ILPQC COVID 19 Webinar 4/24/20: OB Questions/Answers

Answers represent experiences and strategies related to caring for patients during the COVID-19 pandemic from individual providers and institutions, these example strategies are not meant to be recommendations unless national or state guidelines are referenced.

Questions submitted to Info Account & Registration and Chatbox

Testing

- Should an expectant woman test positive for COVID-19 how does this affect the fetus?
- Epidemiologic studies suggest that there may be an increased incidence of adverse pregnancy outcomes such as preterm birth and hypertensive disorders of pregnancy. Whether this represents selection bias (e.g. only individuals with more severe disease were tested) or a broader risk remains unclear.
- There has not been evidence to date of an increased risk of miscarriage or preterm labor to date, although indicated preterm delivery based on maternal status is not uncommon particularly late preterm. No evidence to date of structural abnormalities such as microcephaly , other CNS abnormalities, or hydrops resulting from the infection. Whether infection will place the pregnancy at risk for IUGR is also unknown.
- Based on very limited data, there is currently no evidence to suggest vertical transmission. Risk of miscarriage, preterm delivery and stillbirth has not been quantified given limited data.
- No known maternal-fetal transmission at this time.

- Is there any updates on antibody testing, and how it can be used to provide guidance for proving immunity?
  The clinical utility of antibody testing in the context of perinatal care is unclear.
  There are many antibody platforms, none approved by the FDA for clinical use as yet. We at Loyola are assessing several options to determine clinical utility. Because the predictive value of such antibody tests are unknown at this time, their use is not currently recommended to guide clinical decision making.
- Antibody tests exist and have not yet been validated for clinical use. Antibodies take 1-3 weeks to appear after infection and should not be used to diagnose acute infection. A positive antibody test may indicate prior exposure to SARS-CoV-2 or it may indicated prior exposure to another coronavirus. A specific, validated antibody test has not yet been created. FDA has granted Emergency Use Authorization for several tests that are now marketed and under study. They

have not been FDA-approved. The FDA fact sheet from April 17, 2020 can be found here https://www.fda.gov/media/137111/download

- Interested to hear discussion on the NEJM LTE on universal swabbing dated 4/13/20?
- I think we already talked about this, please see recorded webinar from 2 weeks ago for slides and discussion.
- Please see previous discussion on pros and cons for universal SARS-CoV2 testing for obstetric patients. Individual hospitals have made the decision based on testing capacity, presumed prevalence of disease in the community, turn-around time for the test, availability of PPE, test characteristics (sensitivity, specificity, positive and negative predictive value).

- Should universal testing for Covid be done for all women admitted to labor and delivery units? (I think I answered this last week). Please see the recordings and Q/A from last week's webinar.
- I think we already talked about this and our current pros/cons reasoning
- See previous questions.

- Is there a viral shedding period?
- Yes, there is a viral shedding period of about 4 days that precedes symptom development. Please see link to NEJM editorial and link to study of presymptomatic spreading in a skilled nursing facility in Washington State. https://www.nejm.org/doi/full/10.1056/NEJMe2009758
- Asymptomatic spread has contributed to the rapid increase of SARS-CoV2 infection and presents a compelling argument for universal masking of both patients and providers and universal use of droplet protections.

- Are rapid point of care test reliable? False neg. rate? Sensitivity rates? How does this differ across tests and institutions?
- Protections Sensitivity rates vary by rapid test, most institutions are testing rapid tests and determining testing characteristics before launch. Overall sensitivity with the rapid test is being reported around 70-80%, meaning that there are false negative tests. The negative predictive probability value depends on prevalence in the community and sensitivity of the test.

- Is there a link in the number of positive COVID-19 cases in pregnant patients at birthing hospitals (South side and South Suburbs) with IDPH data provided by zip codes?
- In our Loyola RPC and in our Trinity Health Chicago Hospitals (Loyola, MacNeal, Mercy) we are mapping the zipcodes for our CoVID OB patients.
- I do not have access to IDPH zip code data for COVID-19 cases.

- Is universal COVID-19 testing in L&D happening at all hospitals in Cook County and surrounding suburbs?

Seems to vary based on institution

Not all hospitals are performing universal screening in Cook County/suburbs. It is hospital dependent.

- For institutions with universal testing, what is the sensitivity of their test and turn around times? What % positive patients are you seeing at your institution?

Sensitivity 70-75% at Northwestern for the testing platforms we are using. TAT is 2-3h for testing done on admission, 6-8h for pre-admission testing. We are seeing 3-4% positive rates.

- We have just begun universal testing at Loyola, using the Cepheid test for unscheduled admissions and the m2000 for scheduled csections or inductions. Both are PVR tests, both with sensitivity over 90% reported in a laboratory setting. BUT we do not know our asymptomatic CoVID prevalence yet and that is going to impact the sensitivity and NPV of these screening tests. Turn around time for the Ceheid is an hour on the Loyola campus, for the m2000 not more than 24 hours as it is being run several times a day now.

Management of Positive Patients

- Given recent reports of heightened risk of abnormal coagulation / risk of clot for COVID 19 patient leading to significantly worse outcomes, how are units managing anticoagulation for positive pregnant prenatal patients (inpatient and outpatient) and positive pregnant postpartum patients (both inpatient and outpatient) and how long are units recommending anticoagulation postpartum?
- For pregnant women at low risk of delivery who are admitted with COVID-19, we are prophylactically anticoagulating with LMWH. For postpartum women, we are anti-coagulating for 7 days postpartum.
- At Loyola and MacNeal, we are recommending Lovenox 40mg SQ for two weeks following diagnosis for our outpatients. If inpatient there is a hospital wide Covid VTE algorithm that we follow regarding dosing and length of therapy. For our patients who are CoVID positive and deliver within two weeks of diagnosis Lovenox prophylaxis will continue at least two weeks postdelivery, and longer if other comorbidities are present.
- We currently do not have data and ACOG/SMFM have not yet made any recommendations. NorthShore has been recommending anticoagulation for hospitalized patients –including pregnant women with COVID-19—however the duration and dose seem to be individualized. Non-pregnant outpatients at elevated risk for thromboembotic events (Caprini score over 8) are recommended to maintain mobility and to have VTE prophylaxis for 2 weeks. Anticoagulation for pregnant women with COVID-19 who are managed as outpatients is currently under discussion.
- We recommend prophylactic anticoagulation. For inpatients we discontinue 24 hours prior to planned delivery. Postpartum anticoagulation will be same as for those type of patients who previously required prophylactic anticoagulation (thrombophilia, for example), so we recommend for 6 weeks postpartum.

- Is there a link in the number of positive COVID-19 cases in pregnant patients at birthing hospitals (South side and South Suburbs) with IDPH data provided by zip codes? Is universal COVID-19 testing in L&D happening at all hospitals in Cook County and surrounding suburbs?
- Already answered under Testing

PPE

- For hospitals who are not universal testing all pts are pts wearing a mask when a health care provider is in the room?
- NorthShore has asked all patients and partners in the room to wear a mask whenever interacting with health care providers.
- Yes. All patients and significant others wear masks when a health care provider is in the room.
- This is a discussion point for a meeting this week. We are not doing this as of yet. We do have some nurses asking for this to occur.

- PPE for symptomatic patient with negative POC Testing?
  This decision depends on the clinical suspicion for COVID-19, recognizing the imperfect test characteristics. For women who have a clinical picture congruent with COVID-19, either repeated testing should be performed or COVID-19 PPE utilized.
  Yes at Loyola
- At NorthShore, we use masks/gloves/goggles for all patient interactions given risk of asymptomatic spread. For PUIs, aerosol precautions are used. If the suspicion for COVID remains high despite negative initial testing, continuation of aerosol precautions would be considered. Respiratory precautions would be continued at minimum.
- We still treat ALL patients as if they are (+), so we employ universal PPE on L&D.
- Great question! At Amita Alexian Brothers, if negative we have not required pt to wear mask at this time- this may change by the end of the week however.

- What PPE is a ~~Dad~~ partner/support person given to wear in labor and then in the nursery if mom is covid positive?
- We do not permit partners for women who test positive for SARS-CoV2.
- NorthShore does not allow visitors for known Covid positive patients. If a partner/support person is with a PUI who returns as positive, the partner/support person is treated as a PUI. He/she is given a mask and asked to remain in the room and is provided meals. If he/she leaves, he/she is not allowed to return as a visitor.
- Surgical mask   gown face shield gloves and must stay in the room.

- Although many units are using N95 masks for 2nd stage of labor, Green Journal COVID PPE article states it is not aerosolizing?
- CDC has updated their guidance (https://www.cdc.gov/Coronavirus/2019-ncov/hcp/faq.html) and have clarified that 2nd stage/delivery do not generate aerosols to the same extent as procedures such as intubation.
- Whether the second stage of labor is considered an aerosolizing procedure remains controversial. The CDC states, "Based on limited data, forceful exhalation during the second stage of labor would not be expected to generate aerosols to the same extent as

procedures more commonly considered to be aerosol generating (such as bronchoscopy, intubation, and open suctioning)."

As a result of limited data, professional societies and experts have given varying recommendations.

Given risk of asymptomatic SARS-CoV2-infection and the proximity to patients during the second stage of labor for a prolonged time, NorthShore has opted to use aerosol precautions for all patients during the second stage of labor.

- We consider 2nd stage aerosolizing and employ N95 for 2nd stage and all C/S at SIU.
- We currently are using N95 for second stage and cesareans at Amita Alexian Brothers Med Center.

- What are the recommendations for pelvic exam PPE for asymptomatic positive patients? Symptomatic?
- Droplet/contact precautions (surgical mask should be sufficient in times of PPE scarcity). CDC has updated guidelines (https://www.cdc.gov/Coronavirus/2019-ncov/hcp/faq.html)
- Aerosol precautions for all exams for SARS-CoV2 positive patients (n95, gown and face shield/goggles) at NorthShore.
- Surgical mask on health care provider performing exam and surgical mask on patient at Amita Alexian Brothers

L&D

- Have teams found it difficult to communicate in OR or delivery rooms where staff member have to wear PAPRs or just added PPE in general?
- Yes it is very hard to hear
- Yes. Communication has become more difficult. It is more difficult to hear each other in the room and it is difficult to communicate with others outside of the room. Our Vocera communication is more difficult as well. Alternative strategies (speaker phones in the room and phone line outside the room) can be considered. Vigilant attention to communication/talk back techniques is recommended to ensure that communications are received.
- I have not noticed a difficulty in communicating with staff while wearing PAPR during vaginal delivery. It sounds like you are in an echo chamber, however, staff can hear fine.
- YES

- What have been some ways of helping out with communication?
- Hand signs, no extraneous noise
- Alternative strategies (speaker phones in the room and phone line outside the room) can be considered. Vigilant attention to communication/talk back techniques is recommended to ensure that communications are received.

- With more talk on asymptomatic Covid patients, are facilities still laboring in tubs?

- At NorthShore, our Covid-designated rooms are not our tub rooms so it has not been possible to offer that option.
- We don't allow laboring in tubs.

- how to separate infected patients or PUI from other negative patients, resources?
- We have 2 negative pressure rooms that are in antepartum unit that we will use if needed. We will convert all of antepartum to a COVID unit so as to keep entirely separate from other negative patients.
- We have designated rooms in the unit to use for Covid + patients and our covid plan then is initiated which includes all staff, health care workers and patient & visitor flow from a different door way with signage that directs them.

PUI

- For sites not using universal screening, for pregnant patients / patients presenting for L&D, are you testing for mild symptoms such as fever alone or nasal congestion / sore throat, or GI symptoms?
- At NorthShore, patients with the following symptoms upon presentation would qualify for consideration for testing: cough, shortness of breath, congestion, sore throat, runny now or muscle aches, anorexia, chills, headache, GI symptoms, fever 100 or greater, loss/decrease of taste or smell, contact with a confirmed COVID-19 person.
    - For any patient with mild symptoms, we are being proactive and have a very low threshold to test them. All testing must be approved by the hospital's COVID Command Center.

Postpartum

- I was wondering the status of hearing screens with COVID positive moms and PUIs. Are we deferring hearing screens in the neonate until after discharge? I am asking because Pediarix, the company we utilize, has asked us to defer until after discharge. I want to be certain we are compliant with the state and our APC admin has suggested I reach out to ILPQC and Dr Borders.
- The goal is to complete screening before discharge given the difficulty of obtaining hearing screening in a timely manner in the outpatient setting currently. The concern is that these babies will not have hearing screening completed. If Pediatrix has arranged for a timely outpatient option that can be scheduled prior to discharge, but otherwise this could lead to missed hearing screens. The goal is to complete all routine newborn screening prior to discharge per AAP recommendations.
- For those moms who test positive covid -19 if baby's first test is negative the company will now test the baby in a separate room from the mother. Also we have now set up one testing site to use for those who need repeat testing as an outpatient.

- COVID-19 Positive Breastfeeding Mothers How handling. I know this was shared before. But, again please?

- At NorthShore, we use a shared decision-making model. Moms may opt for separation or they may opt for rooming with baby using distancing precautions (separation of 6 feet, wearing a mask, hand hygiene). Breastfeeding is encouraged for COVID-19 positive mothers. If they are separated from baby, pumped milk (with careful cleaning of containers/supplies throughout the process of pumping and transfer of milk to baby). If they are breastfeeding directly, they are asked to practice droplet precautions (wear a mask) and diligent hand hygiene.
- Postpartum positive moms may breastfeed. They must wash their hands for at least 20 seconds prior to holding her newborn. She must also wear a mask. Lactation consultant is available to help in order to minimize risk of transmission to baby.
- We are supporting options for the parents at Amita Alexian Brothers. Allowing breast feeding with mask hand and breast hygiene or expressing milk and providing milk after cleaning outside bottles or transfer to clean bottle to baby. Healthy care giver encouraged to feed breast milk to baby.

- For shared decision making model around separation of mom/baby for Covid + patients vs rooming in and teaching mom safe separation in the room, can you talk about how this is going and especially for patients who are asymptomatic positive cases?
  When described as a measure to protect infant from potential for high viremia exposure given the unknowns, most women have been accepting of this exposure mitigation strategy.
  With our case we had the mother decided to separate from the baby. The baby was brought to her room for periods of time in an isolette. She also decided to not take the baby home with her as both her and her husband were positive. Another PUI case we had the pedestrian really wanted the baby in separate room- the mom and dad agreed with that. Another PUI we had was on the Mother Baby unit and the baby was already in the room. We kept the baby in the room and did the 6 foot distancing and had both mom and dad wear a mask. Each case is different.

- Recommendation for asymptomatic COVID+ mothers for rooming in/having significant other present?
  We (at Northwestern) continue to recommend against this practice in order to mitigate exposure.

- Is there any evidence in IL's experience about benefit of mother/newborn separation with respect to preventing newborn infection?
- This was discussed on last week's webinar during the neonatal discussion. It was reported that New York has reported transmission to neonates from mom, however, this data is limited. Please see the recording of last week's webinar for this discussion.

- We do universal testing of our laboring moms and scheduled cases and we've been discussing testing dad/significant other as well but wanted to know what others were doing in regards to baby being discharged to a mom who is positive. Our dilemma here also is that in our area many of our families have many adults that live at home with them and we can't test everyone?
  We are not currently testing family members, but working on risk reduction strategies.

Recovery

- NWMH question: for prior COVID+ pt between 14-40 days (drop/contact in hosp), what is your AG for home? Does mom need mask at home until 40 days?
- We would recommend masking while symptomatic. There is no clear recommendation for the duration that masking is required, but education on exposure mitigation should be performed

- Are COVID positive mothers allowed to enter the hospital for visiting or discharge if their newborns are not in the NICU?
- COVID positive mothers are not allowed in the hospital until they meet criteria, > 7 days from positive test and > 72 hrs from improved symptoms. Have also used a 14 day criteria for the NICU.
- Please see recorded webinars for further discussion on this topic.