SOON-ObGyn COVID-19 Meeting

Thursday, March 19th, 2020, 6:00 – 7:00 pm
Virtual Meeting via ZOOM

Attending: 52 attendees

AGENDA

Meeting begins at 6:10PM.

Question and answer period begins:

For the low risk pregnancy, what should we all be doing in regards to confirmed cases? Delaying antenatal care? How long or until what criteria? We should all do the same thing so that becomes the standard of care during the pandemic.

Current information on COVID-19 describes it as a droplet disease, therefore hospitals/clinics should take droplet precautions. Pregnant women should still be seen, but in-person appointments can be reduced using other methods such as telemedicine. First trimester screening should still be in-person and anatomy ultrasound should also be done. Most of other visits can be done via phone or video call. Sunnybrook's Information Sheet for Pregnant Patients contains information that may be useful for this question.

Should the 12-week ultrasound still be booked?

> **ACTION:** Dr. Nan Okun will be developing a response for this question. Dr. Okun requests that any practitioner with an opinion should send her an email at nan.okun@sinaihealth.ca.

Currently, Droplet Precautions are being recommended other than for aerosol generating procedures. What are the thoughts about a confirmed COVID-19 patient in the 2nd stage? (The amount of deep breathing, panting) Should team members in the room be using N95 masks or just droplet precaution?

Current information describes COVID-19 as a droplet disease, therefore droplet precautions should be acceptable. However, procedures such as general anesthesia, intubation and other aerosol procedures may require an N95 mask. Panting is not considered an aerosol procedure, so you would not need to have an N95 for that stage of labour. It could be a waste of N95 masks if used for every procedure. The SOGC currently stands by droplet precautions.

Should we be separating baby from positive mother (SOGC has said to keep together, ACOG + SMFM (US) are saying separate)?

The recommendation is to follow the SOGC guidelines. If mother is well and baby is well there is no need to separate them. If the mother or baby display mild symptoms and are relatively well, they can be kept together. However, if either mother or baby is unwell, they should be separated with baby being taken to the nursery. If the mother has been infected, anyone who has been in close contact with them is considered exposed, and therefore should not have access to the newborn. This can include partners, birthing coaches, relatives and friends who have been in close contact while the mother has been sick. If there is a relative or friend of the parent(s) that have not been in close contact with the sick mother or sick others, they can have contact with the child and can take them out of the hospital, if need be. A healthy person can provide breast milk during the time that the sick mother is unable to do so.

Why no delayed cord clamping? Our neonatologist can find nothing in the literature to support this.

Guidelines say that there is no need to delay cord clamping. However, cord milking is strongly discouraged!

Do you really want all < 32 weekers at a level 3? Can the 2c's continue to keep > 30's?

Transfer of the baby should be the same and should not change because of the COVID-19 situation.

What fetal assessment will you recommend for a Covid positive person who is 32 weeks at time of diagnosis and well enough to remain home?

The guideline says that a pregnant woman's fetus is not at a high-risk for COVID-19. However, if the mother is sick, it may be a good idea to do a fetal assessment. If her symptoms are mild, there is no need to do an assessment. A good rule of thumb is to manage a mother with COVID-19 like you would a mother with a respiratory illness.

Should practitioners use Nitrous oxide?

Many hospitals do not use nitrous oxide in general. It is recommended that those who still use it should stop as it is an aerosol risk.

What should we do when staff get sick?

Some parts of the world say that they should come to work anyway. Hopefully Canadian institutions will not come to that. The best answer is to try and have your staff manage their workload.

What should hospitals do with pregnant staff?

According to the SOGC, they should not be treated any differently. It has been shown that COVID-19 has less of an effect on pregnancy than MERS and SARS. The SMFM also says that pregnant women can keep working, unless they feel unwell.

What gynecology procedures should hospitals look at cancelling?

Most hospitals are not doing elective surgeries. Some procedures that are still going ahead include cancer procedures. Hospitals and clinics are choosing to do telephone or OTN appointments for gynaecology instead. It is believed that laparoscopic procedures can increase risk of COVID-19 due to aerosol. Some hospitals are also choosing to not have surgeons in the room during intubation. Some hospitals are cancelling all surgeries except for those approved by their operating committees. OTN is a good resource to connect with patients. Sinai and NYGH will also still be providing services for pregnancy termination, as community access is becoming more limited.

Provincial Council for Maternal and Child Health will be creating a repository for information on COVID-19, if anyone would like to submit information. The UofT ObGyn website also contains a webpage dedicated to COVID-19 resources for ObGyns. Dr. Jon Barrett encourages anyone with questions about COVID-19 and ObGyn to email him at jon.barrett@sunnybrook.ca.

Meeting ends at 7:07PM.