

With the ongoing COVID-19 pandemic, although less than 15% of affected patients will require hospital admission [3], a significant number of these will require ventilatory support. As part of the management of acute respiratory distress syndrome, patients whose lungs are mechanically ventilated receive neuromuscular blocking drugs and the resultant reduction in orbicularis muscle tone, combined with patients being nursed in a prone position, will increase patients' risk of exposure keratopathy.

Training ICU staff in recognising risk factors and applying preventative measures, particularly during these challenging conditions, is paramount in order to reduce the risk of long-term sequelae from exposure keratopathy. We have designed a training tool and a simple protocol (online Appendix S1) for eye care in sedated or mechanically ventilated patients, based on the RCOphth guideline [2]. These are available via the Microguide smartphone application under the Moorfields Eye Hospital, Pandemic Eye Care Guide. In a joint effort between ophthalmologists and intensivists, this protocol is being implemented in a number of London hospitals providing care for patients with COVID-19.

We invite intensive care and ophthalmology trainee networks in the UK to collaborate in implementing the protocol for eye care and reach a national consensus of standard of eye care in the ICU.

C. Soare 

V. A. Nowak

S. Osborne

Moorfields Eye Hospital NHS Foundation Trust,
London, UK

Email: m.soare@nhs.net

We thank the members of the EyeCU group for their contribution to audit data collection and development of protocol, video and training materials; K. O'Brien (Queen Mary University of London, UK), R. Farwana (Ashford and St Peter's Hospitals NHS Foundation Trust, UK), S. Azizi (St George's University Hospitals NHS Foundation Trust, London, UK) and G. Taylor-Davies, (Kingston Hospital NHS Foundation Trust, London, UK). We thank the Intensive Care Units at St George's Hospital and Moorfields Audit Department for their support in undertaking the Clinical Audit 'Eye Care in ICU (EyeCU)'. We thank Moorfields Eye Hospital NHS Foundation Trust for the support in developing and disseminating the protocol for Eye Care in ICU. No competing interests declared.

References

1. Kousha O, Kousha Z, Paddle J. Exposure keratopathy: Incidence, risk factors and impact of protocolised care on exposure keratopathy in critically ill adults. *Journal of Critical Care* 2018; **44**: 413–8.
2. Hearne BJ, Hearne EG, Montgomery H, Lightman SL. Eye care in the intensive care unit. *Journal of the Intensive Care Society* 2018; **19**: 345–50.
3. Kolifarhood G, Aghaali M, Saadati HM, et al. Epidemiological and clinical aspects of COVID-19; a narrative review. *Archives of Academic Emergency Medicine* 2020; **8**: e41.

Supporting Information

Additional supporting information may be found online via the journal website.

Appendix S1. Eye care in sedated or mechanically-ventilated patients.

doi:10.1111/anae.15154

COVID-19 and access to labour epidural analgesia in UK hospitals

Even before coronavirus disease 2019 (COVID-19) had a significant impact on public health in the UK, there were media reports that access to epidural analgesia for women during labour was being restricted in some National Health Service (NHS) hospitals [1]. To determine whether the crisis management of COVID-19 in NHS hospitals was having an adverse effect on the availability of labour epidural analgesia, the Obstetric Anaesthetists' Association (OAA)

surveyed consultant anaesthetists who are service leads for obstetric anaesthesia in their hospital. The link to an online survey was posted on a WhatsApp group, created for consultant service leads for obstetric anaesthesia to share information about COVID-19 disease, and was also emailed to all 209 consultants who the OAA believed to be service leads. The survey comprised questions about the size and location of the participants' hospitals and details regarding

Table 1 Number (proportion) of survey participants categorised by geographical location and size (annual number of deliveries) of their hospital.

Geographical location of hospital	Size of hospital (deliveries)
East of England/Midlands: n = 42 (21%)	< 2000: n = 15 (8%)
London: n = 30 (15%)	2000–4000: n = 64 (32%)
North East/Yorkshire/North West: n = 36 (18%)	4000–6000: n = 81 (41%)
South East/South West: n = 44 (22%)	> 6000: n = 38 (19%)
Scotland/Wales/Northern Ireland: n = 46 (24%)	

labour epidural availability since the start of the COVID-19 crisis.

There were 198 (95%) responses to the survey. Geographical locations and sizes of the participants' hospitals are shown in Table 1. No restriction in access to labour epidural analgesia during the COVID-19 crisis was reported by 182 (92%) of participants. Six (3%) reported a restriction in access to labour epidural analgesia; three stated it was due to anaesthetist availability; two stated that it was due to personal protective equipment availability; one stated it was due to delivery unit management; and one attributed it to equipment/drug availability issues. The other 10 (5%) participants either did not know or did not have a labour epidural analgesia service in their hospital.

A total of 168 (85%) participants reported that monthly data were routinely collected on the number of epidurals provided for labour analgesia in their hospital. This subset of participants was asked to compare the number of epidurals in the past month during the COVID-19 crisis with the monthly average for their hospital. Eighty-nine (53%) of this subset reported that the number of monthly epidurals was similar ($\pm 10\%$), 10 (6%) reported that the number had increased by $> 10\%$, 5 (3%) that it was less by $> 10\%$ and 64 (38%) did not know. We are unable to confirm that all participants worked in different hospitals, as participation in the survey was anonymous, and we did not collect data on hospital identity.

The results show that very few participants identified that women's access to labour epidural analgesia has been restricted due to COVID-19 disease. This view represents that of the anaesthetist and may not be the views of women or midwives whose perspectives are currently being researched by other surveys [2]. The Care Quality Commission has recently started collecting national data in England on anaesthetic response times to labour epidural requests, and this may also provide information on the impact of COVID-19 disease in maternity units.

In addition to the well-established analgesic benefits of labour epidurals, they also play an essential part in safety in maternity units; enabling rapid anaesthesia for intrapartum caesarean section and, therefore, reducing the need for general anaesthesia. Until further data become available, this snapshot survey provides reassurance that COVID-19 disease is not having a widespread adverse impact on the delivery of epidural analgesia to labouring women.

J. H. Bamber

Cambridge University Hospitals NHS Foundation Trust
Cambridge, UK
Email: james.bamber@addenbrookes.nhs.uk

D. N. Lucas

London North West NHS Healthcare
London, UK

No competing interests declared.

References

- Hill A. Women in labour being refused epidurals, official inquiry finds. *Guardian* 2020. https://www.theguardian.com/lifeandstyle/2020/mar/03/women-in-labour-being-refused-epidurals-official-inquiry-finds?CMP=share_btn_link (accessed 08/05/2020).
- Norfolk and Norwich University Hospitals Research. Questionnaire study exploring pregnant women's perception of COVID-19 [survey now closed]. 2020. <https://twitter.com/NUHRResearch/status/1257337802750074882?s=20> (accessed 08/05/2020).

doi:10.1111/anae.15122