

AOFOG statement on COVID 19 in pregnancy: June 2020

Since the publication of the last statement in March 2020 there is no substantial change in the course of COVID-19 infection-related changes in pregnant women. Available data suggest the majority of pregnant women were asymptomatic and only a minority were with a mild or severe disease condition. Most of the available clinical findings were originated from women in the third trimester and COVID-19 infection on the fetus in the first and second trimester or in patients of moderate to severe disease is unknown. Hence screening of confirmed and recovered cases for long term follow up with mothers and neonates are encouraged.

The interim report from the UK Obstetric Surveillance System (UKOSS), 2.5% of babies (n=6) had a positive nasopharyngeal swab within 12 hours of birth. In a systematic review of 24 pregnant women with COVID-19, there was no evidence of SARS-CoV-2 on PCR testing of placenta, amniotic fluid, cord blood or breastmilk samples. Histopathological changes in COVID-19 placentas show increased prevalence of decidual arteriopathy and other features of maternal vascular malperfusion a pattern of placental injury reflecting abnormalities in oxygenation within the intervillous space associated with adverse perinatal outcomes. These changes may reflect a systemic inflammatory or hypercoagulable state influencing placental physiology.

Moreover, it is important to note that evidence for no vertical transmission to date is all based on the late stages of pregnancy; whether intrauterine vertical transmission could happen during the first or second trimester is still unclear. Further investigation around vertical transmission is required. All pregnant women with or recovering from COVID-19 should be provided with counselling and information related to the potential risk of adverse pregnancy outcomes.

Triaging all women admitted to labour ward is essential as a measure to prevent infection transmission. Women at high risk for infection with respiratory symptoms and signs or draining from epidemiologically high-risk areas should be screened with PCR test prior to admission to labour room. Providing an isolated labour room for infected and highly suspected pregnant mothers helps to prevent infection spreading to others. Implementation of these measures are totally depending on the availability of testing facilities in the hospital and time taken to get test results. It is mandatory to manage all infected and suspected cases with adequate protection by wearing full PPE by the staff.

The consequences of broad public health measures of prevention with modification of antenatal and post-natal care have shown to decelerate the spread of infection and helped to alleviate the stress on the health care systems. But it has shown to increase the incidence of gender-based and family violence, reduction in preventive health care seeking behaviors, increase in postpartum depression, and other mental health concerns. This has shown the importance of providing additional supportive measures at community and health care facility levels with particular attention to mental health.

Provision of adequate family planning services with the availability of contraception should prevail and women requiring abortion services, an individualized decision about postponing abortion should be taken, as abortion is time-bound confined by gestational limits. All affected countries with SARS-COV2 infection should collect information regarding confirmed pregnant mothers to maintain a database and encourage for research studies to recommend public health guidance and messages to local contexts.

Resources:

Interim report from the UK Obstetric Surveillance System (UKOSS),

Am J Clin Pathology. 2020 Jun 8; Placental Pathology in COVID-19

WHO interim Guidance on COVID 19 in pregnancy

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