COVID-19 Considerations

General Considerations:

All Patients:

- Follow unit guidelines on partner/support staff presence (Limited to 1 visitor for all parturients)
- PAPR battery status should be checked each day (2 green bars or greater OK)
- Pre-anesthetic evaluation and consent discussion via phone if feasible
- Use of inhalational N₂O for labor analgesia is no longer available for any patients
- Leave epidural cart outside patient’s room, but bring in epidural supplies and predrawn vasopressors (phenylephrine/epinephrine/epi).

Positive or PUI COVID 19 Patients:

- Patient to don surgical face mask at all times
- Maternal and fetal vital signs to follow usual indications
- If patient requires supplemental O₂ in labor room, consider low flow NC (position under mask)
  - patient remains with modified droplet precautions unless airway management required
- If high flow NC O₂ or face mask O₂ administered then
  - Precautions upgraded to aerosol viral PPE protocol
- Consider encouragement of early epidural (well-functioning catheter may prevent risk of conversion to GA and need for airway instrumentation for emergent cesarean delivery)
- All Neuraxial analgesia and anesthesia should be staffed by OB Anesthesia COVID Team
- 2 “Airway Kits” are located in the lidocaine syringe drawer in the pharmacy cart in the L&D Anesthesia Workroom area. Each kit includes (Small N95 Mask, Regular N95 Mask, HEPA Filter, gown, goggles, shoe covers)
- 2 PAPR’s are located in cabinet above code cart, HUC has the key
- An additional 10 N95 masks are located in the “Med Room”, L&D nurses have access
- Some experts have suggested avoiding NSAIDs for symptoms suggestive of COVID infection. This is controversial and robust data is lacking. It is unknown if the treatment of postpartum pain with NSAIDs will worsen the trajectory of COVID+ patients. NSAIDs can likely continue to be used safely in asymptomatic patients.
- Antiemetics should be administered to prevent vomiting in patients undergoing cesarean delivery. However, due to potential risks of steroids in the setting of COVID infection, consider avoiding the use of dexamethasone for PONV prophylaxis in PUI/COVID+ patients.

Anesthesia Staffing
There will be a separate OB Anesthesia COVID Team (different from airway team), who should be contacted to manage all neuraxial analgesia and anesthesia for cesarean delivery of COVID-19 positive or PUI patients. The specific makeup, scheduling, and pool membership will be coordinated by Dr. Porth.

Location of positive or PUI COVID 19 Patients:

- Intrapartum management and vaginal delivery should occur in OBES Room 25. If two laboring COVID patients, OBES Room 24 can also be used
- Cesarean delivery or operative procedures should be in OR C
- Postpartum / post-op care should occur on MNBC in one of the two negative pressure rooms

Labor Analgesia:

- CBC should be reviewed in all positive or PUI COVID 19 Patients
- Epidurals should be placed with a DPE or CSE technique in all positive or PUI COVID 19 patients to decrease failure rate and chance of needing to replace the catheter
- Neuraxial labor analgesia should be performed by attending anesthesiologist
- Provider Preparation → Don modified droplet precautions for epidural placement. If patient on high flow NC or FM O2, then use aerosol precautions.
- Remember to leave epidural cart outside patient’s room, but bring in epidural supplies and predrawn vasopressors (phenylephrine/ephedrine/epi). These meds should remain in patient’s room in locked lucite box after placement.

Anesthesia Considerations for Cesarean Delivery

Neuraxial Anesthesia

- Even if using neuraxial anesthesia for cesarean delivery, aerosol precaution PPE should be donned by anesthesia providers prior to entering OR with patient (as there is some chance GA may be required in an urgent situation (high spinal/failed epidural), and there would not be time to properly don appropriate PPE)
- Complete pre-anesthetic assessment and consent in OR room (if not already obtained)
- Modified droplet precautions for everyone in OR
- FM O₂ should not be routinely placed on cesarean delivery patients. Low flow NC O₂ may be routinely placed under patient surgical mask.
- If FM O₂ required, all persons in OR should be using aerosol precautions

General Anesthesia

- Aerosol precaution PPE should be donned by anesthesia providers prior to entering OR with patient
- Aerosol precaution should also be donned by 2 OBs and 1 nurse, who should be in room and “ready to cut” status prior to GA induction.
- HEPA filters both on expiratory circuit limb and also just proximal to ETT
- Tight-seal 2 hand seal when preoxygenating with anesthesia mask
- RSI/propofol (2 mg/kg) + sux (1.5 mg /kg)
- Avoid mask ventilation unless needed
- Use Glidescope for intubation – Most experienced provider
- Intubate with HEPA filter on ETT → Inflate Cuff → Connect Circuit
- If using PAPRs, do not auscultate, video visualization + ETCO₂ adequate.
- Maintenance of anesthesia
  - Pre-Delivery: Oxygen with volatile
  - Post-Delivery: Volatile agent ≤ 0.5 MAC with propofol/remi infusion or pure TIVA
- Only anesthesia providers in OR at extubation

**Postpartum**

- Transport patient to negative pressure room in MNBC
- Postpartum anesthesia visits to occur via phone
- Ask postpartum RN to assess back/pull epidural if needed

If questions, concerns, or issues arise, please contact **Candice Morrissey, Mark Rollins or Christine Warrick**.