COVID-19 Forum Questions and Answers
April 22, 2020

At the April 22 Members only Forum, there were many questions that were posted by participants. We have 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 and were considered current at the time of the April 22nd Forum.

COVID-19 Pathophysiology

1. What is the effect of COVID-19 on the lungs and surfactant production?
   - The pathophysiology of COVID-19 includes respiratory infection, especially lower tract infection, which is associated with higher morbidity and mortality, in general.
   - COVID-19 may influence surfactant and oxygen exchange. That said, the reports on these effects are coming from the media and not from peer-reviewed scientific publications. Reminder: that we must rely on rigorous academic review to guide medical practice and not the media!

Indigenous Populations

2. Is there any comment from the SOGC specifically for Indigenous populations? Most of concern around First Nations, particularly in remote communities, is around factors of SES, but H1N1 weighs heavy on the minds in the North.
   - Indeed, evidence does who that infection disproportionately affects communities with lower SES, who are remote, isolated, etc.
   - The SOGC is represented on an Indigenous Services Canada’s Advisory Group and their messaging focusses on working hard to keep COVID-19 out of communities, given their particular risks and vulnerabilities. They are also recognizing the importance and the implications of travel.
restrictions, intimate partner violence and food security and food safety. Provision of care in culturally safe way is also critically important.

- The SOGC, not being an Indigenous organization, is supporting and endorsing the work of Indigenous organizations.

First trimester Complications

3. There is good information from RCOG, NICE guidelines, and the USA on no-test medical abortion, and not requiring RhIG for bleeding in first trimester pregnancy that is not managed using surgery. Will the SOGC provide any guidance to testing and RhIG administration during the COVID-19 pandemic and remote assistance options for women with first trimester bleeding and those requesting abortion?

- There is guidance coming out from the SOGC’s Sexual Health and reproductive Equity Committee that will address how to provide remote care to women for essential reproductive services including medical abortion and contraception and will be posted on the SOGC’s COVID-19 resource page
- A COVID-19 Response Forum is also being planned, with a focus on these topics.

Intrapartum Care

4. Is there any update on Entenox use?

- Use of Entenox remains a careful balance between the evidence regarding the spread of droplets, what’s aerolsilized, how far droplets can spread, etc and wanting to minimize risk of transmission of COVID-19. Current evidence suggests that nitrous oxide use is not an aerolizing procedure and may be safely used in the second stage provided that droplet precautions are followed.
- Mode of administration and the ability to appropriately clean the equipment is a big factor.
- Can we generalize a standard statement for an approach to Entonox use across all hospitals? Probably not – it will be very difficult to provide a generic recommendation because of the differences across centres for administration, cleaning, etc.
5. *Is the second stage of labour aerosolizing?*

- There is no simulated evidence for the second stage of labour, but there is a long standing history of IPAC advice. Respiratory infections are not new; droplet projections are not new. There is nothing of the physics of the second stage of labour that suggest that this is an aerosolizing procedure.

6. *What approaches should be used during aerosolizing procedures?*

- The team should remain under PPE in the operating room; the goal should be to take steps to try to reduce the use of general anesthetic.
- There should be early alert of PUI or COVID-19 positive patients, so there can be discussions with them about the importance of epidural.
- Adequate PPE equipment should be available.
- Because some deliveries (~10%) convert to general anesthetic, this possibility should be considered to ensure adequate staff and PPE.
- As with most practices, approaches vary across regions and provinces and depend on factors such as COVID-19 prevalence in the community, staffing, PPE, etc.
- Some centres have implemented staged frameworks for managing point of care perceived vs real risk, etc as one example of an approach.

7. *For planned C-sections, is there a precedent or protocol for whether support people are allowed in the Operating Room?*

- The SOGC has always taken the position that a support person is an important member of the team and is not just a visitor. The ultimate goal should be to have the staff and the PPE which would allow the presence of a support person, with the priorities always being keeping women in labour safe, women on the labour floor safe, and healthcare providers safe. Again, it is important to assess actual vs perceived risk when making these types of decisions.
- Some centres have had to make the difficult decision to restrict support people for patients and decisions related to support people during a C-section is more individualized, depending on the of risk for having to convert to general anesthetic, to get people out of the room, workflow of teams and rooms, etc.
- Some centres are providing Facetime opportunities for their women in labour.
8. **How do you deal with fever during labor?**
   - Everyone should consider the probability that this could be COVID-19 vs other causes of fever (i.e. chorioamnitis)
   - Some centres have moved to management of fever in labour as PUI; they do swab, put on contact and droplet protection and manage them as such.

9. **Can you comment on maternal transfer of a COVID-19 positive patient within a hospital and also from remote areas or other institutions, etc? Are there any special procedures to keep staff and other patients safe?**
   - There are many conversations about cohorting COVID-19 positive patients; cold zones, warm zones, hot zones, etc. It is difficult to make recommendations because how local/regional resources are managed are so different from place to place. Pulling COVID-19 positive patients from their communities is complex and labour and delivery is a high turnover situation, so IPAC principles rarely apply.
   - The goal is to implement processes that minimize provider contact and that minimize transfers within a facility, but this is highly dependent on resources, COVID-19 prevalence in the region and workflow.

**Pregnant Health Care Workers**

10. **Are there any SOGC guideline updates on pregnant health care providers during the COVID-19 pandemic?**
    - Yes, an updated statement from the SOGC’s Infectious Disease Committee is coming soon! The statement is based on evolving evidence and states that there is no increased risk for pregnant women associated with COVID-19 infection. Decisions should be balanced with the autonomy of pregnant woman.

**Newborn Care**

11. **Is there any comment on the recent study from Peru on possible vertical transmission of COVID-19?**
• One case report came out of Peru, about a neonate who was removed from the labour and delivery room, had respiratory distress and testing 16 h later, and the swab was positive. It is important to note that this is a single case report and not a large academic study. Currently there are no data to support evidence of vertical transmission. It is most likely that transmission occurs post-partum.

• It is also important to consider other confounding factors including test validation (i.e., false positives, chain of the sample swab, supportive evidence of vertical transmission).

**12. What about PPE for newborn resuscitation when there is a COVID-19 positive mother?**

• It is really essential to remind staff that the baby does not require PPE and there is currently no evidence of risk of vertical transmission. This remains true even for CPAP – the baby does not have a cough response and cannot aerolosize. That said, if a baby has been readmitted – leaves hospital and now is back - they should be resuscitated in N95s.

• Any neonatal resuscitation at the time of delivery regardless of the mother’s COVID-19 status is droplet only and there is no need for N95. This is consistent with CPS. Once the baby is transferred to the NICU, the CPS guidelines recommend that baby be treated as COVID-19 positive and use N95 if baby requires aerosolizing procedures.