At the April 15 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 15\textsuperscript{th} Forum.

**COVID-19 Screening/Testing**

1. For COVID-19 positive women, how long are we considering them as COVID-19 positive?
   - One current practice is to consider them positive until 14d out from the onset of symptoms or 48 hrs from when their symptoms have resolved, whichever comes later.
   - Another study used 10 days from the start of symptoms in patients with mild illness and as long as they are no longer febrile.

2. Should COVID-19 swabs be done for all inductions and elective sections in addition to screening questions, due to increased risk of asymptomatic patients (as seen in New York). What approaches are being used in rural sites?
   - Most places are only allowed to swab patients who meet specific criteria, which include symptoms, and have very slow turnaround times.
   - Unknown false negative rates in asymptomatic patients can lead to false reassurance
   - Universal precautions are recommended for all

Society of Obstetricians and Gynecologists
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Intrapartum Care

1. What are the current recommendations for support persons in labour?
   - Approaches vary across facilities. Families are very concerned about the new rules and women may choose a different facility or even give birth unattended.
   - The SOGC supports of family centred birthing but recognizes the need to protect other mothers and staff.
   - Most sites are only allowing one support person for the duration of the hospital stay
   - Some sites allow partners to go out to smoke but most do not
   - Some sites provide food for partners to the room but others instruct them to bring everything they might need with them including food.
   - Some sites do not allow the partner if they are suspected COVID-19 positive on screen

2. Is second stage aerosolized?
   - Valsalva is considered droplet and there is no need to wear N95s in that context, even if the woman is COVID-19 positive. COVID positive labouring women should wear a surgical mask throughout. Providers should wear droplet precaution PPE for all deliveries.

3. Home births – Are there any suggestions for urgent transfers from home to hospital, when required for a COVID positive birth? And is there any need for possible isolation of midwives from hospital deliveries after being involved in a home COVID-19 positive birth?
   - Some centres are suggesting that COVID-19 positive mothers deliver in a hospital – so midwives, in these cases, would only be delivering the unknown positive mothers at home. If they haven’t been wearing proper PPE, they are required to self-isolate afterwards.

4. What are the best ways to support women and HCW’s in remote nursing stations where being transferred out for preterm labour is not uncommon?
• The concern is balancing patient safety and mental well-being but it was felt that in general, minimizing time away from a woman’s community and family, especially when she would need to be in isolation in the larger centre, would be preferable. Easy-to-use print resources would be helpful for nursing stations and other non-obstetrical facilities. It was mentioned that the SOGC’s ALARM manual is freely available for use during the COVID pandemic.

5. What is the definition of fever in labour during COVID-19 and how do we approach management of new fever in labouring patients?
• The Ontario public health guidelines has lowered the fever threshold to 37.8 degrees for healthy outpatients, including labouring women
• One plan is to swab all febrile patients for COVID-19 but only consider transferring out those patients who have no other likely source of fever (ie chorioamnionitis, endometritis) or have worrisome symptoms (see #14).

6. What is the reasoning behind the current recommendation to avoid nitrous oxide? Is this being reconsidered?
• There are many different interpretations and practices happening across the country. Avoiding nitrous oxide (Entonox) is a very cautious recommendation as there is unlikely to be aerosolization. However, there are concerns about cross contamination through the equipment. There are many different systems for the delivery of nitrous oxide and it is difficult to guarantee adequate cleaning of the equipment and appropriate filter use.
• Some sites have limited options for pain management and are still using nitrous with attention to filters and cleaning.
• Other centres have stopped using it altogether because of unclear guidance.

7. Are there alternatives to fentanyl for pain control given current drug shortages?
• There are a number of alternatives to fentanyl available, including other opioids (hydromorphone or morphine),
• Nubain 5-20mg iv/im and gravol are other options
• Nitrous, as discussed could be considered
• The SOGC’s ALARM manual has a chapter on pain management and is currently freely available on the SOGC website.

8. Should the COVID-19 positive patient be wearing a mask in labor and second stage?
• Yes—though the mask may need to be replaced during labour when saturated

9. Should the birthing room be negative pressure for delivering the COVID-19 positive patient?
• Standard vaginal delivery does not require a negative pressure room
• Negative pressure OR’s for cesarean sections if GA needed are helpful for minimizing contamination but there might be a slight increase in wound infections.

10. Does the SOGC have an opinion about staff working in different departments (ie ER/hospitalization participating in obstetrical care) given the possibility of COVID-19 exposure?
• The SOGC has not developed a position on this topic.
• There are differences across the country and even across provinces which tend to be facility-specific, depending on their robustness and how much crossover there is with the maternity care staff and system. Practices are also very dependent on prevalence and incidence of COVID-19 in the community.
• There are a number of centres reporting different approaches:
  o Some have separated ER and maternity to minimize exposure
  o Other centres are trying to limit traffic by having family physicians on a rotating shift, where one is covering labor, post-partum and neonates
  o Some have specific COVID-19 areas for positive or suspect patients and specific physicians care for this ward each week and no other areas.

11. Which PPE should be used for a c-section for a COVID-19 probable/positive patient? (many sites are transferring these if possible)
• There is a balance between preserving stocks of PPE against the risk of needing to convert (<10%)
• For elective CS most sites are wearing droplet protection but having minimal staff in the OR until the spinal is confirmed successful. If a GA is required the
staff then add N95 masks and then enter the room. To protect the baby team in some sites the team remains outside the OR in droplet PPE and the baby is moved out in a bassinet so any resuscitation is done in the baby room.

- **Urgent LSCS is challenging** - if there is time the same process for elective csections is followed.
- **For emergency sections** where the previous process is not possible, in rural hospitals with limited staff the surgeon, assist, anesthetist and scrub nurse wear n95s. This is to avoid risking the loss of the maternity service at the hospital in the event of inadvertent exposure.

12. **Is there guidance for counselling patients for TOLAC?**
   - Some centres have created an internal document about clinical scenarios for which they may not be comfortable supporting TOLAC for patients. These risk factors include previous reasons for the c-section – i.e., breech vs large baby, failure to progress, etc. The goal is to try and avoid intrapartum emergency cesarean sections as much as possible.
   - There must be a discussion between the care provider and the patient and varies from site to site.

13. **Should the provider shower after delivering a COVID-19 positive patient?**
   - Yes, after all deliveries given the unknown prevalence.
   - Some centres have specific decontamination procedures that are recommended after finishing work. For example: https://www.acep.org/corona/COVID-19/covid-19-articles/ed-shift-decontamination-routine/

14. **Should COVID-19 positive patients be transferred to higher acuity centers?**
   - The biggest concern is the potential for rapid decompensation in a COVID-19 positive patient.
   - Many regions recommend all positive patients deliver in a centre with an obstetrician and paediatrician.
   - Other regions (tertiary care) have said that they will accept COVID-19 positive patients, who will be transferred from regional hospitals. Supporting smaller regional hospitals by protecting them from prolonged exposure and the risk of a COVID-19 outbreak minimizes the risk of those hospitals having to shut down.
Each rural site should contact their referral centre to establish/understand the plan.
Additional concern is the difficulty in isolating COVID-19 patients in small hospitals.

15. Is there some simple poster / 8 x11 1/2 resources for nursing stations to refer to in managing PPH (eg with a condom catheter - makeshift bakri), and other complications in labor?

• The SOGC’s ALARM manual has many such resources and is available for free download on SOGC website

Newborn Care

1. The CPS guidelines suggest droplet precautions only for newborn resuscitation - 2m from a COVID-19 positive mother, including CPAP, intubating for the first 24 hrs - with minimal to nil risk of vertical transmission. Is this the recommended practice?

• Newborn resuscitation does not require PPE as 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 aerosolize. That said, if a baby has been readmitted – leaves hospital and returns after 24 hours- they should be resuscitated in N95s as they now could be infected.

• 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

• For home births that come in, it is anticipated that N95s are not required within the first 24 hours of birth.

Other Topics:

Most of these questions are ones that apply everywhere. How supported are people in rural communities feeling about the information and guidance they are receiving for provincial, federal and regional organizations? How do we best get information to all the little places, and not just the bigger ones?
• Some centres have been doing webinars to keep others updated
• The communication piece seems to be variable
• Some provinces have strong rural networks and also maternity networks, but no one seems to belong to all of them
• There should be a way to have this information easily accessible and collected into one website— the SOGC’s COVID Resource page is one place
• If providers find good resources/links that they think would be valuable to other maternity providers they can email jblake@sogc.com to have them uploaded to the page.