

Treatment of COVID-19 in pregnant patients

Version 1: Tuesday 7 December 2021

Initial management of COVID in pregnancy

1. Oxygen – titrate supplemental oxygen to keep sats >94%
2. Thromboprophylaxis – prophylactic LMWH dose according to weight (in the [RCOG thromboprophylactic guideline](#))
3. Corticosteroids – if oxygen dependent give for a total of 10 days
 - a. Oral prednisolone 40mg OD; or
 - b. IV hydrocortisone 80mg BD
4. If steroids used for fetal lung maturation use Dexamethasone 12mg IM 24 hourly (2 doses) **followed by** either (a) or (b) above for 10 days



Clinical deterioration

Increased O₂ requirements: sats<93%, RR>22

- Convene MDT: obstetrician, neonatologist, intensivist, anaesthetist and infectious diseases/microbiology
- Discuss with obstetric physician at regional maternal medicine centre
- Consider:
 - ✓ site and location of care
 - ✓ delivery
- Give [tocilizumab](#)* (or sarilumab if unavailable) if needing escalation of care and/or if CRP>75
- Check COVID-19 antibodies, if negative consider 2.4g [Ronapreve](#)# IV once

If continued clinical deterioration

- Re-consider delivery
- Proning (including self-proning) in discussion with COVID-19 ITU
- Early discussion with an ECMO centre

Discharge

- Thromboprophylaxis for at least 10 days
- Safety net/telephone follow up
- Encourage COVID19 vaccination: can be given 28 days following recovery
- Advise: if given tocilizumab/sarilumab, be aware of an increased risk of infection without typical signs for several months†.



*Limited human data in pregnancy but in clinically deteriorating patient, benefits likely to outweigh risks, may modify neonatal immune system so avoid live vaccines (BCG, rotavirus) in first six months of neonatal life
#no human data, no theoretical risk of harm (targets viral proteins)

†Clinicians to have a low index of suspicion regarding sepsis without obvious clinical signs if patients have been given tocilizumab/sarilumab

