Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Table: Characteristics of COVID-19 cases.

Case	Past Medical History	Intubated	Delivery	Medications	Gestation
1	Asthma	4 Days	Cat 2 CS	Dexamethasone Tocilizumab	27 weeks
2	No PMH	3 Days	Cat 2 CS	Dexamethasone Tocilizumab	30 weeks
3	No PMH	No	Cat 2 CS	Dexamethasone	38 weeks
4	No PMH	1 Day	Cat 2 CS	Dexamethasone	36 weeks
5	No PMH	1 Day	Cat 2 CS	Dexamethasone Tocilizumab	33 weeks
6	Depression high BMI	12 days	Cat 2 CS	Dexamethasone Tocilizumab	28 weeks
7	No PMH	2 Days	Cat 3 CS	Dexamethasone	37 weeks

Discussion: Proven therapies (such as corticosteroids and tocilizumab) should be offered to pregnant and breast-feeding women as in the non-pregnant population. Women should receive multidisciplinary care with input from senior physicians and early escalation when required.

References

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P.149 Impact of COVID-19 on maternity and anaesthetic services: a one-year survey

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Introduction: The COVID-19 virus can pose a serious threat to mother and baby if contracted during pregnancy. We aimed to ascertain the impact of COVID-19 on our maternity patients at Luton and Dunstable Hospital.
Methods: Data were collected retrospectively from the archived electronic files over a year period from 31 March 2020 to 31 March 2021. Data collected were maternal age, BMI, ethnicity, comorbidities, ante- or postnatal infection, gestational age, single or twin gestation, mode of delivery – vaginal or caesarean section (CS), anaesthetic involvement, location of patient care, oxygen requirement, type of respiratory support, need for critical care admission, duration of hospital stay, maternal mortality and neonatal impact [1].
Results: There were 68 COVID-19 positive patients in hospital over the study period. 72% patients had BMI <30. Significantly more (54%) positive patients were of Asian or Afro-Caribbean origin ($P = 0.006$). 85% patients of patients were positive antenatally with a mean gestation of 33 weeks (SD 4.79). Of the 15% postnatal infections, most occurred within first five days of delivery, indicating possible cross-infection. With regards to treatment, 88.2%, were asymptomatic and did not require oxygen support, 7.4% required supplemental O2, 2.9% required NIV, and 1.5% required invasive management and transfer for ECMO to a higher centre. Mortality in our study was 2.9% for mothers, both patients were of BAME origin. However, neonatal outcome was good with no associated mortality. 47% of the patients were delivered by CS of whom 20% needed their CS expedited due to COVID-19 having a mean gestation of 29 weeks (SD 4.7). Among the patients who had CS, 93% had a regional anaesthetic and 7% had a GA.
Discussion: BAME was a significant risk factor for pregnant COVID-19 positive patients to be hospitalised. BAME category patients were more symptomatic and required prolonged hospital stay [1]. BMI>30 was not found to be a significant risk factor. COVID-19 caused a high incidences of CTG abnormalities and hence lead to a higher incidence of CS during this period. Regional anaesthesia was performed safely in these patients. Cross infections in maternity unit paved the establishment of Closed Monitoring Unit (CMU) at our centre. Due to the ongoing pandemic, further study is needed to see impact of vaccination on maternity.

Reference

1. RCOG-Coronavirus (COVID-19) infection in pregnancy – guide for healthcare professionals v14.3 2022. https://www.rcog.org.uk/globalassets/documents/guidelines/2022-01-11-coronavirus-covid-19-infection-in-pregnancy-v14.3.pdf

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P.150 Anaesthetic care of women with obesity in pregnancy

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Introduction: Obesity in pregnancy is associated with an increased risk of anaesthetic complications, such as failure of airway management, intravenous access and neuraxial blockade [1]. Therefore, the Royal College of Anaesthetists defined a set of standards for the care of obese pregnant women. Our aim was to measure current practice against these standards; 100% of women with a booking BMI (body mass index) of 40 kg/m^2 or greater to have an antenatal consultant anaesthetic review and 100% of these patients to be reviewed by the duty anaesthetist on arrival to delivery suite.
Methods: A retrospective audit of 50 sets of patient notes with a BMI 40 kg/m^2 or greater at booking during the period of January–June 2020 at Sunderland Royal Hospital. It was identified whether the patient had been referred to anaesthetics, the outcome of this referral (either no action required or an appointment in the high-risk clinic) and whether an assessment was made by anaesthetics on the delivery suite. Ethics approval was not required for this audit as advised by the trust's clinical effectiveness department.
Results: A total of 54% of eligible patients were referred to anaesthetics; 100% of these patients were screened by an obstetric anaesthetist with 41% of those patients being seen in the high-risk clinic. Only 6% of all patients were assessed by a member of the anaesthetic team on arrival to delivery suite with a plan documented in the notes.
Discussion: There must be a more robust system for the referral of high BMI patients to anaesthetics both antenatally and on delivery suite in order to plan early for the management of predicted difficult airway, intravenous access and neuraxial blockade as well as the early involvement of senior anaesthetic help. We have now written a guideline to ensure the above standards are met in future and this will be re-audited after the guideline is implemented.

Reference

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