**COVID-19 Inpatient Obstetric Care Guidelines**

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**Delivery and Postpartum**

Only send placenta to pathology for history of COVID-19 in the pregnancy if patient was hospitalized.

Do NOT consider the history of COVID-19 during the pregnancy as a single risk factor when completing the VTE assessment postpartum.

**Admit/Transfer**

* Admit > 20 weeks gestation.
* **Grand Rapids** - Admit to the OB service on antepartum floor with MFM consult. Consult ID if indicated.
* **Regions** – Admit to either the OB service with medicine consult or medicine with OB consult (varies by location).
* Admit < 20 weeks gestation – Admit to medicine service with OB consult

**General Admission Criteria for non-obstetrical related admission**

Severe and critical categories merit inpatient admission (see below)

**Classification of Disease Severity by NIH**

* **Asymptomatic**: SARS-CoV-2 test (+) with no symptoms
* **Mild**: usual signs or symptoms **without** SOB, dyspnea, or abnormal chest imaging
* **Moderate**: added e/o lower respiratory dx (clinically or by imaging) but SaO2≥94% on RA
* **Severe**: RR >30 bpm, SaO2<94% on RA, Pa/FiO2 <300 or lung infiltrates >50%
* **Critical**: respiratory failure, septic shock and/or multiple organ dysfunction

Symptoms present: Admit patient to Obstetrics > 20 weeks or medicine if < 20 weeks if severe or critical illness. (Do not follow for asymptomatic, COVID-19 + patients)

Discharge criteria:

* Patient on room air, has mild symptoms
* If pregnant, reassuring fetal well being
* See full [Discharge Readiness Criteria](https://spectrumhealth.sharepoint.com/:w:/r/sites/disaster-preparedness/_layouts/15/Doc.aspx?sourcedoc=%7B57F53065-DF46-474F-9B6C-F1EF969B327B%7D&file=COVID-19%20Discharge%20Readiness%20Criteria.docx&action=default&mobileredirect=true) on InSite

**With any new O2 requirement consider:**

* Start corticosteroids
  + <23 weeks or ≥37 weeks: dexamethasone 6mg qd x 10d
  + 23-36w6d: dexamethasone 6mg bid x 2d, followed by methylprednisolone 32mg qd x8d
  + Can discontinue after 10d or upon hospital discharge, whichever comes first
* Add azithromycin if evidence of pulmonary infiltrates; add ceftriaxone only if microbial evidence of bacterial pneumonia
* Start remdesivir (200mg IV x1d + 100mg IV QD x4 d)
* Other therapies per ID consultation (eg tocilizumab, baricitinab)
* Prone positioning for any patients with PaO2/FiO2 <150 mmHg for 2-3 hrs. per shift; NST before and after prone positioning

**For all COVID patients:**

* No maintenance IV fluids; no boluses unless clear evidence of septic shock
* Consider dose of Lasix for patient that is normotensive and requires oxygen
* Start prophylactic heparin for VTE prophylaxis while inpatient. Dosing: 5000 U bid (1st trim), 7500 U bid (2nd trim) and 10,000 U bid (3rd trim) (please refer to Ambulatory Antepartum COVID-19 Care Guidelines for outpatient anticoagulation regimen)
* Consider using Magnesium sulfate regimen for neuroprotection if <32 weeks
* Use normal postpartum pain management regimen (NSAIDs are okay to use)
* **Baseline:** CBC with diff, CMP, CK, CRP, D-dimer, coags (PT/PTT/fibrinogen), LDH, troponin; EKG and CXR

If sepsis suspected add lactate, procalcitonin and BCx/UCx/VagCx

* **Daily:** CBC with diff, CMP; trend any above if abnormal
* **Continuous**: O2 via nasal cannula; titrate to SpO2 ≥ 95% (surgical mask over nasal cannula)

If using > 3L O2 or progressed to worsening illness, discuss with MICU