an individual patient. This statement is not intended to ensure a successful patient outcome in every situation and is not a guarantee of any specific outcome. This consensus statement is subject to periodic revision as additional data becomes available. In all cases, it is assumed that the obstetric patients with thrombocytopenia do not have additional contraindications to neuraxial anesthesia.

The decision of whether to proceed with a neuraxial procedure in an obstetric patient with thrombocytopenia occurs within a clinical context. Potentially relevant factors include but are not limited to comorbidities, obstetric risk factors, airway examination, available airway equipment, risk of general anesthesia, and patient preference. Invariably, concern for spinal epidural hematoma with a neuraxial procedure must be weighed against the consequences of withholding neuraxial analgesia and/or proceeding with general anesthesia. Each of these factors was considered during the modified Delphi process. Additionally, in some centers, expert hematologic consultation is available 24 hours a day, 7 days a week; at others, it is rarely or never available. In response, the recommendations were crafted to account for patient and practice setting variation. Finally, there were lengthy discussions of whether the risk of spinal epidural hematoma was lower in the setting of a spinal versus an epidural procedure because this distinction appears in some publications and international professional organizations' recommendations. This hypothesis is intuitively plausible, given the smaller gauge (25–29 g) and "pencil point" needle tip commonly used in obstetric practice, compared with epidural needles (17–18 g), larger (20–22 g) "cutting" needle tip used for lumbar punctures, and the lack of in situ catheter. However, the literature to support this notion in patients with thrombocytopenia is sparse. In the 2020 systematic review of spinal epidural hematomas in patients with thrombocytopenia, the largest number of hematomas occurred in severely thrombocytopenic oncology patients (<50,000 × 10^6/L) that received lumbar punctures, in part because relatively few obstetric and other patients received spinal or epidural anesthetics with that degree of thrombocytopenia.[6] The taskforce, with its representatives from SOAP, ASRA, ASH, ACOG, and SMFM, chose the threshold platelet count for neuraxial procedures of 70,000 × 10^6/L with the caveats described below based on the available data suggesting a low sample spinal epidural hematoma event rate at or above that platelet count, and the known hypercoagulability of pregnancy. The taskforce acknowledged, however, that (a) the CBC has an approximately ±3% coefficient of variation, meaning these data and recommendations cannot be precise and (b) there are maternal comorbidities and competing risks that will impact clinical decision making.

For guiding the assessment of whether to proceed with neuraxial anesthesia in the pregnant patient, we have divided the thrombocytopenic obstetric population into 2 categories: (a) the patient with a known thrombocytopenia etiology and (b) the patient without a known thrombocytopenia etiology. For the purposes of this consensus statement, patients with a known diagnosis of ITP have had a workup by a hematologist before pregnancy. Patients with gestational thrombocytopenia will have had a normal platelet count before pregnancy or early pregnancy and had a decline during pregnancy to ≥70,000 × 10^6/L. Patients with hypertensive disorders of pregnancy have met diagnostic criteria. Patients with an unknown thrombocytopenia etiology may include a patient that presents during pregnancy with new thrombocytopenia compared to previous platelet counts, without a clear etiology, or one for whom no previous platelet counts are available for comparison. Neuraxial procedures are defined as the following: spinal, epidural, combined spinal epidural, dural puncture epidural, and epidural catheter removal procedures.

The Obstetric Patient With a Known Etiology of Thrombocytopenia by Prior Workup or Confirmed Diagnosis of Hypertensive Disorders of Pregnancy[a]

1. Assess for history of bleeding associated with thrombocytopenia (Table 2) and confirm no visible signs of DIC such as bleeding from intravenous (IV) sites, catheters, wounds, or new mucocutaneous bleeding (Figure).
    a. For confirmed diagnosis of gestational thrombocytopenia or ITP, or confirmed diagnosis of hypertensive disorders of pregnancy (eg, preeclampsia):
        i. If concern for a history of bleeding associated with thrombocytopenia or DIC (as described above), then it may be reasonable to avoid neuraxial procedures or seek expert hematologic evaluation before proceeding with the neuraxial procedure (class IIb and level C-LD).
        ii. If the platelet count is ≥70,000 × 10^6/L, then there is likely to be a low risk of spinal epidural hematoma and it is reasonable to proceed with a neuraxial procedure if clinically indicated (class IIa and level C-LD).
        iii. If the platelet count is between 50,000 and 70,000 × 10^6/L, then there may be scenarios when competing risks/benefits justify proceeding with a neuraxial procedure (class IIb and level C-LD).

[a]Assumes patient has no additional risk factors. Clinical context and competing risks might include, but are not limited to, the presence of high-risk comorbidities or difficult airway, the need for urgent or emergent general anesthesia, or the choice of neuraxial technique (ie, spinal versus epidural anesthetic).