Technical Taskforce of Corona in Pregnancy- Lebanon

COVID-19 Virus Infection and Pregnancy

Quick reference for OBGYN and Health Facilities

This booklet is prepared by the Technical Taskforce of Corona in Pregnancy- Lebanon as part of Q&A series related to COVID-19 infection and role of OBGYN and Health Facilities

April 2020

مقدمة

تعمل اللجنة الوطنية التقنية للكورونا والحمل في وزارة الصحة العامة على إعداد بروتوكولات وطنية موحدة تتعلق بمتابعة الحمل والطلق والولادة وما بعد الولادة للمصابات او المشتبه بإصابتهنّ بالكورونا، وذلك لتوحيد وتسهيل الأعمال الطبية للزميلات والزملاء. كما وتعمل أيضًا على إعداد مواد تدريبية لتدريب الزملاء من خلال ورش عمل عن طريق تقنيات التواصل المعلوماتية، اضافة الى مواد تثقيفية تحاكي تساؤلات الحامل وأسرتها فيما يتعلق بالحماية والمتابعة والممارسات الصحية اليومية. كما وتعمل اللجنة على رصد ومتابعة حالات الحمل المصابة بالكورونا لضمها الى السجل الوطني للإحصاء.

المعلومات حول كورونا تتجدد بشكل دوري وسريع وتتغير معها بعض الارشادات. سوف تصلكم الموارد من اللجنة تباعًا بحسب الدراسات والأدلة التي يتم تجديدها وتحديثها.

تتطلع اللجنة الى تعاونكم واقتراحاتكم في هذا المجال.

د فيصل القاق

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I. General Issues

Q 1: How should visitation rules be modified in the setting of the COVID-19 pandemic?

Modifications to visitation policies should be made on an individual facility level based on community spread and local and state recommendations. In both the inpatient and outpatient setting, it is recommended that the number of visitors be reduced to the minimum necessary.

Q 2: Should pregnant patients wear a mask?

Pregnant patients should follow the same recommendations as the general population with regard to wearing a mask. Masks should only be worn by those experiencing symptoms of COVID-19 or those with confirmed COVID-19 when they are in public or around other individuals.

DISCLAIMER: Technical Taskforce of Corona in Pregnancy- Lebanon has developed this guidance to aid good clinical practice and clinical decision-making. It is based on the best evidence available at the time of writing, and the guidance will be kept under regular review as new evidence emerges

II. Responsiveness: Personnel, Staffing, and Resources

Q 1: Should pregnant health care personnel be transferred to roles where they are not providing in-person patient care to help reduce their risk?

Based on limited data regarding COVID-19 and pregnancy, current data does not propose creating additional restrictions on pregnant health care personnel because of COVID-19 alone. Pregnant women do not appear to be at higher risk of severe disease related to COVID-19. Pregnant health care personnel should follow CDC risk assessment and infection control guidelines for health care personnel exposed to patients with suspected or confirmed COVID-19. Adherence to recommended infection prevention and control practices is an important part of protecting all health care personnel in health care settings.

Facilities may want to consider limiting exposure of pregnant health care personnel to patients with confirmed or suspected COVID-19 infection, especially during higher-risk procedures (e.g., aerosol-generating procedures), if feasible, based on staffing availability.

Q 2: How can facilities prepare obstetric care providers to respond to COVID-19?

Hospitals that provide maternity services should create, or- if already established- mobilize their perinatal subcommittee in charge of disaster preparedness (likely to include representatives from obstetric, pediatric, family medicine, and anesthesia teams among others).

In some areas with high prevalence and community spread, a shortage of obstetric health care personnel may occur. Regardless of whether an area is currently experiencing wide community spread, ACOG encourages all facilities to begin strategizing how to expand their obstetric work force. Facilities should consider rapid credentialing and privileging of temporary obstetric care providers not currently practicing obstetrics to enable augmentation of the work force, retraining these individuals as necessary, and ensuring proper insurance coverage.

Additionally, if not already doing so, facilities are encouraged to find innovative ways to collaborate with family physicians, midwives, and other obstetric care professionals.

Q.3: How can elective procedures be managed to optimize personnel and resources?

In areas where COVID-19 is particularly prevalent or where there is particular stress on the health care system, it may be advantageous to identify and modify surgical scheduling, including for procedures that are medically indicated, when a patient's health and safety would not be harmed by such delay.

For obstetrics, it may be appropriate to temporarily consider tubal sterilization only when performing cesarean birth (unless the patient is considered high-risk) and all others as elective, so long as an alternative form of contraception is provided (e.g., immediate postpartum long-acting reversible contraception), if desired by the patient. However, any decision regarding which procedures to consider elective should be made on a local and regional level, considering the risks and resources specific to each area. Obstetric and gynecologic procedures for which a delay will negatively affect patient health and safety should not be delayed. This includes gynecologic procedures and procedures related to pregnancy for which delay would harm patient health.

III. Antenatal Care

Q 1: Is it appropriate to modify prenatal care delivery to decrease the risk of COVID-19 spread and exposure?

Yes. Alternate prenatal care delivery approaches have been proposed as a strategy in the effort to control the spread of COVID-19 among patients, caregivers, and staff. Although evidence is limited regarding the safety and efficacy of these approaches, ACOG recognizes the need to implement innovative strategies during this rapidly evolving public health emergency, with consideration of differences in care settings and population risks. Any decision to modify prenatal care delivery should be made at the local and individual level.

- Obstetrician–gynecologists and other obstetric care providers should continue to provide medically necessary prenatal care, referrals, and consultations.
- Obstetric care providers should be prepared to explain the rationale for any change in prenatal care or delivery scheduling, emphasizing that these modifications have been made in order to limit the risk of exposure to the virus for the mother and the fetus or infant.
- It is recommended that the patient–physician discussion regarding a plan for alternate prenatal care in the setting of the COVID-19 pandemic be documented in the medical record.

Some examples of approaches to modifying prenatal care that may be considered are listed below. However, modifying or reducing care is only appropriate because the risk of inadvertent exposure from receiving or delivering care can be high at this time; normal care approaches and schedules should resume when this risk subsides. Plans for modified care are best made at the local level with consideration of patient populations and available resources.

- Spacing out appointments.
  - Health care providers may choose to continue in-person prenatal care appointments for patients who are not sick, if staffing is available, but space out in-person appointment times where appropriate to reduce the number of patients in the office or facility at one time.
  - This may be accompanied by postponing some nonemergent gynecologic or well-woman appointments to facilitate social distancing and to maintain availability to accommodate medically necessary appointments; appointments for which a delay will negatively affect patient health and safety should not be delayed.

- Alternate or reduced prenatal care schedules.
    - Consider grouping components of care together (e.g., vaccinations, glucose screenings, etc) to reduce the number of in-person visits.
    - Examples of alternate or reduced prenatal care schedules are listed below as resources. These examples are shared with the express permission of their developers, and without identification when requested.

Q 2: Can telehealth communication strategies help assist obstetric care delivery?

- Yes, many medical societies encourage practices and facilities that do not yet have the infrastructure to offer telehealth to begin strategizing how telehealth could be integrated into their services as appropriate. Make sure of the client ability to access telemedicine fairly to ensure equitable care. Refer to Lebanese Order of Physicians (LOP) president statement

Q 3: Should I screen patients before they come in for face-to-face clinic appointments?

Health care providers can also consider an approach (phone, telehealth) to implement routine screening of patients, and their guests if permitted, for potential exposure or COVID-19 symptoms (cough, sore throat, fever) before face-to-face clinic appointment to prevent any potential persons under investigation (PUI) from entering the facility. Patients should be instructed to call ahead and discuss the need to reschedule their appointment if they develop symptoms of a respiratory infection (cough, sore throat, fever) on the day they are scheduled to be seen. This can be done through phone calls before appointments asking about: recent travel, potential exposure, and symptoms. It is advisable to communicate proactively with all patients (via email, text, recorded phone calls) advising individuals with possible exposure to or symptoms of COVID-19 to call the office first. Additionally, health care providers should confirm whether a person is currently undergoing testing for COVID-19.

If, after screening, the patient reports symptoms of or exposure to a person with COVID-19, that patient should be instructed not to come to the health care facility for their appointment and health care providers should contact the local or state health department to report the patient as a possible person under investigation (PUI).

Q 4: Which antenatal fetal surveillance and ultrasound examinations are essential to continue as recommended?

Antenatal fetal surveillance and ultrasonography should continue as medically indicated when possible. Elective ultrasound examinations should not be performed, and ultrasonography should be used prudently and only when its use is expected to answer a relevant clinical question.

It may be appropriate to postpone or cancel some testing or examinations if the risk of exposure and infection within the community outweighs the benefit of testing. However, this should be a decision made at the local practice or facility level, balancing the risks and benefits of decreased exposure, completing the test, and site capacity. As with other components of prenatal care, reducing care is only appropriate because the risk of inadvertent exposure from receiving or delivering care can be high at this time; normal antenatal testing or ultrasonography scheduling should resume when this risk subsides.

Any modifications made to care should be relayed to patients with a discussion of the altered balance of risks and benefits of coming to the office for testing or ultrasonography in the setting of a global pandemic, and should be documented in the medical record.

Q 5: Are there any special considerations regarding use of low-dose aspirin or other nonsteroidal anti-inflammatory drugs (NSAIDs) during pregnancy or the postpartum period in a patient with suspected or confirmed COVID-19?

Reports suggest that the use of NSAIDs, such as ibuprofen, could worsen COVID-19. ACOG. Currently, ACOG is not aware of scientific evidence connecting the use of NSAIDs, like ibuprofen, with worsening COVID-19 symptoms. Low-dose aspirin should continue to be offered to pregnant and postpartum women as medically indicated. For patients with suspected or confirmed COVID-19 for whom low-dose aspirin would be indicated, modifications to care may be individualized.

Q 6: How should I counsel patients who are considering home birth because of concerns about COVID-19?

Although recognizing that many patients are experiencing new concerns because of the COVID-19 pandemic, ACOG continues to recommend following existing evidence-based guidance regarding home birth. Please see Committee Opinion 697, *Planned Home Birth,* for additional guidance, including counseling regarding risk and benefits and absolute contraindications.

Q 7: Additional components to prenatal care that should be considered?

- Offer mental health or social work services or referrals to provide additional resources, particularly for patients who are experiencing anxiety regarding the COVID-19 pandemic or are at an increased risk of intimate partner violence.
- Provide enhanced anticipatory counseling to patients regarding:
    - Any potential changes to length of hospital stay and postpartum care.
    - How to best communicate with their obstetric care team, especially in the case of an emergency.
    - Signs and symptoms of labor and when to call their obstetric care provider.
    - Any special considerations for infant feeding.
    - Checking with their pediatric provider or family physician regarding newborn visits because pediatric providers or family physicians also may be altering their procedures and routine appointments.
    - Postpartum contraception. Ideally, all methods of contraception should be discussed in context of how provision of contraception may change within the limitations of decreased postpartum in-person visits. For patients who express interest in postpartum contraception, providers should discuss the additional benefit of immediate postpartum long-acting reversible contraception (LARC): an additional visit for placement is not needed and placement is not resource intensive. (For information on tubal sterilization, please see **How can elective procedures be managed to optimize personnel and resources?**)
    - Any potential changes to their postpartum care team and support system. Most patients will likely have had changes to expected care support resources at home (family who can no longer travel, childcare providers who are no longer available). To the extent possible, patients should be connected to community support resources.

It should be noted that it may be necessary to provide these services or other enhanced resources by phone or electronically where possible. If telehealth visits are anticipated, patients should be provided with any necessary equipment (blood pressure cuffs) if available and as appropriate.

IV. Intrapartum Care

When a pregnant patient with suspected or confirmed COVID-19 is admitted and birth is anticipated, multidisciplinary team to be notified (obstetric, pediatric, and anesthesia teams).

Q 1: What about COVID-19 and delivery timing?

Timing of delivery, in most cases, should not be dictated by maternal COVID-19 infection. For women with suspected or confirmed COVID-19 early in pregnancy who recover, no alteration to the usual timing of delivery is indicated. For women with suspected or confirmed COVID-19 in the third trimester who recover, it is reasonable to attempt to postpone delivery (if no other medical indications arise) until a negative testing result is obtained or quarantine status is lifted in an attempt to avoid transmission to the neonate. In general, COVID-19 infection itself is not an indication for delivery.

Q 2: Is COVID-19 (suspected or confirmed) considered an indication for cesarean delivery?

No. Currently, based on very limited data on patients delivered primarily by cesarean deliveries, there does not appear to be a risk of vertical transmission via the transplacental route. Additionally, based on limited data, outcomes for individuals appear to be similar between pregnant and nonpregnant patients. Cesarean delivery should therefore be based on obstetric (fetal or maternal) indications and not COVID-19 status alone.

In the event that an individual should request a cesarean delivery because of COVID-19 concerns, obstetrician–gynecologists and other obstetric care providers should follow ACOG's guidance provided in, *Cesarean Delivery on Maternal Request.*

Q 3: How can scheduled inductions of labor or cesarean deliveries be managed to optimize personnel and resources?

Inductions of labor and cesarean deliveries should continue to be performed as indicated. Decisions on how to schedule these procedures in the time of the COVID-19 pandemic are best made at the local facility and systems level, with input from obstetric care professionals and based on health care personnel availability, geography, access to readily available local resources, and coordination with other centers.

Q 4: Is delayed cord clamping still appropriate in a patient who has suspected or confirmed COVID-19?

Yes, delayed cord clamping is still appropriate in the setting of appropriate provider personal protective equipment. Although some experts have recommended against delayed cord clamping, the evidence is based on opinion; a single report later confirmed COVID-19 transmission most likely occurred from the obstetric care provider to the neonate. Current evidence-based guidelines for delayed cord clamping should continue to be followed until emerging evidence suggests a change in practice.

Q 5: How should umbilical cord blood banking be managed during the COVID-19 pandemic?

Respiratory diseases are typically not transmitted by the transfer of human cells. Currently, there are no reported cases of transmission of COVID-19 by blood products; therefore, umbilical cord blood banking can continue to be managed according to clinical guidance, in the setting of appropriate provider personal protective equipment. A variety of circumstances may arise during the process of labor and delivery that may preclude adequate cord blood collection. Umbilical cord blood collection should not compromise obstetric or neonatal care or alter routine practice of delayed umbilical cord clamping with the rare exception of medical indications for directed donation.

V. Postpartum Care

Q 1: Should expedited discharge be considered during the COVID-19 pandemic?

Yes. To limit the risk of inadvertent exposure and infection, it may be appropriate to expedite discharge when both the mother and the infant are healthy. For example, discharge may be considered after 1 day for women with uncomplicated vaginal births and after 2 days for women with cesarean births depending on their status. Early discharge will require discussion with the facility's pediatric care team and should be linked to home telehealth visits for the mother and infant.

Q 2: Additional components to postpartum care that you may consider? Check Q7 ANC

It should be noted that it may be necessary to provide these services or enhanced resources by phone or electronically where possible. If telehealth visits are anticipated, patients should be provided with any necessary equipment (e.g., blood pressure cuffs) if available and as appropriate.

Q 3: Is it appropriate to modify postpartum care delivery approaches to decrease the risk of COVID-19 exposure?

As with prenatal care, yes (see **Is it appropriate to modify prenatal care delivery to decrease the risk of COVID-19 spread and exposure?** for important considerations). However, modifying or reducing care is only appropriate because the risk of inadvertent exposure from receiving or delivering care can be high at this time; normal care approaches and schedules should resume when this risk subsides. Plans for modified care are best made at the local level with consideration of patient populations and available resources. Some examples of approaches to modifying postpartum care that may be considered are listed below.

- Perform the initial three week (or sooner) assessment, wound checks, and blood pressure checks by phone or telehealth visits, if possible.
- Delay the comprehensive postpartum visit to 12 weeks, with the intention of seeing the patient for the comprehensive assessment in person and using telehealth visits as needed before 12 weeks. However, it should be noted that some patients may lose insurance before 12 weeks postpartum; in this case, the comprehensive postpartum visit should be prioritized and scheduled before the patient loses insurance and also can be completed by telehealth visit.

VI. References (up to April 2020)

https://www.acog.org

https://www.acog.org/clinical-information/resource-center

https://www.who.int

VII. Acknowledgement

Faysal El Kak	Development and Editing
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Eli Attieh	Revision
Rabih Chahin	Revision
Saad Itani	Revision
Rana Skaf	Revision
Toni Zreik	Revision