TOH DAPM Obstetric Anesthesia for Covid-19

- Minimizing exposure
  - Droplet / contact precautions as per hospital protocols
  - N95 mask as per current TOH guidance on aerosol producing procedures
  - Telephone pre-op assessment for the OB anesthesia clinic
  - Agree with current OB guidance:
    - Avoid unnecessary health care personnel in the room
    - Limit the presence of family members in attendance of delivery
    - Utilization of negative pressure room for labour in possible

- Labour analgesia
  - Epidural analgesia highly recommended – place early and ensure effectiveness to minimize need for general anesthesia if c-section is required
  - Notify anesthesia early if concerns regarding poor analgesia from labour epidural
  - Nitrous oxide not currently recommended even in asymptomatic laboring women given risk of aerosolization
  - Thrombocytopenia has been reported in Covid-19 patients – recommend a platelet count in moderate to severely symptomatic patients.

- Cesarean section
  - All staff in the OR should wear N95 masks for confirmed or suspected Covid-19 c-sections due to the potential need for conversion to general anesthesia intra-operatively
  - **Avoid the need for a C-section under GA**
    - Early and proactive communication with Obstetrics team about parturients to facilitate planning of potential urgent delivery
    - Low threshold to re-site a non-functioning labor epidural
    - If an obstetric emergency occurs, use all measures to support utero-placental blood flow and fetal oxygenation to facilitate a neuraxial technique over a GA
    - Most experienced surgeon to minimize operative time and risk of exposure to OR team

- General anesthesia and airway management
  - As per current TOH DAPM guideline for airway management of Covid-19 patient. Key points:
    - Adhere to all PPE protocols – preparation will take time and strict adherence should not be compromised even in an emergency c-section scenario
    - Use intubation cognitive aid in the OR
    - Appropriate trained support for the anesthetist – 2 assistants
    - Pre-oxygenate with BMV device with HEPA filter
    - Rapid sequence induction without BMV (unless absolutely required)

    - Videolaryngoscopy should be used once patient fully paralyzed
  - At this stage we are recommending that both intubation and extubation occur in the operating room for c-section patients
  - Recommend using the troop pillow for all patients to improve first pass intubation success
  - Patients should be recovered for 30 min in the operating room to ensure patient stability and minimize the risk of unnecessary transfer back to the operating room
  - If possible – anesthesia should remain in the OR for the 30min recovery period to minimize PPE changes
  - Recommend a second staff anesthetist (if available) be present for suspected or confirmed positive Covid-10 c-sections
    - Informal schedule will be arranged by the obstetric anesthesia groups