COVID-19 Forum Questions and Answers
April 8, 2020

At the April 8 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 8th Forum.

COVID-19 Screening/Testing

1. **What does PUI stand for?**
   - PUI stands for “Person Under Investigation” and is used for patients when there are risk factors and symptoms consistent with COVID-19 and a nasal swab sent for analysis. “COVID-19 Suspect” is also used when there are symptoms but a swab has not yet been sent for analysis. Other terminology includes PWR – “Person with Risk” and ILI - “Influenza Like Illness”.

2. **How do you decide to stop treating someone as COVID-19 positive (recent case at our centre of confirmed COVID-19 positive patient, day 15 after start of symptoms, still coughing)?**
   - German data show that 10 d post onset of symptoms is when the COVID-19 virus stops replicating, but viral RNA can be detected out to 20 days post onset of symptoms. General recommendations currently are that after 14 d post- onset of symptoms, individuals should not be considered infectious. It is important to note that some provinces may have different requirements, so be sure to look at provincial guidelines.

3. **What if everyone is being consider COVID positive? What is the role if universal testing for women admitted for delivery?**
   - Without widespread availability of a rapid COVID-19 test, universal testing of all women admitted for delivery has no additional benefit over testing women who are symptomatic.
4. Where are pregnant patients who are COVID-19 positive but not in labour and admitted with nonobstetric, but respiratory disease, housed? Is this Gestational Age dependent?

- Yes, management is gestational age dependent. One hospital admits these patients to a COVID-19 wing where they are managed by medicine and Obstetrics would provide back up. These patients may end up in the ICU or step down unit and may deliver there, but this is not ideal.

Prenatal Care

1. Are there any protocols for telehealth monitoring of COVID positive patients with mild, at home disease - is there a suggested timeline of when to see them next, when considered “clear” if they present for delivery?

- The approach is dependent on gestational age. If there is mild disease, HCPs would assume the patient would be cleared by 10 days after onset of symptoms, if they did not have symptoms other than a mild residual cough. During that time, the patient would be being managed with daily phone calls, with a standard questionnaire that any health care provider could administer, including questions about fetal movement, monitoring contractions, taking temperature, leakage of fluids, etc. If at day 10, there is a question as to whether patient is to be cleared, public health should be consulted. If there are other risk factors, (i.e., high blood pressure) where we do not feel comfortable not seeing the patient, we will have to look at ways they can be seen, using an individualized logical approach.

Intrapartum Care

1. I understand that the recommendation is to avoid water birth, but what about the use of tubs in early labour. We are a level 1 centre with a low epidural rate, and we commonly have women in the tub during the first stage of labour.

- Because of concern for HCPs helping women in and out of the tub, some centres say No. That said, there is no specific data looking at environmental sampling when there is a shower or bath for someone COVID-19 positive; no data that show whether this increases dispersion of virus, but droplets can contaminate the area. The critical question is can HCPs maintain water resistant PPE while caring for someone in the bath.

2. What about COVID negative, no symptoms and the use of hot tub?

- The decision would depend on local prevalence – is there a high probability of asymptomatic positive people? The attempt to try to keep the labour and delivery process as normal as possible and to try to allow people the experience they are hoping for remains the objective, if feasible and safe.

3. Should all women with intrapartum fever be considered PUIs? If so, what criteria should be used to clear them?
• **This is a hot topic with no clear answer yet!** It is important to keep in mind that there are many other reasons to have an intrapartum fever other than COVID-19 that must be considered (i.e., chorioamnitis). There are also newer data reporting that women who are asymptomatic may have a fever during labour. One NY study suggested that when universal screening was implemented for term patients, 30% were asymptomatic on presentation and a proportion developed symptoms in labour.

4. **Given the recent US data showing 33% of women in labour with COVID presenting as asymptomatic, should all women in labour be wearing a procedure mask?**

• **Different institutions are handling situation differently – not just for pregnant women.** Epidemiologic modelling shows that the growth of this pandemic shows that the asymptomatic setting is important for this virus. One institution is having all providers use masks and shields rather than having the patients use them. They also have a low threshold for wearing full gown and gloves, which is encouraged for vaginal delivery and support in second stage of labour. Another Centre has providers wearing a mask in all patient care areas, to ensure that HCPs are protected from each other and from the patient. Everyone is striving to try to develop guidelines that balance the patient, the judicious use of PPE and minimizing as much of the decision tree as possible with respect to the supplies to make it easier on HCPs by cutting down the number of decisions that need to be made. Yet other centres require laboring woman to wear a mask as much as possible, if they are presumed COVID-19 positive.

5. **What are decisions around partners are being allowed to accompany women in Labour and Delivery or post-partum?**

• **Ideally, this should be a provincial decision, because people may avoid one institution and go to another to bypass the rule, which would impact delivery of care in the second hospital.** Some centres have moved to 1 support person if patient and support person screen negative. A COVID-19 positive, partner would not pass screening questions to be able to enter the hospital. Some will allow a support person who COULD pass the screening test (ie. Someone they haven’t seen in 14d), but they are moving to having NO support person for COVID-19 positive patients.

6. **Is there a national recommendation for support persons during labour?**

   No – and there likely won’t be. Access of support persons for labour and delivery depends on the local context, but eliminating a support person should be last resort.

7. **What about support people on antenatal units? Triage?**

• Some centres have an exception to the no visitor rule that applies to labor and delivery and post partum. If it hasn’t been decided if you are staying in the hospital in labour, the no visitor rule still applies. Others have a 1 person visitor policy.

8. **Are most centres recommending epidurals to COVID-19 positive and PUI patients?**
There is a need to balance patient autonomy and patient experience. Epidural for COVID-19 positive patients allows for a rapid switch to a c-section. It is important to have an informed discussion with the patient.

9. Any recommendations for stillbirth investigations in a COVID positive patient?
   - The are some recommendations that nasopharyngeal swab should be done for stillbirth born to COVID-19 positive woman. There is no evidence that COVID-19 positive woman would have any virus in amniotic fluid. Standard stillbirth investigation should occur, sending the placenta for testing. Again, there is no reason to suggest placental infection.

Newborn Care

1. Could you comment on the use of airborne precautions for neonatal AGMPs born to COVID + mothers or PUIs?
   - The NICU tends to use a lot of non-invasive respiratory support, which is an aerosizing procedure. When a woman is labelled PUI or COVID-19 positive, then the baby is labelled PUI and won’t be cleared to have normal contact with staff and family until they are cleared (usually when the mother is cleared). The baby will go into a negative pressure room and there will be full aerosol PPE for patient on noninvasive respiratory support. The baby will be taken out when the mother is deemed negative, but this will differ across institutions. At present, there is no evidence of vertical transmission so baby would be expected to be negative. For resuscitation efforts right at delivery – these are being done with surgical mask and contact droplet precautions, assuming what’s being aerosolized are fluids not containing the virus (amniotic fluid).
   - If baby admitted to NICU, they are being treated as COVID-19 positive and isolated.

2. 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?
   - The current understanding is that testing revolves around the mother. If she is positive, then baby is PUI. If the baby is term and healthy it stays with the mother and there is no reason to test. If the mother is COVID-19 positive, it may be important to test the baby to see if there is evidence of transmission. There is no evidence to for an optimal time to test. So far, there is no evidence for vertical transmission.
   - Early swab for baby of COVID-19 positive woman within 1-2 hr of birth and after baby’s face has been cleaned and no contamination from delivery suite.

Key issues:

Society of Obstetricians and Gynecologists
April 2020
ID: Procedures are very different from centre to centre, but the SOGC’s ID committee working to provide uniform guidelines for perinatal care providers across the country.

Neonatal challenges: There are many protocols about how to manage neonate born to a mother with COVID-19 or PUI, but there is still controversy. Neonatal units, like others, are working on how teams should function with handover, rounds, etc as well as contingency planning for when a team is symptomatic.

Anesthesiology – There is still confusion around what PPE should be used under what circumstances (C-section that may convert to general anesthetic, etc). There is a huge volume amount of information being put out, but there is no national body for Anesthesiology to filter and disseminate the information. Different practices depend on a number of factors, including number of cases in hospital, community spread and amount of PPE. Everyone is trying to find balance between protecting staff and conserving N95 masks, as well as the unknown predictions around availability of PPE in the future. Some centres are using N95s for all emergency sections. Others are compromising because of PPE availability; not having everyone with PPE for delivery – 1 member of Anesthesiology team, the surgeon and the scrub nurse. If conversion is required, other team members leave, don appropriate PPE and come back in.

It is important to remember that each hospital needs to look at what is happening locally and regionally – and this is dependent on COVID-19 prevalence and availability of PPE. Processes may also differ between the main OR and Labour and Delivery in the same facility. Approaches will be staged and may not be national, or regional – these may exist within individual centres.