COVID-19
Provincial Guidance on the Management of Obstetrical Patients

The number of cases of COVID-19 is increasing outside China as the outbreak continues to evolve. This is an emerging, rapidly evolving situation. Manitoba public health officials continue to monitor, gather information, assess risk and recommend evidence based approaches for healthcare providers and precautions for returning travelers.

At this time, the risk associated with COVID-19 in Canada is low however all health regions are involved in a coordinated provincial planning and response effort.

Information and resources are being regularly updated and staff are encouraged to refer to https://www.gov.mb.ca/health/coronavirus/ and https://sharedhealthmb.ca/health-providers/coronavirus-resources/ for up-to-date information and resources.

An evidence-informed guideline for the management of obstetrical patients who may be under investigation or identified as probable or confirmed cases of COVID-19, has been developed in consultation with representatives from obstetrics, neonatology, anesthesia and pediatric infectious diseases.

These suggestions are written with the acknowledgement that the epidemiology and evolution of information about COVID-19 is rapidly evolving and the relevance of the information herein should be reviewed in light of the current clinical context.


Some information has been derived from literature related to SARS-CoV and MERS-CoV and there should be acknowledgement that there is important genetic variation between these viruses and COVID-19 that may not make conclusions for all three viruses interchangeable.

Public Health Agency of Canada Case definitions are outlined in the provincial document and the following guidance is based on those definitions for Person under investigation (PUI), probable case and confirmed case.

- Infection Prevention and Control must be notified when a patient is suspected to have COVID-19. The procedures to contact Infection Prevention and Control are also outlined in the provincial document.
- Guidelines for staff working at any entry point to the hospital have been developed to ensure that any patients and escorts are screened appropriately upon arrival at the site. There are no additional considerations related to entry points for obstetrical patients.
• Guidelines for management of visitors of PUI, probable or confirmed cases of COVID-19 have been developed. There are no additional considerations related to visitor management of obstetrical patients. The guidelines can be accessed at COVID-19 https://sharedhealthmb.ca/files/COVID-19-highlights-winnipeg-march-3-2020.pdf.

Clinical Pathways: the intention is to provide some evidence informed guidance to assist with patient care, acknowledging that this list is not and exhaustive list of all possible clinical scenarios that occur.

Patient presenting to triage

1. PUI, probable or confirmed cases of COVID-19 should be cared for in a private room.
2. All HCW caring for PUI, probable or confirmed cases of COVID-19 should utilize PPE appropriate for enhanced droplet/contact transmission as per the provincial guideline available at: https://www.wrha.mb.ca/extranet/ipc/files/manuals/acute/Enhanced_Droplet_CP.pdf.
3. Assessment by clinical staff will determine whether the patient is appropriate for discharge home or admission for medical or obstetrical indications:
   a. A patient who is clinically well enough for discharge may be sent home to wait for COVID-19 testing results in accordance with provincial recommendations
   b. A patient who requires admission should be transferred to the appropriate ward with appropriate enhanced contact/ droplet precautions during transport

Patients on labour floor

1. If a PUI, probable or confirmed case is being managed on labour floor, they should be cared for in a private room. Please note as per the provincial guidelines, the patient is not required to be in an Airborne Infection Isolation Room (AIIR) room.
2. All HCW should don appropriate PPE for enhanced droplet/contact precautions.
3. Transfer out of the labour room to an OR should be dictated by obstetrical indications as for any other labouring patient
4. For vaginal delivery, delivery can occur with enhanced droplet/contact precautions
5. In the delivery room or resuscitation area, newborn resuscitation should occur under enhanced droplet/contact precautions using a procedure/surgical mask and NOT an N95 respirator. This extends to and includes intubation of the newborn. This recommendation is based on a lack of evidence that COVID-19 leads to vertical transmission of the newborn.
6. After initial stabilization of the infant and transfer to either the post-partum area or NICU, any deterioration requiring intubation or institution of CPAP (AGMPs) requires airborne precautions in addition to enhanced droplet/contact precautions. Use of an N95 respirator is specifically indicated.
7. If enhanced droplet/contact AND airborne precautions are being used because of the need for AGMPs for the care of the mother, including use of N-95 respirators by everyone present, these precautions would remain in place should emergency intubation of the infant be required immediately after delivery.
8. Following delivery, delayed cord clamping should be facilitated unless obstetrical or newborn considerations prevent it, there are no different recommendations related to PUI, probable or confirmed cases of COVID-19.

9. Skin-to-skin contact in the immediate post-partum period can occur, however the mother should wear a surgical/procedure mask when near the baby, practice proper hand hygiene before and after close contact with the baby and thoroughly cleanse the chest/breast area before and after breastfeeding with soap and water. Guidelines for breastfeeding mothers have been developed.

10. Following recovery from obstetric delivery patient should be transferred to the postpartum ward with appropriate enhanced droplet/contact precautions during transport.

11. If intubation of the mother is required during care on labour floor, prior to COVID-19 being ruled out, the procedure should be done under appropriate IP&C precautions for airborne transmission (N95 respirator should be donned in addition to gloves, gown, and face/eye protection).

Patient on the postpartum ward
1. Clinical care should take place in a single room with enhanced droplet/contact precautions.
2. Mother and infant pair should be roomed together unless the maternal or newborn medical condition prohibits this.
3. Breastfeeding and skin-to-skin contact should not be discouraged and education on the provincial guidelines should be provided to the mother and family.

Patient requiring enhanced care for respiratory deterioration
1. If a patient’s respiratory status deteriorates at any point in her hospital stay, anesthesia and ICU should be notified early.
2. Low threshold for transfer to a high acuity setting to facilitate early intubation, if required.
3. In these situations, if clinically indicated, administration of antenatal corticosteroids for fetal lung maturity should be considered.

Newborns requiring NICU admission with PUI, probable or confirmed COVID-19
1. Clinical care should take place in a single room with appropriate enhanced droplet/contact precautions.
2. Aerosol-generating medical procedures (AGMPs) such as intubation that are required during NICU care should be carried out under airborne precautions (https://sharedhealthmb.ca/files/IPC-acute-care-manual-winnipeg.pdf)

General management principles for all pregnant patients with PUI, probable or confirmed COVID-19
1. Counselling patient about the possible effects of COVID-19 on the parturient and pregnancy outcomes
   a. Possible risk of maternal respiratory failure
   b. Possible need for iatrogenic preterm delivery
   c. Possible pregnancy complications including spontaneous abortion, intrauterine
2. Consideration for antenatal corticosteroids for fetal lung maturity if gestational age 23+0 to 34+6 weeks gestation.

3. Mode of delivery, timing of delivery, type of anesthesia, use of IV antibiotics, use of corticosteroids and possible perimortem Caesarean delivery in the case of maternal demise should be considered on a case-by-case basis.

4. If corticosteroids have been used for the maternal condition in the antepartum period, consider stress-dose corticosteroids at time of delivery or other surgical intervention to prevent Addisonian Crisis.

5. Neither epidural nor spinal anaesthesia are contraindicated and in some cases may be preferred over general anesthetic.

6. Psychological support should be a priority for any patients who have some visitor restrictions in place as the separation from support networks as well as anxiety over the unknown may be stressful for the patient.

7. If mother and infant must be separated, pumping should be encouraged and this breast milk should be offered to the newborn to facilitate resumption of breastfeeding once the pair are reunited.

REFERENCES:


