THROUGH THE CORDS
Next-Generation Airway Tools

Mothers in Surgical Pain During C-Section

What's Happening, Why It's in the News, and What You Can Ask Before Surgery

An educational guide for expecting families — not medical advice

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Why You're Hearing About This

In February 2026, *The New York Times' The Daily* aired an episode called "When Anesthesia Fails and the Patient Is Cut Open." It shared stories from women who felt sharp, severe pain during C-sections — and who felt dismissed when they spoke up.

Listen here

The episode cited a large study across 15 hospitals in the U.S. and Canada. The findings: **8% of patients reported significant pain** during their C-section — pain they rated 6 out of 10 or higher. Nationally, that translates to roughly **100,000 women per year**.

If you're pregnant, that number can be frightening. But understanding what's behind it — and what you can do about it — is more useful than fear.

What You Should Feel — and What You Shouldn't

Most C-sections are performed under spinal or epidural anesthesia, which numbs your midsection while you stay awake. With this type of anesthesia, it is normal and expected to feel:

- **Pressure** — sometimes intense
- **Tugging and pulling**
- **Movement** — especially when the baby is delivered

These sensations can be startling, but they are not the same as pain.

What you should not feel:

- Sharp cutting
- Burning
- Severe pain that makes you cry out, shake, or panic

The study found that when women described their pain, they used words like *searing, blinding, tearing, grueling, vicious, cruel.* Those are not "pressure."

Why Some Women Feel Pain

Pain during a C-section doesn't usually mean someone was careless. It can happen for several reasons:

The anesthesia may be incomplete or patchy. This is more common when a labor epidural — originally placed for labor pain — is "topped up" with stronger medication for surgery. The study found that **13% of women reported significant pain** when a topped-up epidural was used, compared with only **4% when a fresh spinal** was placed.

Time pressure matters. When a C-section becomes urgent, there may not be enough time to replace a poorly working epidural or place a new spinal. The team must balance speed (for the baby's safety) against completeness (for the mother's comfort).

Pain perception varies. The same block may feel adequate for one patient and inadequate for another. There is no perfect test that guarantees the anesthesia will work for the entire surgery.

Language can fail. Patients are often told they'll feel "pressure." That's true — some pressure is normal. But when "pressure" becomes the automatic response to everything a patient reports, real pain can go unrecognized. This is one of the most consistent themes in patient accounts: **"I told them I was in pain, and they told me it was just pressure."**

If Pain Can't Be Controlled — What Happens Next?

If pain persists and cannot be quickly relieved with additional medication, the team may decide to **convert to general anesthesia** — meaning you are fully asleep for the rest of the surgery.

This can be the right decision. But it is a serious one, and the team approaches it carefully. Here is why.

Placing a Breathing Tube Is Harder During Pregnancy

When you are under general anesthesia, you cannot breathe on your own. The anesthesiologist must place a breathing tube (called an endotracheal tube, or ETT) into your windpipe to breathe for you and protect your lungs.

During pregnancy, several changes make this more challenging:

- **Airway swelling.** Pregnancy hormones and fluid shifts cause the tissues in the throat to swell, narrowing the space the tube must pass through.
- **Faster oxygen drop.** Pregnant women carry less oxygen in reserve. Once breathing is interrupted — even briefly, during the seconds it takes to place the tube — oxygen levels fall faster than in non-pregnant patients.
- **Full stomach risk.** During labor, the stomach doesn't empty normally. This creates a risk that stomach contents could enter the lungs during the process (called aspiration), which can be life-threatening.

Even With Good Technology, It Can Be Difficult

Many hospitals now use **video laryngoscopy** — a small camera device that lets the anesthesiologist see the vocal cords clearly on a screen. This has significantly improved safety.

But seeing the vocal cords doesn't always mean the tube goes in easily. Sometimes the angle is wrong, or the tube won't pass through despite a clear view. Clinicians call this being **"unable to place ETT"** and it is a recognized challenge, not a sign of incompetence.

In studies of C-sections performed under general anesthesia, **difficult intubation occurred in about 1 in 49 cases**, and **failed intubation in about 1 in 808**. All failures in the study were rescued successfully — but the numbers explain why the decision is taken seriously.

Two Lives

There is one more reason the decision carries weight. In obstetric anesthesia, if something goes wrong with the airway during general anesthesia, **both mother and baby are at risk**. No other type of surgery routinely involves this. It is the reason your anesthesia team prepares so carefully before making the change.

Bottom line: When your team pauses before converting to general anesthesia, they are not dismissing your pain. They are making sure they can protect your airway — and you — safely. But that preparation should happen *before* the moment of crisis, not during it.

What a Prepared Team Looks Like

You don't need to know equipment names to recognize preparedness. A well-prepared team generally has:

- A clear method for confirming you're numb before the first incision — and they take your answer seriously

- A plan for what happens if you report pain, including who responds and how

- **Video laryngoscopy available in the room** — not stored on a cart somewhere else in the hospital
- **Advanced airway tools** ready in case placing the breathing tube is difficult — including what's called a **dynamic introducer**, a steerable device designed to help guide the tube precisely when standard tools struggle
- Backup devices if the first approach doesn't work quickly
- A team that has discussed roles and limits *before* the surgery begins

Preparedness is not dramatic. It's disciplined. And it's what separates a reactive response from a confident one.

Questions to Ask Before Your C-Section

A short conversation before surgery can reduce anxiety and speed up action if you need help. These questions are calm, practical, and designed to show your team that you want to understand the plan — most clinicians welcome that.

About Numbness and Pain

1. **"How will you confirm I'm numb enough before starting?"**
2. **"If I feel sharp pain during the surgery, what words should I use so the team responds immediately?"**
3. **"If the block isn't working well, what are our options?"**

About Converting to General Anesthesia

4. **"If pain can't be relieved quickly, when would you convert to general anesthesia?"**
5. **"How would you communicate that decision to me?"**

About Airway Readiness

6. **“Is the Unit up to date with new DAS and ASA difficult intubation Guidelines?**
7. **"If you needed to convert to general anesthesia, what is the airway plan?"**
8. **"Do you use video laryngoscopy?"**
9. **"What happens if placing the breathing tube is difficult?"**
10. **"Do you have advanced airway tools — such as a dynamic introducer — immediately available in this room?"**

That last question is not telling anyone how to do their job. It's asking whether the team is equipped for the harder scenario. Prepared teams answer it confidently.

Your Experience Matters

You will hear — from family, friends, sometimes even providers — that "all that matters is a healthy baby."

A healthy baby matters deeply. But so does your safety. So does your psychological wellbeing. So does your experience of bringing your child into the world.

Research shows that unaddressed pain during C-section is associated with post-traumatic stress disorder, postpartum depression, flashbacks, fear of future pregnancy, and difficulty bonding with your newborn. These are not minor inconveniences. They are real injuries that deserve real prevention.

Speaking up about pain is not selfish. It is not dramatic. It is part of your care.

If Something Goes Wrong

If you experience significant pain during a C-section, it is reasonable — afterward — to ask for:

- **An explanation** of what happened and why
- **Acknowledgement** that your experience was real and difficult
- **Follow-up support** — including referral to perinatal mental health resources if you are experiencing intrusive memories, anxiety, or symptoms of trauma
- **Documentation** in your medical record so future care teams are aware

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Closing

You deserve a healthy baby, safe surgery, and to be heard if you are experiencing surgical pain.

Understanding the plan before you are in the moment is one of the most powerful things you can do. It reduces fear, improves communication, and ensures that if something unexpected happens, the response is prepared; not improvised.

Ask the questions. Trust the answers. And know that the best teams welcome a patient who wants to understand.

This guide is educational, not medical advice. Please discuss your specific situation with your obstetric and anesthesia care teams.