



# Obstetrics and Gynecology COVID-19

## Interim Guidance (Version 3.0)

### **Introduction:**

- COVID-19 is a new strain of coronavirus. It is expected that a large majority of pregnant women will experience only mild or moderate cold/flu like symptoms, but it is known from other respiratory infections (e.g. influenza, SARS) that women who get respiratory infection in the late pregnancy (after 28 weeks) are more likely to become seriously unwell.
- More severe presentation such as pneumonia appear to be more common in those with weakened immune systems or long-term conditions such as cardiovascular diseases, asthma or diabetes. Furthermore, obese, older than 35 years and black Asian women are at increased risk of hospital admission.
- There is limited data on the effect of COVID-19 to a pregnant woman and its effect on the fetus. Currently there is no data suggesting an increased risk of miscarriage.
- COVID-19 might be associated with increased risk of maternal venous thromboembolism (VTE).

### **Transmission:**

- COVID-19 can be transmitted through close contact with an infected person (within 2 meters) or from contaminated surfaces. Transmission is through respiratory secretions.
- Incubation period of COVID-19 is 0-14 days, but infected persons can transmit the virus via close contact and respiratory droplets.
- PCR tests of cord and neonatal blood samples (within 48 hrs. of birth) diagnosed neonatal COVID-19 infection in 4-5 % of 71 neonates born to infected women in their third trimester, indicating possible vertical transmission.

### **Prevention:**

- It is advisable that pregnant women refrain from unnecessary travel, avoid crowds, public transport, and contact with sick people, and more importantly, practice and maintain good personal and social hygiene.
- Pregnant women with symptoms of fever, cough, fatigue, myalgia, sore throat or shortness of breath should seek timely medical consultation and help.

### **Antenatal care During COVID-19 Pandemic**

- Antenatal Care Visit: refer to MOH “*Ambulatory clinical care guidelines*” regarding virtual clinic and in-person appointment.
- Infected women who missed their antenatal appointment, should be seen as soon as possible after the period of self – isolation.
- Women who suffered severe or critical COVID -19 infection, should have her antenatal care with a consultant obstetrician.
- Fetal growth assessment by U/S examination should be planned 14 days post recovery from of the acute illness.
- 

### **Management of COVID-19 Confirmed or Suspected Case in Emergency Room (ER)**

Refer to MOH “*OBGYN- ER Flow chart* “ updated on 1<sup>st</sup> of September 2020.

#### **A. If Admission is not indicated clinically:**

- Patient should be seen with full PPE in isolated room.
- Check fetal heart if she is more than 18 weeks pregnant.
- NST if she is more than 28 weeks pregnant.
- Advice for self- isolation with written instructions.
- Scheduled antenatal care visit should be delayed after the period of self-isolation.
- Fetal well-being including U/S examination should be offered to the patient after the period of self-isolation.
- In case of emergency, the patient is advised to seek medical advice and the medical services should be alarmed upon arrival of the patient to the hospital.

#### **B. If admission is indicated clinically:**

- Patient should be seen with full PPE in an isolated single room.
- Check fetal heart daily if she is more than 18 weeks pregnant.
- NST daily if she is more than 28 weeks pregnant.
- For confirmed COVID 19 pregnant woman please follow the Interim guidance of “*Management of hospitalized adult patient with COVID-19 Pneumonia*”
- If any medical conditions associated with pregnancy like diabetes and hypertension should be managed as per local protocol.
- The use of steroid for fetal lung maturity should be based on obstetric indication.
- Delivery might be indicated for maternal or fetal distress.

- Baseline U/S for fetal wellbeing should be done at admission and after 14 days post resolution of the acute illness.
- **VTE thromboprophylaxis should be given for admitted patients:**
  - I. All pregnant women infected with SARS-CoV-2 should receive DVT-risk reassessment as COVID-19 infection is considered a transient risk factor.
  - II. If pregnant woman who is in self – isolation started VTE prophylaxis, she should continue till she recovers from the infection. In case of ongoing morbidity or limited mobility, the decision to continue the prophylaxis should be made by a clinician and hematologist.
  - III. All pregnant patient or patient within 6 weeks post-partum, who are admitted with suspected or confirmed COVID-19, should receive LMWH prophylaxis during the admission (unless birth is expected within 12 hours) and for 10 days post discharge, and may be longer if there is persistent morbidity or limited mobility.
  - IV. In case of severe complications of COVID-19, the dose of LMWH should be reviewed by senior obstetrician and hematologist.

#### **Induction of labor or planned LSCS for suspected or confirmed cases**

- Consider delaying elective delivery for patient in self- isolation, if it is possible and does not increase the maternal or fetal risk; but If delivery cannot be delayed the patient should be admitted to the assigned isolated labor ward
- Mode of induction is per local policy.

#### **Management of COVID 19 Confirmed or Suspected woman in labor:**

- Mode of birth should not be influenced by the presence of covid19 unless woman respiratory condition demands urgent delivery.
- Admission to the designated labor room, using negative pressure birthing room if available.
- Health care personnel (HCP) should use appropriate PPE including gown, gloves, face mask and eye protection.
- Minimize the number of HCP entering the room.
- For normal labor, apply standard, contact and droplet precautions.
- Full maternal and fetal assessment should be performed by a senior obstetrician and all the following should be informed: consultant obstetrician, consultant

physician, consultant anesthetists, consultant neonatologist, senior midwife and neonatal ward.

- Inform the preventive medicine and COVID19 medical team.
- Continues maternal observation and assessment including hourly oxygen saturation.
- If Oxygen to be given, it should be titrated to more than 94%.
- Epidural analgesia should be strongly recommended for labor analgesia, to women with suspected/confirmed COVID-19 to minimize the need for general anesthesia if urgent delivery is required.
- To check the platelet count before insertion of epidural or spinal, and possibly before removal of the epidural catheter.
- If Entonox® is to be used, it should be used with a single-use microbiological filter.
- Continues Fetal monitoring
- Decision for operative delivery such as LSCS should be made based on maternal or fetal indications.
- When urgent delivery of the baby is required to aid supportive care of a woman with severe or critical condition and vaginal birth is not imminent, consider whether the benefits of an urgent caesarean birth may outweigh any risks to the woman.
- An individualized decision should be made regarding shortening the length of the second stage of labor with elective instrumental birth in a symptomatic woman who is becoming exhausted or hypoxic.
- When *caesarian section* or other obstetric operative procedure is needed, follow the guidance for “*infection control guidelines for procedures and surgeries on suspected or confirmed COVID 19 patients*”.

**In case of cesarean section:**

- Provide epidural or spinal anesthesia as required, and check the platelet count before insertion of epidural or spinal, and possibly before removal of the epidural catheter.
- Consider plans for the management of a failed regional technique.
- Minimize the use of general anesthesia unless necessary for standard indications.
- Donning PPE is mandatory and time consuming and will impact on decision to delivery time for emergency caesarean delivery, no matter what the anesthetic technique used. Women and their families should be told about this delay.
- Full evaluation of the neonate after delivery by the neonatologist.

**Management of recovered COVID 19 woman in labor:**

- No change to the standard care during labor and birth for woman who recovered from only mild disease and had completed self- isolation.
- For woman who have recovered from severe or critical COVID 19 illness fatal growth and maternal condition should be assessed by a consultant obstetrician.

**Management of COVID 19 Confirmed (tested positive and within 10 days pre-birth)**  
**or**  
**Suspected woman in postpartum and postnatal care**

- Newborn of suspected or confirmed mother should be considered as suspected COVID19.
- Apply standard contact and droplet precautions for the mother and newborn baby.
- Neonate of a confirmed COVID 19 patient should be cared for as per MOH  
*“COVID 19 Guidelines for Neonatal Services”*
- After delivery mother is isolated with no allowed visitors until discharge as per local preventive medicine /infection control policy.
- The newborn will be examined carefully by the neonatologist in the allocated place.
- HCP should use appropriate PPE including gown, gloves, facemask, and eye protection.
- For aerosol-generating procedure on the mother or baby consider airborne precautions.
- If mother COVID- 19 Nasopharyngeal (NP) swab Test is negative, the decision of discharge or deposition is a shared responsibility of COVID-19 team members.
- Consider and support the mother's intention to breastfeed, but the decision to give breast feeding should be a conjoint decision between the consultant neonatologist and the parents.
- In case of breast feeding, the following precautions should be taken to limit viral spread to the baby:
  - Wash hands before touching the baby.
  - Avoid coughing or sneezing on the baby while feeding.
  - Consider wearing a face covering or fluid-resistant face mask while feeding or caring for the baby.
- When expressing milk using breast pump the following should be considered:
  - It is advisable that a dedicated breast pump should be provided.
  - Before expressing breast milk, mothers should practice hand hygiene.
  - Considering asking someone who is well to feed the baby.
  - After each pumping session, all parts that come into contact with breast-  
milk should be thoroughly washed and the entire pump should be

- appropriately disinfected per the manufacturer's instructions.
- Provide the parent with the following information leaflet:

1- “Parent *Information for Newborn Babies*”

2- “Frequently *Asked Questions About Breastfeeding and COVID 19* “

### **Management of Gynecological Emergencies in Suspected or Confirmed COVID-19**

- Admission to the designated isolated room.
- Give the woman surgical face mask and ask to put on
- Health care personnel (HCP) should use appropriate PPE including gown, gloves, face mask and eye protection when come in contact with the patient.
- Minimize the number of HCP entering the room
- Manage the gynecological emergencies as per local protocol
- If surgical management is needed, follow the guidance for” *infection control guidelines for procedures and surgeries on suspected or confirmed COVID 19 patients*”.
  - Provide spinal/epidural anesthesia as required. Check the platelet count before insertion of epidural spinal, and possibly before removal of the epidural catheter.
  - Minimize the use of general anesthesia unless necessary for standard indications.
  - Consider plans for the management of a failed regional technique.

### **Management of Elective Gynecological surgeries**

Refer to MOH guidelines

1- “*Resumption of normal elective surgery and procedure capacity*”

and

2- “*COVID 19: Elective case triage Guidelines for OBGYN surgical Care*”

*\*This guideline is made from the published data until today, should any new updates become available, this guideline will be updated accordingly.*

**Prepared by:** Dr. Amal K. Ayed, Consultant Obstetrician and Gynecologist, Head of Obstetrics and Gynecology

Department (Farwanya Hospital)

Dr. Manal E. Jaber, Consultant Obstetrician and Gynecologists, Head of Medical Technical

Department in Technical Administration (MOH)

**Approved by:** Council of Obstetrics and Gynecology

**Revised by:** Dr. Klould Alfedalah, Head OF Infection Control Department (MOH)

### **References:**

- 1- Royal college of obstetrics and gynecology. *Coronavirus (COVID-19) infection and pregnancy Information for healthcare professionals Version 6: updated Friday 24, July 2020.*
- 2- ISUOG *Interim Guidance on 2019 novel coronavirus infection during pregnancy and puerperium: information for healthcare professionals. First published: 11 March 2020*
- 3- American college of obstetricians and gynecologists. *Practice Advisory: Novel Coronavirus 2019 (COVID-19)*
- 4- Huan Liang and Ganesh Acharya. *Novel corona virus disease (COVID-19) in pregnancy: What clinical recommendations to follow? 05 March 2020 <https://doi.org/10.1111/aogs.13836>*
- 5- Chen H, Guo J, Wang C, et al. *Clinical characteristics and intrauterine vertical transmission potential of COVID-19 infection in nine pregnant women: a retrospective review of medical records. Lancet. 2020.*
- 6- Centers for Disease Control and Prevention (CDC). *Interim Considerations for Infection Prevention and Control of Coronavirus Disease (COVID-19) in Inpatient Obstetric Healthcare Settings.*