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Special Notice: Clinical Management Considerations Timing and mode of delivery of pregnant women requiring hospitalization for H1N1 Influenza-Like-Illness (ILI)

Developed by the SOGC Maternal Fetal Medicine (MFM) Committee

Background: Several clinicians across the country are inquiring about the timing and mode of delivery of pregnant women requiring hospitalization for H1N1 Influenza-Like-Illness (ILI) during late second and third trimester. Approximately 10-12% of pregnant women with ILI require hospitalization.

While data collection worldwide is still on-going at the time of this notice, **in order to minimize the risk of maternal death**, the SOGC Maternal Fetal Medicine committee makes the following recommendations for caring of pregnant women with ILI requiring hospitalization:

1. Assessment of maternal and fetal wellbeing is recommended at every presentation including maternal pulse oximetry, physical examination, low threshold for chest X-Ray and arterial blood gas sampling. Specific fetal surveillance will depend on gestational age, severity of the maternal condition, and local practices for antepartum fetal surveillance in high risk situations.
2. Admission should be in a hospital where there is ready access to an adult intensive care unit since maternal deterioration can occur suddenly. Hospital resources should be available to manage acute Adult Respiratory Distress Syndrome (ARDS), acute renal failure, adult mechanical ventilation and acute Disseminated Intravascular Coagulation.
3. If the pregnancy is at less than 34 weeks' gestation, in addition to the above, access to a level 2 or level 3 neonatal intensive care unit is also required. A list of these designated hospitals should be made available to the general public as well as health care professionals for each province across Canada.
4. There is not enough information available suggesting an advantage in expediting the birth of the baby. However, several case reports have been published requiring emergency caesarean section for maternal ARDS and hypoxemia with ensuing abnormal fetal heart rate monitoring.
5. Pregnant women in the third trimester have decreased oncotic pressure and are particularly susceptible to fluid overload, increasing the risk of ARDS. Careful attention to fluid status is recommended and aggressive diuresis may be indicated particularly for women mechanically ventilated.
6. Utilization of antipyretic medication is recommended.
7. Early administration of steroids to enhance lung maturity between 24-34 weeks is recommended, because the potential for preterm birth is high.

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8. Although ideally treatment with oseltamivir 75 mg po BID for 5 days should be started within 48 hours of symptoms, it is still recommended to give it after the first 48 hours of ILI symptoms since it still can reduce the severity of the ILI and the risk of complications such as bacterial pneumonia.
9. Prophylaxis against thromboembolic events is recommended for all women on mechanical ventilation.
10. There is not enough information available to state whether or not early delivery is beneficial to the mother with ILI. Multidisciplinary approach with adult medicine subspecialists, maternal fetal medicine specialist and neonatologist is recommended for individualized management. The health of the mother should always be the first priority.