to deliver is challenged by raised body mass index (BMI). Conversion to GA during CS is challenging and potentially distressing for the mother. The study aims were to quantify how surgical time (ST) and anaesthesia time (AT), at CS, vary by BMI.

Methods: A cross-sectional, retrospective review of electronic patient records (EPR) and theatre database. Women delivering in NHS Lothian between 1 Jan 2011 and 31 Dec 2019 were identified (n = 83,713). Data collected included mode of delivery, BMI and where applicable urgency of CS, ST, AT and mode of anaesthesia (GA, spinal, epidural top-up or combined spinal-epidural (CSE)). Missing data were excluded.

Results: Of 81,929 women, 29.8% delivered by CS. In BMI ≥40 kg/m² (n = 2099), 47% had CS compared with 29% of controls (P < 0.001). Emergency CS occurred in 516 (24.6%) of BMI ≥40 kg/m² compared with 13,839 (17.3%) of controls (P < 0.001). Data were available for 20,989 singleton CS, 900 (4%) with BMI ≥40 kg/m². AT and ST both increased with BMI (Kruskal-Wallis test: AT χ²(3) = 256.4, P < 0.001; ST χ²(3) = 294.7, P < 0.001). 10% of BMI ≥40 kg/m² and 8.2% controls had GA. Of these, more occurred following regional or attempted regional in BMI ≥40 kg/m² vs. controls (39% vs 21%, P < 0.001). When GA was used for emergency CS, mean ST in BMI ≥40 kg/m² was 22.3 min vs. 16.8 min in controls. In BMI ≥40 kg/m², AT for epidural and GA were similar (25.3 vs. 22.3 min).

Discussion: Approximately 50% of BMI ≥40 kg/m² women delivered by CS; 25% had an emergency CS. AT and ST increase with BMI. The study demonstrated that ethnicity, deprivation and SARS-CoV-2 requires further investigation and may have implications for future resource allocation and service planning.

References


P.1 Deprivation and SARS-CoV-2 in obstetric patients
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Introduction: The UK Obstetric Surveillance System (UKOSS) has reported on risk factors for admission to hospital amongst obstetric patients with SARS-CoV-2, however, it did not evaluate deprivation as a risk factor.1 Deprivation is a recognised risk factor for mortality from COVID-19 amongst the general population.2 We, therefore, investigated the demographics, including deprivation scores, of obstetric patients diagnosed with SARS-CoV-2 within our local health board.

Methods: Caldicott Guardian approval was obtained and requirement for ethical approval was waived by the local research ethics service. All pregnant or recently pregnant patients (within 6 weeks postpartum) within our health board area with a positive SARS-CoV-2 test between 16 March 2020 and 18 December 2020 were retrospectively identified from regional infection surveillance and local obstetric unit reports. Residential area deprivation was classified using the Scottish Index for Multiple Deprivation (SIMD), with quintile 1 representing the most deprived and quintile 5 representing the least deprived areas. R version 4.0.3 (R Foundation for Statistical Computing) was used to perform analyses.

Results: Over the study period, 97 patients tested positive for SARS-CoV-2. Comparison between those in the lowest and highest SIMD quintiles is as shown below. Those from a black or ethnic minority background accounted for 31.9% of positive test results and 50% of admissions to critical care.

Discussion: In this cohort of obstetric patients, mothers from socioeconomically disadvantaged areas accounted for a higher proportion of SARS-CoV-2 positive cases (and hospital / critical care admissions) than those from more affluent areas. This is, to our knowledge, the first study to investigate this association in obstetric patients. The relationship demonstrated between ethnicity, deprivation and SARS-CoV-2 requires further investigation and may have implications for future resource allocation and service planning.

References


P.2 Complaints analysis in obstetric anaesthesia: Can we learn from Scottish ombudsman enquiries?
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