SSM Maternal Fetal Medicine Interim Guidelines – COVID-19 Response
Updated: April 2nd, 2020

I. Magnesium Sulfate in the Context of COVID-19

- Magnesium for neuroprotection
    - Eligibility: Women at risk for imminent preterm birth (risk of delivery within 24 hours) who are <32 weeks 0 days.
    - The used of magnesium sulfate for neuroprotection is discouraged in women who are (1) COVID positive with symptoms or (2) PUI with respiratory symptoms
    - In general, the benefits of magnesium sulfate for neuroprotection should be weighed against the potential risks of maternal respiratory distress depression. Therefore, in women with increasing oxygen requirement, magnesium sulfate for neuroprotection should be deferred given the likely limited benefit in light of the increased risk.

- Magnesium for seizure prophylaxis
    - For women with preeclampsia without severe features, suggest avoiding magnesium sulfate.
    - Dose/Rate: unchanged based on local institutional standards and protocols.
    - For women with renal dysfunction, dosage and fluid administration should be adjusted accordingly.
        - Example: Stand loading dose with adjusted hourly rate (1/g hour if creatinine is > 1.1 and < 2.5 mg/dL and no maintenance dose if creatinine >2.5 mg/dL.

II. Antibiotic Therapy with Azithromycin

- PPROM (<34 weeks)
    - Substitute with 1 (one) time dose of Azithromycin 1g PO
    - No additional PO doses of Azithromycin suggested.
    - Continue standard dosing regimen:
        - Ampicillin 2g IV every 6 hours for 48 hours, followed by:
        - Amoxicillin 875mg PO every 12 hours or 500mg PO every 8 hours for 5 (five) additional days.
- Cesarean Deliveries (in labor or with rupture membranes)
    - Discontinue use of IV Azithromycin (500mg) until the shortage is resolved.
    - Continue routine prophylaxis per institutional protocols and standards

III. Steroids for Fetal Lung Maturity

- **Betamethasone (glucocorticoids), <34w0d**

    - **<u>Asymptomatic patients and those NOT under investigation:</u>**
        - Considered use for the usual obstetric indications in those who are <34 weeks and have no symptoms or exposures.
        - Obtain a thorough history and ask about any sick contacts prior to proceeding with betamethasone.

    - **<u>Persons under investigation, COVID-19 positive and/or critically ill:</u>**
        - <u>Avoid routine glucocorticoid use.*,</u> especially >32 weeks, and in patients critically ill and/or requiring oxygen.
        - If intensivist or pulmonologist deems steroids are necessary for another indication, then consider using a glucocorticoid that has transplacental passage (betamethasone, dexamethasone) if feasible.

- * *These guidelines are intended to decrease the risk of maternal harm and decompensation. Certain clinical situations will need to be assessed on a case-by-case scenario. If delivery is imminent, then evaluate gestational age, overall clinical situation and have discussion of risks and benefits. Use of steroids will need to be individualized in some clinical situations, as there is insufficient data to guide precise recommendations.*

    - **Second Course Betamethasone**

        - Eligibility:
            - Asymptomatic patients, not under investigation and/or known COVID-19 negative
            - Clinically estimated to be at high risk of delivery within the next 1-7 days.
            - Prior exposure to antenatal corticosteroids at least 14 days earlier

IV. NSAIDs

- While some have suggested avoiding the use of nonsteroidal anti-inflammatory drugs (NSAIDs) for symptoms suggestive of COVID-19 infection, this practice is controversial and lacking data.

- Tocolysis

    - It is reasonable to consider nifedipine for tocolysis.
    - The use of any tocolytic should be limited to no more than 72 hours (e.g. through betamethasone optimization/steroid benefit).

- Postpartum
    - While some have suggested avoiding the use of nonsteroidal anti-inflammatory drugs (NSAIDs) for symptoms suggestive of COVID-19 infection, this practice is controversial and lacking data.
    - At this time, women who are asymptomatic or mildly symptomatic that require analgesic medication beyond acetaminophen, NSAIDs can continue to be used versus opioids.

Disclaimer: This information is designed as a resource to aid clinicians in providing obstetric care. This information should not be considered as inclusive of all proper treatment or methods of care as a statement or the standard of care. It is intended to substitute for the independent professional judgement of the treating clinician. Variation is practice may be warranted when, in the reasonable judgement of the treating clinician, such course of action is indicated by the condition of the patient, limitations of available resources, or advances in knowledge or technology.