P.19  Project on regional to general anaesthesia conversion rate in obstetric anaesthesia and the implication of COVID-19 pandemic, a three year data analysis

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Introduction: All international obstetric anaesthesia guidelines recommend spinal and epidural anaesthesia over general anaesthesia (GA) for caesarean section (CS) due to the risk of failed intubation and its associated complications. RCoA best practise guidance recommends most of CS are carried out with regional anaesthesia and also to reduce the conversion rate from failed regional to GA [1]. Limited information is available on this failure rate due to the impact of COVID-19. We wanted to determine if we were meeting the RCoA standards and also analysed our data to see any changes in the GA conversion rate during the COVID-19 pandemic.

Methods: This was a retrospective project, conducted during from August 2018 to July 2021 after our institutional audit committee approval. Data were collected from anaesthetic obstetric database, theatre records and case notes. A total of 1406 CS were performed during August 2020-July 2021 with 1264 and 1513 CS during 2019–2020 and 2018–2019, respectively.

Results: From this project we could infer that we have been achieving the RCoA standards during the last three years. The percentage of CS under regional has increased in all categories. After the COVID-19 pandemic our GA conversion rate for category 1 CS dropped significantly (1.77%), with minimal change in category 2 and 3 (2.5%) whereas for category 4 it has slightly increased (0.77%).

Discussion: We have consistently exceeded the RCoA standards in the last 3 years with a significant decline to <2% (as opposed to <15%) in GA conversion rates for category 1 CS. This was similar to the cross-sectional analysis done in six hospitals in the north-west of England [2]. The reasons for this could be due to routine use of ultrasound in technically challenging cases and heightened awareness amongst theatre teams and junior trainees on airborne COVID-19 risk.

References

Figure: (abstract P.19). RCoA standards and impact of COVID-19.

P.20  “Out of severe COVID in peripartum women”

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Introduction: Although pregnant women appear to have a similar risk of contracting SARS CoV2, morbidity for obstetric patients is increased for ethnic minorities, maternal age >35 years, associated co-morbidities and lower socio-economic groups [1]. SARS-CoV2 infection leads to an increased risk of preterm delivery, caesarean section (CS), stillbirth, and possible fetal growth restriction. Guidance recommends senior multidisciplinary involvement in decision making on how and when to deliver. A retrospective observational survey was performed, looking at maternal and fetal outcomes in women needing ICU admission with SARS CoV2 from March 2020 to November 2021 in our hospital.

Methods: Following the registration of the audit with Hospital Trust, electronic notes were retrospectively reviewed. Data collected were: demographics, mode of delivery, platelet count, type of anaesthetic, days of ventilation and outcome.

Results: During the study period 13,223 women were admitted to hospital of whom 201 tested positive for SARS CoV2; 10 were admitted to ICU. Three patients were from ethnic minorities and all were unvaccinated. Only one parturient who was ventilated before delivery had a stillbirth. Of the nine who delivered in our hospital, seven were admitted to ICU within 48 h of CS, one at 10 days, and one at 46 days postpartum. The decision to deliver was due to increasing respiratory distress in all patients except one who had resistant SVT. All patients required invasive ventilatory support in ICU, five required proning, two needed tracheostomy and two died.

Discussion: There was a significant increase in SARS CoV2 severity after unlocking the “second wave” (1/8/2020) vs. none in the first. SARS CoV2 infection was seen in 1.5% of all maternity admissions and mortality was 0.99%. Worsening maternal condition was the deciding feature for GA, not thrombocytopenia [2]. Two women who were not delivered early had significant events; one had a maternal peri-arrest at delivery, the other had a stillbirth. Their deteriorating condition required prompt delivery for maternal and fetal optimisation prior to ICU admission.