of problems that occur during pregnancy. They should not be interpreted as a standard of care, but instead represent guidelines for management. Variation in practices should take into account such factors as characteristics of the individual patient, health resources, and regional experience with diagnostic and therapeutic modalities.*

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