

COVID-19 Forum Questions and Answers

April 1, 2020

At the April 1 Members only Forum, there were many questions that were posted by participants. We have taken compiled the questions, and provided answers from experts within our field, with guidance that is applicable in the Canadian context.

With limited published evidence, most answers represent consensus of expert opinion.

COVID-19 Screening/Testing

- 1. Is it necessary to test twice, 24h apart for COVID-19 diagnosis?**
 - *One test is sufficient and reliable; two tests are not necessary.*

- 2. Are hospitals screening patient's temperature at the door, given that fever is only one symptom of COVID-19?**
 - *If patient presents as asymptomatic and becomes febrile, do nose swab.*
 - *If patient presents as asymptomatic and becomes febrile, consider COVID-19 testing in line with provincial/territorial guidance.*
 - *If patient presents as symptomatic, have the patient wear a mask and advise staff to take appropriate precautions.*
 - *Note; initial screening is done when patient comes in and a second screening is performed when patient is going onto the labour and delivery floor.*
 - *All pregnant women may soon be asked to put on a mask and wash their hands.*

- 3. Are you testing all peripartum patients with respiratory symptoms?**
 - *Yes*

- 4. What is the process to determine once a pregnant woman has "recovered" and no longer would require isolation/PPE for patient care following a COVID-19 positive result?**
 - *Given increases in volume, some centres no longer have the resources to do "negative testing".*
 - *Another centre suggests that testing to confirm that previously positive patients are negative is not indicated for a number of reasons. Perhaps one is testing availability, but more than anything it is because this is a PCR test, and will remain positive even after the viral cultures, if they could be done, would be negative.*
 - *Guidance from local ID and Public Health is to assume that the patient is negative if they are at least 10 days from initial symptoms and now asymptomatic apart from a residual cough, as long as they had mild disease (i.e. no hospitalization). For patients with moderate to severe illness, requiring admission to hospital, the*

recovery may be longer and will be determined by Public Health. The 10-day rule is really the minimum time frame and is based on a German study that looked at viral culture on subsequent days, reporting that the virus was only viable until day 8 but was detectable by PCR after that. So, PHAC conservatively decided on 10 days in those with mild illness, provided they are no longer febrile.

Prenatal Care

- 1. In terms of delaying antenatal visits, has a particular schedule been adopted? Should there be something formal, or is it unit dependent?**

One example (Low-risk clinic):

- *Patient with no co-morbidities*
 - *Phone visit at 10 weeks*
 - *NTN bloodwork at 12 weeks*
 - *Anatomy scan at 20 weeks*
 - *Connect with patient by phone at 24 weeks*
 - *Do GCT outside*
 - *28 weeks for growth*
 - *See at 34-36 weeks and again before 40 weeks.*
 - *Patient to monitor blood pressure and fetal movement at home*

Another Example:

For low-risk women and those for whom there are no identified maternal obstetrical or fetal concerns, it is acceptable to adjust the prenatal visit schedule to align with the WHO Antenatal Care Model (2016). The visit schedule below includes 9 prenatal visits and is a slight modification of the WHO schedule:

- First prenatal visit up to 12 weeks
- 20 weeks
- 26 weeks
- 30 weeks
- 34 weeks
- 36 weeks
- 38 weeks
- 39 weeks
- 40 weeks

Intrapartum Care

- 1. Why did China report such a high CS rate?**

- *Although China tends to report a high caesarean rate normally, more information is required to answer this question.*

2. **What are the experiences on rates of fetal intolerance of labour/maternal intolerance of labour?**
 - *The current recommendation is that, unless the mother is really sick, there is no logic reason to do anything other than follow normal obstetrical procedures*
 - *Guideline (ACOG, Royal College) suggesting continuous fetal monitoring is recommended*
 - *A Surveillance system is being develop across Canada to collect Canadian data.*
3. **What is recommended related to use of whirlpool tubs in the LDRPs?**
 - *RCOG recommends avoiding the tub and the jets.*
4. **What are the present recommendations about support people in labour given that some can be asymptomatic or not acknowledge their level of risk?**
 - *Most centres seem to have adopted a “one support person only in room during labour” policy.*
 - *Any support person would have to wear a mask, wash hands, and not leave the room at any time.*
 - *In order to get into some hospitals, the support person has to screen negative. If a woman is COVID-19 positive, then her partner is presumed as well.*
 - *The ideal situation is that the partner does not come in.*
 - *Virtual options for attending (e.g. facetime) can be considered.*
 - *This is a decision that should be made at a Provincial level to avoid public dissent.*
5. **Is the partner or doula allowed in with the patient for a vaginal delivery if COVID-19 positive or should COVID-19 be ruled out first?**
 - *Some centres allow a COVID-19 positive woman to have a partner, but NOT her household partner. The partner can be someone else who doesn't live with her (i.e., mom, sister, friend). If mom is positive, we aren't letting household partner in.*
 - *Other centres have adopted the policy of NO support person for the COVID-19 positive patient.*
6. **Should a support person allowed to be present in the OR for elective/non-GA C/S?**
 - *Some centres have disallowed any support people in any caesarean section (not just COVID-19 positive ones) in an attempt to conserve PPE. They also do not allow partner in room when epidural is placed.*
7. **If all caesarean sections in COVID-19 positive are done in the main OR, how are they transferred to the main OR while minimizing risk of transmission? Are partners still allowed in the main OR?**
 - *There are variable approaches to maternal transfer. For example:*
 - *Mother wears mask*
 - *Providers wear PPE but not N-95 for transfer*

- *Most centres are allowing one support person in OR but policy of no support people in OR being adopted by some.*
- 8. Is it recommended that every patient wear a surgical mask, given the risk for asymptomatic spread?**
- *If the labouring patient is not wearing a mask, then the providers wear a mask and eye protection (face shield)*
- 9. Are outpatient inductions permitted (i.e. come to hospital for foley, cervidil/prostin etc, then discharge home to return for admission only when in labour)? Or is the goal to try to limit the in/out and just keep/admit them?**
- *Outpatient inductions may be considered in asymptomatic women who are not suspected of being COVID-19 +. Symptomatic, suspected or COVID-19 + women should be admitted for induction, isolated and testing as appropriate.*
 - *One Level 1 hospital always sends cervidil patients home, and they return the next morning for rupture of membranes and oxytocin, if favorable.*
- 10. What are the indications for vaginal/caesarean delivery in a COVID-19 positive patient?**
- *Obstetric indications, unless delivery is necessary for the health of a compromised mother.*
 - *Try to avoid the emergency caesarean delivery in the COVID positive patient. Look at the patient's history and determine if a planned caesarean would be better – avoid trial of labour.*
 - *Think about clinical scenarios where a trial of labour would not be recommended in someone who is COVID-19 positive.*
- 11. The CDC (without support of ACOG, SMFM, etc.) has released a statement that obstetric providers should wear N-95 masks in the setting of L&D when dealing with a COVID-19 positive OR suspect patient. Does Canada have a similar statement?**
- *The SOGC Committee Opinion on COVID-19 in Pregnancy suggests that N-95 masks be reserved for aerosol generating procedures, but it is important to note that this is being interpreted differently in different sectors and centres. This recommendation is based on the fact that N-95 mask numbers are very low and consideration should be made on when use is necessary.*
 - *Some examples are:*
 - *N-95 mask required to be worn when doing caesarean section under general anaesthetic, otherwise a face mask and shield is to be worn*
- 12. Along the lines of above questions related to N-95 masks in labour and delivery, is there evidence that vaginal delivery is an aerosolizing procedure?**
- *It is currently believed that pushing with Valsalva etc and spitting in the second stage of labour is not aerosol generating, and therefore no N95 necessary. There is a lot of*

debate about the mother wearing a mask in labour. If the care providers are wearing masks and taking precautions, it is not necessary to "double mask"; there is no harm but the mask is likely to get saturated more quickly and need to be changed and may fall off her face. For a long labour, a number of masks might be required. Clearly, it is difficult to know exactly what to do, but the sentiment is increasingly around the need to make decisions based on reason about who should wear masks and when, because of the limited supply of N-95s, in particular.

13. Has the use of Entonox in the second stage of labour been discouraged?

- *One centre has stopped using Entonox based upon anesthesia and RT review and the manufacturer's information – it is thought that the lines cannot be cleaned well enough to prevent transmission of COVID-19.*
- *It is important to note that the normal procedure is not aerosolizing, but if you get an expulsive effort against a valve, it might become aerosolizing.*

14. Is there any protocol for fetal wellbeing monitoring in COVID-19 positive patients?

- *There should be some plan in place for monitoring, but there have not been specific recommendations to date.*
- *With mild disease, there is probably no need for significant need in increased monitoring, which is based on the need to protect sonographers and ultrasound staff to be able to maintain that service.*

Newborn Care

1. What is the recommendation for PPE for resuscitation of the newborn, including CPAP, PPV, intubation? Should this be different for non-symptomatic mom vs suspected/PUI/COVID-19 positive mom?

- *There is agreement that the N-95 masks should only be used for aerosolized procedures.*
- *Some centres presume that newborns are negative and therefore N-95 masks for newborn resuscitation are not required. The risk of transmission to the newborn is very low, so suctioning is not necessary.*

2. What are the PPE recommendations for neonatal providers?

- *Some examples of responses are outlined below:*
 - *For spontaneous delivery, go in with regular PPE, if general anaesthetic needed, N-95 put on prior to general anaesthetic.*
 - *Baby unprotected in OR if general anaesthetic administered, do initial assessment and remove from OR as quickly as possible*
 - *With normal vaginal delivery, as soon as baby is delivered, mom should have mask, sanitize hands, gown should be removed so baby not going onto exposed gown, etc - all before she is given the baby, with the goal of protecting the baby.*

3. What are the recommendations related to breastfeeding? Is separation of a COVID-19 positive mother and baby required?

- *SOGC Committee Opinion on COVID-19 in Pregnancy states that breastfeeding can continue, as well as skin to skin.*
- *There is currently no recommendation of mother and baby being separated.*
- *Current evidence does not suggest that COVID-19 is present in breast milk.*
- *The following procedures are recommended:*
 - *Physical distancing by not having the bassinet right beside the mother's bed.*
 - *Hands should be washed before touching the baby.*
 - *The number of people touching the baby should be limited.*

4. Is there any update on standard swabbing of the newborn of COVID-19 positive mothers after delivery? Is there any information on the timing of the swab?

- *Nobody is aware of anything at this time and there seems to be consensus that utility is limited, except for research purposes.*

Health Care Workers

1. What are the recommendations related to pregnant health care workers? The RCOG is suggesting they should be working from home after 28wks GA.

- *The SOGC recognizes that the situation for pregnant health care professionals is challenging in a very rapidly changing environment.*
- *The SOGC Infectious Disease Committee's Statement of Health Care Workers During the COVID-19 Pandemic will be revised if/as the evidence evolves. At this time, it reports that:*
 - *There is no evidence-based data to support the need to be off, unless co-morbidities are present.*
 - *Whenever possible, pregnant healthcare workers should be assigned to COVID-19 negative patients.*

2. Are there any suggestions in terms of tips for maintaining adequate working manpower, particularly in smaller centers as this pandemic progresses?

- *It is critical to identify the tipping point – when safety and protection of nursing and physician staff becomes jeopardized. Patient volumes and hospital supplies may influence the extent of Personal Protective Equipment available to health care providers.*
- *Modify schedule if possible, so there is a back-up team ready to fill in.*
- *Consider staggering shifts where feasible so groups of workers do not all have the same exposure.*