INPATIENT MANAGEMENT OF PREGNANT WOMEN WITH SARS-CoV-2 INFECTION

Admission Criteria

- Appears unwell
- Haemodynamic instability,
- Hypoxaemia (SaO2 on room air <95%),
- RR ≥20 bpm,
- Reduced platelet count ≤120,
- Medical comorbidities eg asthma, pre-exiting diabetes, on immunosuppressive drugs
- Unsuitable home environment

Consider for discharge if:

- No symptoms, or only mild upper respiratory tract symptoms
- Stable clinical picture
- No medical comorbidities
- $SaO_2 \geq 94\%$
- RR <20bpm
- Haemodynamically stable
- Platelets count >120
- Suitable home environment
- No fetal concerns

If for discharge must notify ID consultant for ongoing follow up in the community

Disposition

- Notify ID, Infection Control; MDT involvement
- Until test results are available, treat as COVID positive
- Single or COVID-cohorted room
- **Contact plus droplet precautions** unless aerosol generating procedure
- Donning and doffing with a buddy

Initial Workup

- SARS-CoV-2 PCR swabs x2
- Influenza PCR swab (if multiplex unavailable)
- ABG, lactate
- 2 sets blood cultures if febrile
- FBC, EUC, CRP, LFT, coags, LDH
- Baseline serum for storage for paired SARS-CoV-2 serology
- Bacterial pathogen testing
- CXR, ECG
- Depending on severity, can consider ferritin, troponin and CK
- Consider differential diagnoses and assess as per usual practice
- SOMANZ guidelines for the Investigation of Sepsis in Pregnancy https://obgyn.onlinelibrary.wiley.com/doi/pdf/10.1111/ajo.12646

Note: 2 or more of systolic blood pressure (SBP) <90mmHg, RR ≥25bpm, and altered mentation are **associated with poor outcomes** and should trigger ICU review. (*omqSOFA*)

INPATIENT MANAGEMENT OF PREGNANT WOMEN WITH SARS-CoV-2 INFECTION

General management

- Daily MDT review (ID, MFM, Obstetric Medicine, Anaesthetics, Midwifery)
- Maternal Observations (Use SMOC)
    - Q4h observations if **not** on supplemental oxygen
    - Continuous oxygen saturation monitoring and q1h observations, particularly respiratory rate, if on supplemental oxygen
- Supplemental O_2 if saturations <94%, begin with 0.5-3L/min
- DVT prophylaxis
- Paracetamol if pyrexic
- Antibiotics if suspected bacterial coinfection (hypoxaemic (<92%), pleural effusion or purulent sputum)
- Oseltamivir 75mg BD until negative influenza PCR
- Restrictive fluid strategies
- If hypotensive, administer 2 x 250ml fluid boluses and refer to ICU for vasopressor therapy if hypotension persists
- Avoid nebulisers, high flow nasal prongs and NIV
- Metered dose inhaler use is available

Daily management

- Monitor CRP, FBC, EUC, LDH and LFTs every 1-3 days, depending on severity
- Repeat CXR only if clinically indicated (e.g. if patient is deteriorating)
- Regular fetal and uterine contraction monitoring

URGENT ICU REVIEW

- Requiring ≥ 4L/min to maintain O2 saturations >94%
- rapidly worsening tachypnoea or hypoxaemia
- Haemodynamic instability

Aim for early intubation and ventilation in those who are deteriorating

Poor Prognostic Indicators

- Neutrophil to lymphocyte ratio >3.13
- Absolute lymphocyte count <0.8
- LDH >245 U/L
- Ferritin >300 ug/L
- CRP >100 mg/L
- D-dimer >1000 ng/mL
- Evidence of DIC
- Elevated troponin