Greater Glasgow and Clyde Obstetric Guideline re Covid-19

CATEGORY 1 CAESAREAN SECTIONS IN WOMEN WITH SUSPECTED OR PROVEN COVID-19

The risks of a women with suspected or proven Covid-19 infection receiving a GA are substantial – for the woman herself, her baby and the staff in theatre. Given the risks or aerosol droplet transmission FFP3 masks are required for all staff in theatre and the theatre requires to be sealed (ie no entry or exit) for 20 minutes after both intubation and extubation. The vast majority of Category 1 LSCS therefore should be performed under spinal – with the most senior anaesthetist present performing this. Exceptions to this would be if a GA is required for maternal reasons.

Any LSCS performed in women with suspected or proven COVID19 should ideally be performed by a senior obstetrician to try and minimise complications and any need to convert to GA.

Every attempt should be made to avoid a category 1 caesarean section. Thresholds for intervention in laboring women need to be lowered and full use made of in-utero resuscitation once the decision is made for a category 1 caesarean section.

A) CHANGE IN THRESHOLDS

1 Proven or High Risk Covid-19 :

Confirm presentation on arrival in LW (to avoid late diagnosis of Breech)

CTG abnormalities that would normally merit FBS should be reviewed by a Consultant to confirm the CTG is suspicious / pathological. FBS should in the majority of case not be performed but instead an EARLY CS under SPINAL should be arranged.

Antenatal CTG concerns that would ordinarily result in consideration of ARM if cervical findings suitable> No ARM> Offer CS

Twins> CS unless imminent vaginal delivery

Previous CS > Explain heightened risks of VBAC and recommend CS (unless vaginal delivery imminent)

Early concerns about dysfunctional Labour if ARM and Syntocinon not effective in 4 hours action line > no further augmentation > CS

All these women should be given 'superactive' third stage , unless there are maternal contraindications.

2 Women with no suspicion Covid 19 Infection

Confirm presentation on arrival in Labour Ward

Labour or PROM and pyrexial - Usual sepsis 6 and antibiotic management including GBS -
If persistent Fetal tachycardia> CS unless imminent vaginal delivery

3 Aim to reduce emergency Labour ward theatre work as a Covid 19 will occupy more staff.

Placenta Praevia deliver all by 37+6 weeks
NO cervical rescue sutures attempted
If woman suspicious or proven COVID 19 defer cervical suture / ovarian cystectomy
If good lighting 3A tears be repaired by a Senior person in the delivery room

B. INTRAUTERINE FETAL RESUSCITATION (IFR)

IFR consists of specific measures aimed to increase the delivery of oxygen to the placenta in order to alleviate or treat fetal hypoxia and acidosis.

IFR should be employed in those women who qualify for a Category 1 Caesarean section for fetal distress. It should not substantially delay delivery and should be instituted as arrangements continue to transfer the woman to theatre.

1) The anaesthetist, obstetric team and the senior midwife should be alerted: CATEGORY 1 Caesarean Section.

2) Inform neonatology to attend.

3) The woman should be examined to **exclude Hypotension, Hypovolaemia and cord accident.**

RESUSCITATE

4) Any Syntocinon infusion should be turned off.

5) The woman should be placed in a left lateral position.

6) Oxygen should ONLY be administered for maternal indication e.g. hypoxia / pre oxygenation – not routinely for IFR.

7) 1 litre of Hartmann's should be run through **(NOT if woman has pre-eclampsia or cardiac disease**).

8) If contracting consider Terbutaline 0.25mg subcutaneously from 0.5mg/ml ampoule dose of 0.25mg = 0.5ml. **Contraindications include Cardiac Disease, Hypovolaemia, Abruption**

9) If the patient continues to have uterine contractions and there are still concerns regarding the CTG then second line tocolytic would be GTN – IV cannula required to be in-situ.

The Nitrolingual spray should be primed before using it by pressing the nozzle once. 1-2 sprays (400mg – 800mg) administered beneath the tongue. Ask woman to close her mouth after spray is administered. This can be repeated after 5 minutes if required.

Contraindications – uncorrected Hypovolaemia/Hb <60g/l/increased intracranial pressure/constrictive pericarditis/Hypersentivity to GTN, nitrates, ethanol.

TRANSFER

10) The woman should be transferred to theatre as the IFR is proceeding.

REASSESS

11) The fetal heart rate should be assessed continuously. A vaginal examination in theatre should be considered in laboring women.

NOTE
If there are no contraindications to the use of propranolol a 1mg **intravenous dose** can be used to reverse the effects of terbutaline on the myometrium if required.