COVID 19 Advisory 10 Saturday 18th April 2020

Association of Anaesthetists Webinar 5 'COVID 19 - The Challenge continues'

Jane and I joined over 600 delegates for this Webinar. The mood was sober and there were sombre take home messages

- this is a marathon not a sprint
- we (Health & Care staff) are all out of our comfort zone
- we will be living in "COVID - land" for months if not years
- no prospect of resumption of normal service as we progress to a *"new normal"*

The first two speakers were specialists in Obstetrics. Dr. Nuala Lucas, Consultant Anaesthetist at Northwick Park Hospital, reported that their PPE practices had been quite variable in the first 5 weeks, caused by successive changes in Rules and Regulations but were now more consistent Working in PPE proved to be hot, stressful and communication is difficult. End-of-shift 'doffing' must not be carelessly eager – it is a time of heightened risk of spread. Protocol must be followed! In some hospitals, Obstetric Theatres and Wards are becoming segregated, and separate, for **COVID and NOVID patients.**
In a New York study of 215 consecutive labour ward admissions, all were tested for COVID, and 4 of 215, who were symptomatic, tested positive. So did 29 of 215, who were **not** symptomatic. Dr Lucas recommended the testing of **all** hospital admissions, labour and general wards, regardless of symptoms. She also posed the ethical dilemma – if bedside visits are prohibited near death, can they be indulged at birth?

Prof. Catherine Nelson-Piercy, Obstetric Medicine at Guys & St.Thomas's warned doctors against becoming mentally 'COVIC – centric'. When relying on clinical signs & symptoms, breathlessness can be the first symptom of an unknown heart disease. Advancing pregnancy places an additional strain on maternal cardio vascular system and the enlarging uterus increasingly restricts the down movement of the diaphragm with each month. Seasonal asthma and Hay-fever can confuse. She reminded us that spread of disease was by a continuous spectrum of particle size – from larger droplets through to fine aerosol.

Prof. Nelson-Piercey presented the progression of COVID infection as three stages (**Slide 1**) **Stage 1 early infection. Stage 2 pulmonary phase and Stage 3 Hyper-inflammatory response phase.** I recall Dr. Mike Davies (Advisory 3) remarking that some vulnerable adults experience an exaggerated immune response to the virus.

Prof. Nelson-Piercy emphasised the importance of multi disciplinary consultation for difficult decisions, such as if faced with a 27 week pregnant woman already proving difficult to ventilate. French colleagues had shared their experience and the regret at their decision not to deliver such a patient by Caesarean Section to improve maternal lung function.

The Guys/STH practice is to cover any febrile pregnant patient with an antibiotic and every COVID positive pregnant woman also receives anti blood-clotting prophylaxis.

Chiming with recently expressed concerns about people staying away from hospital, Prof. Nelson-Piercey recalled that during the Ebola epidemic antenatal attendances fell and maternal morbidity (compliciations) increased by one third.

Prof. Mike Grocott, Anaesthesia & Critical Care at Southampton University Hospital and Vice President of the RCoA, declared that the ventilator was the 'Poster Child' of our fight against the **first surge of COVID 19.** ICU admissions UK wide appear to have plateaued. **CPAP has won its spurs.** Those who improve after CPAP may have had a milder pneumonitis (Slide 1 stage2). Full blown ARDS (Adult Respiratory Distress Syndrome) may feature more of the hyper-immune reaction (stage 3). Up to 25% of these have kidney failure with poorer outcomes. Prof. Grocott told us that "proning" is always tried when oxygen levels fall. CPAP patients can turn themselves. The ventilated patient takes teams **of 4 aside** to turn them prone and again to turn them supine. This procedure can be done daily for 3 days, 16 hours prone per session.
He apologised that he could not bring their latest anticoagulant protocol. His colleague had written it the night before and he had not had time to read it!
Antimicrobial Stewardship is the watchword as we enter the marathon and try to husband our resources.

Dr. Chris Carey, Brighton and Sussex and Member of Council, RCoA, told us that the 7 year professional training programme for anaesthetists had taken a massive hit (Slide 2). This has negatively impacted trainee morale. Normally, the Certificate of Completed Specialist Training is awarded to about 400 anaesthetists each year enabling them to apply for a Consultant post. The reason that senior trainees, visiting clinical fellows and the consultants in anaesthetics have been able respond so flexibly is because of their broad and long training across surgical specialties, Intensive Care and Pain Management. Although everyone will retain a vivid memory of the first surge of COVID 19, the experience is deep but relatively narrow. The College (RCoA) plans to get back on track for August 2021, meantime asking for a pragmatic approach to signing off training modules. He also spoke of elasticised timetables and periods of grace.

Prof. Sandeep Pandit of Oxford University explained why Public Health England (PHE) advice has been so difficult **both to devise and to digest**. The challenge is to make a statistical analysis of at least three variables comprehensible! Consider -

the contagious risk presented by the patient (partly determined by COVID status)

the degree of protection offered by any given form of PPE

the degree of risk of any given activity

He reminded us of the judgement in **the Montgomery Case**

- Mrs. Montgomery was only offered a vaginal delivery (the best risk statistically) but the baby suffered harm. The Supreme Court ruled that the patient has the right to interpret risks important to them. Substituting
  PHE for the Doctor
  the general public for the patient and
  the different types of PPE for the treatment options,
  he concluded that, like Mrs Montgomery, ***we should have the freedom to choose, based on information.*** The alternative approach would be to be given certain information -
- Available levels of PPE, estimated degree of protection, cost & availability
- A list of example tasks and their estimated risks
- A "best analysis" attempt to match the two, leaving staff to choose using the information in points one to three

He added the rider – "make room for the Wisdom of Crowds"

The weighing of future choices will depend upon disease incidence. It may seem sensible to follow PHE Policy when new cases of COVID exceed 4000 per day but, as the infection rate falls and the relative risks change, so individual choice becomes more prominent. The **"Montgomery approach" is even more important as COVID incidence declines**.

An article in "The Week," 18th April 2020, reports that First Class lounges have opened at the Whittington & North Middlesex Hospitals. Exhausted staff enter the lounge after their shift to be pampered. In **"Project Wingman",** grounded aircrews from half a dozen airlines "use the skills aircrews have to spoil Hospital staff!"

I like the sound of that!

Dr. David R Hughes **President** **20th April 2020**