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PRESENTATION
NOTABLE SX - SAME AS NON-PREGNANT
• ~65-80% Cough • ~45% Febrile initially
• ~15% URI Sx • ~10% GI Sx
• Anosmia
• Acute worsening after early mild sx

INCREASED RISK FOR SEVERE DZ
• Comorbid diseases:
  • Cardiac, pulm, renal
  • Diabetes, HTN
  • Immunocompromise

LABS INDICATING SEVERE DZ
• LDH >245
• Abs lymphocyte count <0.8

PREGNANCY CONSIDERATIONS
• Tachycardia over 120bpm is abnormal
• Tachypnea over 18rpm is abnormal
• Elevated D-dimer is expected
• Low HCO3 18-22 is normal

DIAGNOSTICS
DAILY LABS
• CBC with diff (trend lymphocyte ct)
• CMP, in particular LFT
• Consider whether development of Preeclampsia/HELLP syndrome

MONITOR FOR WORSENING DISEASE OR DRUG TOXICITY PRN
• Ferritin/ESR/CRP • PT/PTT/INR
• EKG/CPK/ Troponin • Lactate (<2)
• Procalcitonin

ONE TIME TEST FOR ALL PTS
• Influenza A/B. RSV
• Additional resp virus per ID guide
• Tracheal aspirate if intubated
• SARS-CoV2 (if not already sent)
• Additional tests for trial enrollment as needed

RESPIRATORY FAILURE
CONSIDER EARLY INTUBATION IN ICU
Consider RICU consult, Anticipate DIFFICULT intubation
WARNING SIGNS: INC Fio2, DEC SaO2, CRX WORSE

LUNG PROTECTIVE VENTILATION
• Vt 40% greater in pregnancy than 4-6 ml/kg PBW
• Plateau pressure <30
• Driving pressure (Pplat-PEEP) <15
• Target SaO2 >93-95%, PaO2>70
• Starting PEEP 8-10 cmH20

CONSERVATIVE FLUID STRATEGY
• Post resuscitation: NO maintenance fluids
• Only diuresis if evidence of pulmonary edema

PEEP TITRATION
• ARDSnet low PEEP table
• Best PEEP considered w/ ICU attending input

PRONE - ACCEPTABLE IN PREGNANCY
• Early if cont. hypoxemia (P:F<150)
or elevated driving/plateau pressure
• Supine with left lateral uterine displacement ~qAM

ADDITIONAL THERAPIES
• Paralytics for vent dysynchrony, not routine
• Inhaled NO (no epoprostenol)

ECMO CONSULT
if continued hypoxemia or elevated airway pressures

PATIENCE
Anticipate possible prolonged intubation

EMO CONSULT 26955 ECMO 29151 BIRTHTHREATS 26876 MFM 17977

HEMODYNAMICS
• Norepinephrine first choice pressor
• MAP 60-65 with BP < 160/110
• CO mean 6.2 L/min, 43% greater
• SVR decreased 21%, CVP unchanged
• IF WORSENING:
  • ? myocarditis/cardiogenic shock
  • Obtain POCUS, EKG, trop, lactate. CVO2, consider TTE

USUAL CARE
• “Empiric abx per usual approach”
• Sedation PRN vent synchrony
• Daily SAT/SBT when appropriate
• ABCDEF Bundle
• Heparin for VTE prophylaxis

CHANGE TO USUAL CARE
• CXR safe prn with uterine shielding
• MINIMIZE staff contact in room
• HIGH THRESHOLD for bronchoscopy
• HIGH THRESHOLD to travel
• BUNDLE bedside procedures
• AVOID nebs, prefer MDIs
• Appropriate isolation for aerosol generating procedures
• Maintain left lat uterine displacement
• ABG should demonstrate compensated respiratory alkalosis:
  • pH 7.40-7.44
  • PaO2 27-32mmHg
P 72-104mmHg
  • SaO2 95-100%

THERAPEUTICS
• Delivery may improve maternal status
• Compassionate care med use if eligible
• Hydroxychloroquine is acceptable
• NO ROUTINE STEROIDS for resp failure, may consider in the setting of septic shock
  • May consider for fetal lung maturity
• Avoid NSAIDS