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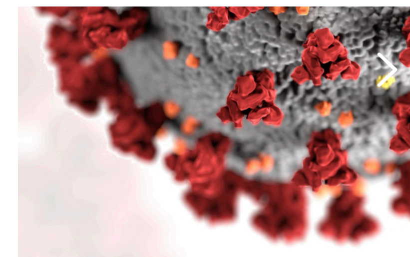

CONSIDERATIONS FOR OBSTETRIC ANESTHESIA CARE RELATED TO COVID-19

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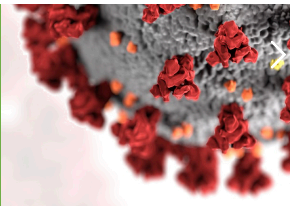
BEFORE ADMISSION FOR DELIVERY



Screen every pregnant patient admitted to your L&D unit

Fever
Cough or shortness of breath
Diarrhea
Close contact with (+) case

Fit-testing for respirators
Donning/doffing training

Encourage frequent drills:
- Donning/doffing PPE
- Patient transfers
- Intubation

Establish back-up coverage for your unit

Use phone/video for pre-anesthesia encounter: Assessment, counseling and consent

Minimize interactions with patient

Keep log of all staff in contact with patient

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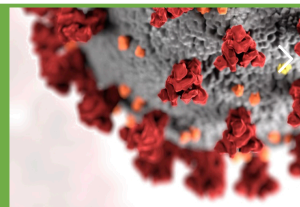
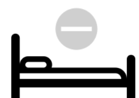
DURING LABOR & DELIVERY
(for suspected or confirmed COVID-19+)





Admit patient to negative pressure room, if available

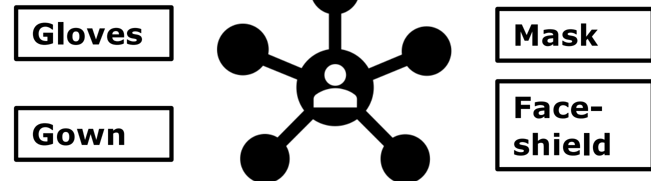
Support person per institutional guidelines

Pre-anesthesia assessment via phone/video

Video-assisted electronic multidisciplinary discussions

Surgical mask for patient at ALL TIMES

PPE for direct patient care



PPE cart outside room
Paired donning/doffing

Encourage early neuraxial labor analgesia

Minimize crash cesareans
Response time will be delayed

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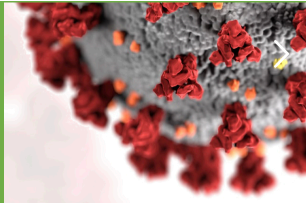
DURING NEURAXIAL PLACEMENT
(for suspected or confirmed COVID-19+)



Nitrous Oxide?
Discuss the relative risks & benefits and consider suspending use
There is insufficient data about cleaning, filtering and potential aerosolization of nitrous oxide in labor analgesia systems

COVID-19 in itself NOT a contraindication for neuraxial analgesia/anesthesia

IV PCA Opioids?
Risk of respiratory depression and emergent airway instrumentation

Assemble a separate COVID-19 neuraxial procedure kit/cart

Experienced provider

PPE
DROPLET/CONTACT PRECAUTION
Gloves, gown, face-shield, mask
(per institutional guidance)

Rescue medications bag/kit to remain inside labor room

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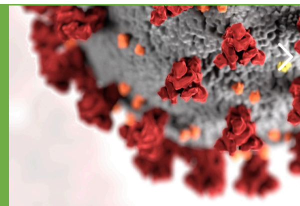
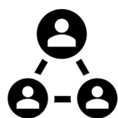
DURING CESAREAN DELIVERY
(for suspected or confirmed COVID-19+)





Activate back-up coverage for L&D

Assemble kits/bags for neuraxial anesthesia and general anesthesia/intubation

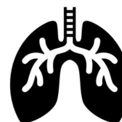
Identify a *runner,* to be stationed outside OR, who will provide help/supplies

Minimize number of staff per case

Anesthesia providers and assistants should implement droplet/contact and ideally airborne precautions (N95 or PAPR)

Use donning/doffing checklists under direct observation

DOUBLE GLOVE for all procedures



Consider avoiding Carboprost (Hemabate) if concerns with bronchospasm

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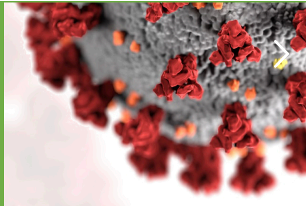
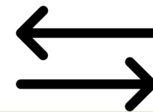
DURING INDUCTION & MAINTENANCE OF GENERAL ANESTHESIA
(for suspected or confirmed COVID-19+)



Minimize personnel in OR for induction – only essential staff



PPE for personnel within 6 feet
During intubation/extubation
AIRBORNE PROTECTION
Gloves, gown, N95 with face shield or PAPR
(per institutional guidance)

Ensure HEPA filter between patient and anesthesia circuit

Pre-oxygenation: 100% O_2

Rapid sequence induction (RSI)

Avoid positive pressure bag-mask ventilation except if assisting spontaneous respiratory efforts

If needed: 2 operators,
- **one to hold mask with tight seal**
- **one to manually ventilate (maintain $P < 20\ cmH_20$, small tidal volume)**

Use video-laryngoscopy if available

Extubation in the OR to nasal cannula or O_2 mask with low flow
or
Consider transferring to ICU or a negative pressure room for extubation

Maintain surgical mask on patient

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