

Frequently Asked Questions for Managing Pregnant Patients in the COVID-19 Pandemic

The SOGC, working with our ID Committee and the Public Health Agency of Canada, will attempt to find answers for all your COVID-19 questions.

Please note that the information on best practice is rapidly evolving, we can only be accurate to the time of writing. Links are provided to source documents with accession dates, please double check the source for any updates.

Please always check for specific guidance in your jurisdiction,

Do give us feedback and send your questions to SOGC at info@sogc.com.

What is the advice on prenatal care during this COVID-19 outbreak? Can telephone consults be done instead of physically seeing the patient and if so which prenatal visits are less important than others to do that?

- Any reduction or alteration in antepartum care will need to be individualized according to the particular circumstances of the patient, the capacity of the health system, and access to virtual visits.
- Recent literature supports some reduction in frequency of visits in the later trimesters if the first trimester screening indicates a low-risk pregnancy but there is no consensus on a reduced schedule at this time.
- Virtual visits and telephone support should be offered where appropriate.

What should hospitals do with respect to planning for separating affected moms/babies?

- Conduct patient-centered discussions about the available evidence and its limitations.
- Do not advocate for universal isolation of the infant from the mother for all mother-infant pairs. Do advocate for good handwashing, and the use of a mask while engaging in infant care is recommended if the mother has symptoms of any respiratory infection, including COVID-19.
- Allow women with COVID-19 who choose to breastfeed to do so with appropriate handwashing and a mask.

How do ORs handle a caesarean section for a woman with COVID-19 who requires intubation? Are there suggestions for delays in OR post-intubation to allow droplets to settle?

- Intubation is a potential aerosol generating procedure. PPE, including N95 respirators, should be used based on published advice from CDC, WHO and expert guidance. Please check the sources cited as this information is changing rapidly. The Society for Obstetric Anesthesia and Perinatology currently advises:
 - *Donning and doffing takes time. Avoid crash situations by anticipating needs.*
 - *Early epidural analgesia may reduce the need for general anesthesia for emergent caesarean delivery.*
 - *A COVID-19 diagnosis itself is NOT considered a contraindication for neuraxial anesthesia.*
 - *Avoid emergent caesarean deliveries as much as possible - proactive communication with obstetrical and nursing teams.*
 - *For respiratory distress intubate early using appropriate PPE.*
 - *Assign the most experienced anesthesia provider whenever possible for procedures (neuraxial, intubation)*
 - *Avoid junior learners in direct care of COVID-19 patients.*
 - *Minimize the number of personnel in the room.*
- *If general anesthesia and intubation is required;*
 - *Anesthesia providers and necessary assistants should wear N95 respirators or powered air-purifying respirators (PAPRs) prior to pre-oxygenation*
 - *Apply N95 respirator or face shield impermeable gown, gloves, and head covers.*
 - *Use donning and doffing check lists and trained observers.*
 - *Minimize to only essential personnel during intubation - use your best judgement, while making sure you have some assistance readily available*
 - *If GA indicated, and it is a life-threatening situation, wear PPE including an N95 respirator - All personnel in the OR at the time of intubation should also wear an N95 respirator and, if not wearing a N95 respirator or PAPR should contact occupational health*
 - *Pre-oxygenation (»5 L/min flow) should occur with a circuit extension and HEPA filter at the patient side of the circuit*
 - *Use a closed suction system (if available).*
 - *Intubation should occur via a means to maximize success on first attempt and minimize any need to provide bag-mask ventilation (video-laryngoscope)*
 - *Extubation is equally, if not more of a significant risk; minimize personnel, utilize N95 respirator and PPE Precautions. If proceeding with extubation at the end of case, extubate in the OR, keep PPE (PAPR/N95) on until after extubation. Consider transporting intubated to a negative pressure room (e.g. ICU) for emergence/ extubation.*

https://soap.org/wp-content/uploads/2020/03/SOAP_COVID-19_Obstetric_Anesthesia_Care_031620-2.pdf Accessed March 21, 2020

<https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2020/03/novel-coronavirus-2019> Accessed 21-03-2020

Should visitors/support be limited to 2nd stage?

- A support person in labour is important, and not considered a visitor. There is no reason to limit the support person to the second stage; their support is valuable throughout.
- It is important that anyone who accompanies a woman in labour be screened to ensure that they are not sick.
- Equally important is that they are not exposed to the risk of infection.
- The CDC provides some general and useful guidance.

https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html#manage_access Accessed 21-3-2020

Are N95 respirators to be worn at delivery?

- N95 respirators are not required for vaginal delivery: patients who are positive for COVID-19 should wear masks (and wash hands). Physicians should wear regular masks with face shield (plus gown and glove).
- If the patient is positive for COVID-19 and unstable, or at risk of sudden deterioration, aerosol precautions, including N95 respirators are prudent.
- At caesarean delivery the need to change to GA may arise rapidly, N95 respirators are advised.

<https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2020/03/novel-coronavirus-2019> Accessed 21-03-2020

Should there be dedicated COVID-19 patient clinics?

- All patients should be screened coming into the hospital and visitors should be limited.
- A visitor restriction to one person means only one per person with no hand offs/tag teaming.
- If a patient has any fever, cough, respiratory illness they must put on a mask and sanitize or wash their hands.
- If patient is known to have COVID-19, there should be a dedicated waiting space and clinic room.
- Hospitals with high volume of COVID-19 positive patients or persons under investigation may find it efficient to cohort COVID-19 patients.