Abnormal laboratory findings

| Characteristics            | Patient 1                                      | Patient 2                                      | Patient 3                                      | Patient 4                                      |
|----------------------------|------------------------------------------------|------------------------------------------------|------------------------------------------------|------------------------------------------------|
| Obstetric antecedents      | 2 late fetal growth restrictions at 39 and     | -                                              | Late severe pre-eclampsia with                 | -                                              |
| (previous pregnancies)     | 40 weeks                                       |                                                | thrombocytopenia in previous pregnancy        |                                                |
|                            |                                                |                                                | at 40 weeks                                    |                                                |
| Obstetric antecedents      | Severe pre-eclampsia with                     | Light for gestational age 7, 5th centile,      | Fetal growth restriction                      | Dichorionic twin pregnancy                     |
| (current pregnancy)        | severe thrombocytopenia                        | normal Doppler and                            |                                                | HELLP Syndrome                                 |
|                            | Fetal Growth restriction                       | apnoeic fluid at 34 weeks                      |                                                | Preterm premature rupture of                    |
|                            |                                                |                                                |                                                | membranes                                      |
| COVID-19 symptoms on       | Asymptomatic                                   | Asymptomatic                                   | Asymptomatic                                   | Fever and cough                                 |
| admission                  |                                                |                                                |                                                |                                                |
| Gestational age at fetal   | 39 weeks                                       | 35 weeks and 4 days                            | 38 weeks and 5 days                            | 30 weeks and 3 days                            |
| death                      |                                                |                                                |                                                |                                                |
| Abnormal laboratory        | 21×10⁹/L platelets, AST 50 unit/L, ALT 31     | 14.7×10⁹/L leukocytes, CRP 1.98 mg/dL,         | 109×10⁹/L platelets,                           | 62×10⁹/L platelets,                            |
| findings                   | unit/L, LDH 478 unit/L, 400 mg/dL proteinuria, | CRP 2.42 mg/dL                                 | CRP 1.98 mg/dL,                               | AST 280 unit/L, ALT 114 unit/L, Total           |
|                            | 8.7 mg/dL uric acid, CRP 2.42 mg/dL,          |                                                | 500 mg/dL leukocyturia                         | bilirubin 1.0 mg/d,                            |
|                            |                                                |                                                |                                                | protein/creatinine ratio 2.6, LDH 1460         |
| Placental histopathology   | infarctions 60% surface, chorioangioma, MVM    | intravillous lymphocytes and fibrin, avascular | mild acute chorioamnionitis,                   | disseminated intravascular                     |
|                            | signs.                                        | villi, syncytial knots, MVM signs.             | FVM signs.                                     | coagulation                                    |

COVID-19 can place at greater risk of in utero fetal demise pregnancies that are already complicated by obstetric conditions related with impaired placental perfusion.

Fetal deaths in COVID-19 infected pregnancies

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Fetal death as an ultimate consequence of COVID-19 infection in pregnancy, is a complication that must not be underestimated. Maternal infection can trigger a hyper-inflammatory response, causing endothelial vascular dysfunction and coagulation abnormalities. These lesions compromise placental perfusion which consequently affects fetal perfusion and leads, in some situations, to fetal anoxia and death. Our case series report clinical, analytical and histopathological findings of four cases of in utero fetal demise in COVID-19 infected pregnant women, without any other obvious cause, managed at a tertiary hospital, in Portugal. All pregnancies were uncomplicated until the third trimester and either had obstetric history or developed obstetric conditions related to placental vascular compromise such as hypertensive disorders of pregnancy and fetal growth restriction. Three cases were asymptomatic for COVID-19 on admission, whereas the fourth presented mild symptoms and developed disseminated intravascular coagulation. All fetuses were morphologically normal and two of them tested positive for COVID-19. Placental histopathological examinations revealed multiple signs of maternal and fetal vascular malperfusion, chorioangioma and increased perivillous fibrin deposition, findings that are consistent with those observed in hypertensive disorders of pregnancy and fetal growth restriction. This observation suggests that

VP31.21 Prevalence of SARS-CoV-2 infection in labour companions of asymptomatic women

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Objectives: Describe the prevalence of SARS-CoV2 infection in companions of asymptomatic women during labour.

Methods: This is a prospective cohort study based on data collected at Fundación Santa Fe de Bogotá, University Hospital, between 2020 and 2021 of companions of asymptomatic women admitted for childbirth. All individuals without a prior COVID-19 diagnosis underwent SARS-CoV2 polymerase chain reaction (PCR) testing with nasopharyngeal swab. Patients scheduled for a Caesarean delivery were examined and evaluated at preoperative visits. Hospital policies recommended the use of universal masks and the N95 markings in clinical units by physicians, patients, and support persons, and limited to 1 birth companion. Universal tests of patients already diagnosed with COVID-19 and patients not admitted for delivery were excluded.

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Results: 174 companions for childbirth were examined, all were males. The average age was 42 years with a standard deviation of (±) 4 years, the average gestational age at the time of delivery was 37.5 weeks (±) 2.1 weeks. None of the pregnant women in labour was positive for SARS-CoV2 by PCR. None of the companions tested positive for SARS-CoV2 by PCR, showing a prevalence of SARS-CoV2 infection lower than 1% in this cohort of asymptomatic pregnant women and their husbands or partners. No health worker in obstetric units was removed from work due to exposure to SARS-CoV2 or a disease transmitted through known or possible contact with a patient. These results are limited to a hospital setting and a single geographic region.

Conclusions: These findings found a low prevalence (<1%) of positive SARS-CoV2 test results among partners of asymptomatic patients in a pregnant population. Until June 2021, the city of Bogotá, Colombia, was considered a highly endemic region.

VP31.22 Multidisciplinary team management in a pregnancy with Takayasu arteritis complicated by COVID-19 infection
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Takayasu arteritis (TAK) is a rare systemic, inflammatory large-vessel vasculitis, most commonly affecting women of child-bearing age. Its incidence in pregnancy is 2.6 cases/million/year. Obstetrical complications are increased by 13 fold. We present the management of a pregnant female with TAK with COVID-19 infection, with threatened preterm labour and superimposed pre-eclampsia. A 20-year-old female, G3A2 at 33+2 weeks of gestation presented with threatened preterm labour. She was diagnosed with Takayasu Arteritis in first trimester during work up for chronic hypertension. Patient was on labetalol 300 mg three times a day, aspirin 150 mg and prednisolone 7.5 mg OD from first trimester. On admission, patient had raised blood pressure records of 160/110 mmHg in left limb and 160/108 in right limb. Investigations were reviewed. MRI showed right common carotid and right renal arterial stenosis. Patient also turned out to be COVID positive. Multidisciplinary management with involvement of cardiologist, endocrinologist, anesthetist was done within two hours of admission despite the patient being COVID positive. Intravenous labetalol 20 mg and tocolysis were given and dexamethasone started for fetal lung maturity. Contraction ceased after one hour, BP was decreased progressively (60-70%) so the mother being intubated and put on oxygen mask. She was admitted to intensive care unit due to the extensive involvement of lungs that was seen in chest CT. Remdesivir 100 mg, Dexamethasone 6 mg, Enoxaparin 60 mg were prescribed for her. During the second day of hospitalisation O2 saturation decreased progressively (60-70%) so the mother being intubated and put under mechanical ventilation. Because of repetitive late deceleration in CTG, emergency Caesarean section was done. The Apgar score of the neonate was 2/10 and 6/10, so resuscitation protocol was done immediately. She was admitted to the neonatal intensive treatment unit. The result of the newborn’s COVID-19 test was negative. The mother was successfully extubated after 3 days and discharged 7 days after Caesarean section. Presently, the condition evaluation of the mother and her newborn is normal. Both babies were admitted to NICU. She developed postpartum psychosis, which was managed in liaison with psychiatrist. Patient's condition improved and she was shifted out of ICU on postoperative day 14. She was discharged in satisfactory condition, after 22 days of hospital stay. Both babies and the mother are currently doing fine and following up in the OPD. To conclude, timely diagnosis, multidisciplinary approach and availability of intensive care facility resulted in optimal outcome of the case.

VP31.24 Preterm Caesarean section in a pregnant woman infected with COVID-19
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Since the outbreak of COVID-19 disease in 2019, many reports have been describing the pregnancy situation among COVID-19 positive patients. We report a pregnant woman in whom early medical management for pneumonia due to COVID-19 and Caesarean section leads to saving the life of both mother and infant. The patient was a 37-year-old Iranian woman, gravida 1, with a singleton pregnancy, at 32 weeks and 6 days of gestation. She was previously healthy without any prior comorbid diagnosis. Her body mass index (BMI) was 30. Because of dyspnea, fever, and a positive COVID-19 RT PCR test, the patient was transferred to our tertiary centre on April 13, 2021. At admission time, O2 saturation was 98% with lower lobe atelectasis. Serum amylase and lipase were raised. Acute pancreatitis was managed conservatively and fine intravenous fluid balance was maintained to prevent worsening of ARDS and to prevent pancreatitis induced acute kidney insult. There was a dilemma, whether to terminate the pregnancy to improve maternal hypoxemia. she underwent emergency Caesarean section for poor biophysical profile with worsening hypoxemia to improve maternal and perinatal outcome. Both babies were admitted to NICU. She developed postpartum psychosis, which was managed in liaison with psychiatrist. Patient’s condition improved and she was shifted out of ICU on postoperative day 14. She was discharged in satisfactory condition, after 22 days of hospital stay. Both babies and the mother are currently doing fine and following up in the OPD. To conclude, timely diagnosis, multidisciplinary approach and availability of intensive care facility resulted in optimal outcome of the case.

VP31.23 Pregnancy complicated by acute pancreatitis and COVID-19 infection
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Acute pancreatitis is a very rare and potentially life threatening complication in pregnancy. Its incidence is 3 per 10,000 pregnancies. We present a case of pregnancy with multiple comorbidities complicated by moderate COVID-19 disease and acute pancreatitis. There have been case reports of COVID-19 infection and acute pancreatitis indicating a possible association between the two. A 34 year-old primigravida at 31-week gestation with dichorionic diamniotic twin pregnancy (IVF conception) presented with complaints of acute epigastric pain radiating to the back with bilious vomiting and breathing difficulty. She had a moderate bout of COVID-19 disease and was referred due to non-availability of intensive care bed. Her pregnancy was also complicated by cholestasis of pregnancy and gestational diabetes mellitus. Patient’s condition deteriorated after admission and she was shifted to ICU. Contrast enhanced CT chest and abdomen showed features suggestive of acute pancreatitis with left sided pleural effusion with lower lobe atelectasis. Serum amylase and lipase were raised. Acute pancreatitis was managed conservatively and fine intravenous fluid balance was maintained to prevent worsening of ARDS and to prevent pancreatitis induced acute kidney insult. There was a dilemma, whether to terminate the pregnancy to improve maternal hypoxemia. she underwent emergency Caesarean section for poor biophysical profile with worsening hypoxemia to improve maternal and perinatal outcome. Both babies were admitted to NICU. She developed postpartum psychosis, which was managed in liaison with psychiatrist. Patient’s condition improved and she was shifted out of ICU on postoperative day 14. She was discharged in satisfactory condition, after 22 days of hospital stay. Both babies and the mother are currently doing fine and following up in the OPD. To conclude, timely diagnosis, multidisciplinary approach and availability of intensive care facility resulted in optimal outcome of the case.