

# Labour analgesia



There is no evidence that epidural or spinal analgesia or anaesthesia is contraindicated in the presence of coronaviruses.

All usual contraindications to neuraxial block apply as normal



Epidural analgesia should be strongly recommended for labour analgesia, to women with suspected/confirmed COVID-19 to minimise the need for general anaesthesia if urgent delivery is required, and because there is a risk that use of Entonox® may increase aerosolisation and spread of the virus.



Approximately one third of patients in a case series from Wuhan developed thrombocytopenia (platelet count <150) so it would be prudent to check the platelet count before insertion of epidural or spinal, and possibly before removal of the epidural catheter.



If Entonox® is used then the breathing system must contain a hydrophobic filter to prevent it being contaminated with the virus ( $\leq 0.05\mu\text{m}$  pore size).

# Anaesthesia for caesarean delivery



Provide epidural or spinal anaesthesia as required.



Avoid general anaesthesia unless absolutely necessary for standard indications but consider plans for management of failed regional techniques. Local SOPs for the type of anaesthesia used for Category 1 delivery may need to be reviewed for these cases.



Donning PPE is mandatory and time consuming and will impact on decision to delivery time for category 1 caesarean delivery, no matter what the anaesthetic technique used. Women and their families should be told about this delay.

## General advice

Consider transfer arrangements in different scenarios for a woman who needs an emergency caesarean delivery. e.g. labour ward room to theatre.

Practise donning and doffing PPE.

Undertake simulation training.

Hospitals will also be preparing local protocols based on national guidance and recommendations. You should familiarise yourself with these protocols.

# General anaesthesia for caesarean delivery



Use of PPE causes communication difficulties: an intubation checklist should be used with closed loop communication.



Rapid sequence induction as per usual practice. Ensure a tight seal during pre-oxygenation to avoid aerosolisation. Do not use HFNO for pre-oxygenation or apnoeic oxygenation.



For intubation videolaryngoscopy is preferable, by the most experienced anaesthetist available. Do not ventilate until cuff inflation is confirmed.



In case of difficult intubation, plan B is to use a 2<sup>nd</sup> generation supraglottic airway, plan C is to use FONA scalpel-bougie-tube.



The anaesthetist performing intubation is likely to get respiratory secretions on their gloves. They should wear a second pair of gloves and remove the outer pair once the ETT is secured.



Determine the position of the ETT without using auscultation – chest wall expansion R=L, End Tidal CO<sub>2</sub>.



Extubation is a high-risk procedure for aerosol generation. Avoid coughing and minimise the number of staff in the room.