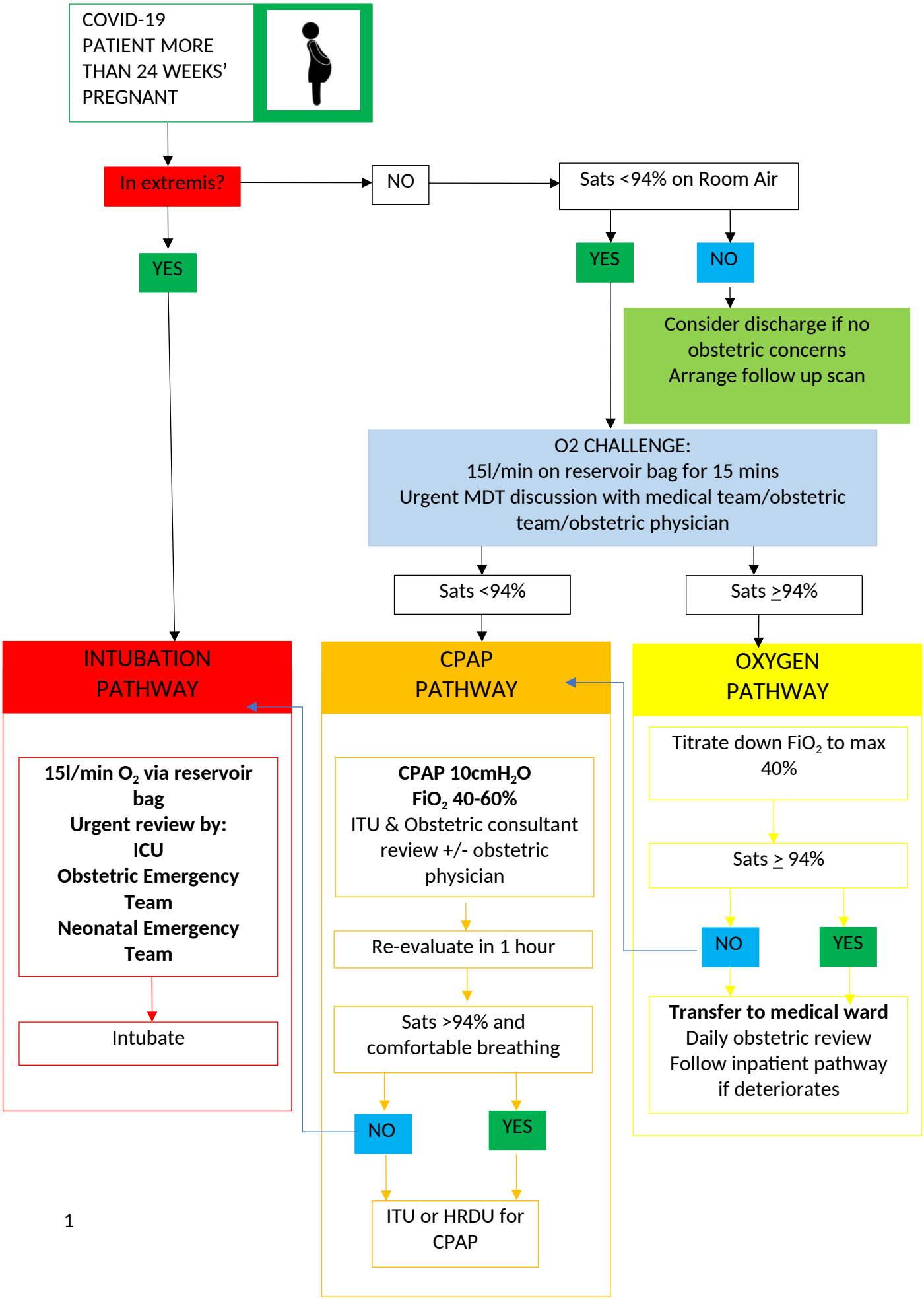
Figure 3: Proposed pathway for respiratory support in a pregnant woman with SARS-CoV2 infection



Considersations for Inpatient management of Pregnant Woman with COVID-19

- Prior to 24 weeks', consider treatment similar to non-pregnant patients.
- After 24 weeks' gestation the medical and obstetric teams should make a decision on treatment, mode and timing of delivery should considering the points below:

ACTIONS FOR THE MEDICAL TEAM:

- Pregnancy and COVID infection are both risk factors for thromboembolic disease. All pregnant women with SARS-CoV2 infection who are admitted to hospital should receive thromboprophylaxis with low molecular weight heparin.
- In a woman with prolonged or severe hypoxia, clinicians should have a low threshold for undertaking bilateral leg dopplers and/or CTPA to look for venous thromboembolism. Treat with treatment-dose LMWH while awaiting imaging. D-dimers and clinical risk scores such as the Wells Score are not useful in pregnancy, so clinical suspicion around venous thromboembolism must be used. For modern CT scanners, fetal radiation exposure is very low (0.05-0.5mGy); exposure to the maternal breast is 3-10mGy. This gives a theoretical increased life-time risk of breast cancer of 1.0003-1.0007 compared to the background rate.
- Women requiring oxygen therapy should be offered systemic steroids. Dexamethasone 6mg daily for 10 days should be offered, but a decision on timing of childbirth to take account fetal wellbeing must conside gestation of pregnancy with obstetricians and neotatologists (see discussion).
- Prior to discharge, ensure that the woman does not desaturate <94% on room air on exercise, and consider discharge with a home pulse-oximeter and advice to reattend if sats <94% on air.
- Ensure all pregnant women admitted with SARS-CoV2 are discharged with an appropriate supply of prophylactic LMWH. This is for a minimum of 10 days post-partum regardless of delivery method, and 10 days after discharge following an admission for any other reason.

ACTIONS FOR THE OBSTETRIC TEAM:

For all pregnant women over 24 weeks' gestation admitted due to COVID-19, the obstetric team should:

- Assess for any maternal or fetal concerns regarding the pregnancy (including, but not limited to, co-existent pre-eclampsia, previous delivery methods, risk of pre-term delivery and fetal growth).
- Arrange daily fetal monitoring (by CTG or ultrasound scan as appropriate).
- Document plans regarding timing and mode of delivery, recognising childbirth does not necessarily improve respiratory function in pregnant women with pneumonia and ARDS.
- Document requirements for magnesium sulphate (for neonatal neuroprotection) and dexamethasone/betamethasone (for fetal lung maturation).
- If the pregnancy continues after recovery from COVID-19, ensure fetal growth scan is arranged for two weeks' after discharge from hospital.