**Department Of Anaesthesia, SGPGIMS, Lucknow**

**OBSTETRIC ANAESTHESIA PROTOCOL**

*For COVID positive or COVID suspect pregnant patient*

*(Adapted from SOAP, RCOA)*

**Considerations Covid screening (RT PCR) for all patients at admission**

**Labour Analgesia**: Not to be done. However **early epidural placement is desirable.**

**Planned LSCS**:

* GA should be avoided as far as possible.
* **Prefer neuraxial anaesthesia**
* Prefer CSE over spinal anaesthesia as it provides a back up option for failed spinal anaesthesia

**Emergent LSCS:**

* + Avoid emergent cesarean deliveries as much as possible
  + **Prefer neuraxial anaesthesia**
  + GA should be avoided as far as possible. For respiratory distress intubate early using appropriate PPE (**take extreme care as it exposes the HCW to aerosol**)
  + Assign the most experienced anesthesia provider whenever possible for procedures
  + Consider minimizing use of trainees in direct care of COVID19 patients.
  + Minimize the number of personnel in the room.
  + GA to be given only after surgery team is scrubbed, patient painted and draped and Neonatologist available in OT.
  + As donning and doffing takes time, inherent delay involved should be explained to the patient and obstetrician
  + Patients under neuraxial anaethesia will be asked to wear N 95 mask

**Postoperative course:**

* Patient who has been given regional anesthesia should return to isolation room (negative pressure room) for recovery
* Patient who has been extubated after GA should return to isolation room (negative pressure room) for recovery
* Patients that remain intubated will be transported to a negative pressure room in critical care area. If a separate negative pressure room is unavailable, patient will emerge and extubate in the operating room and be subsequently moved to an appropriate isolation room (negative pressure) based on maternal condition
* Deterioration in maternal status if any after delivery has been documented