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This guideline was peer-reviewed by the SOGC's Infectious Disease Committee in March 2015, and has been reaffirmed for continued use until further notice.

No. 225-Management Guidelines for Obstetric Patients and Neonates Born to Mothers With Suspected or Probable Severe Acute Respiratory Syndrome (SARS)

This Clinical Practice Guideline has been prepared by the Maternal Fetal Medicine Committee,* reviewed by the Infectious Disease Committee,* and approved by the Executive and Council of The Society of Obstetricians and Gynaecologists of Canada.

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Key Words: Severe acute respiratory syndrome (SARS), pregnancy, perinatal morbidity, perinatal mortality, maternal morbidity, maternal mortality, acute respiratory distress syndrome (ARDS), neonatal care

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Abstract

Objective: This document summarizes the limited experience of SARS in pregnancy and suggests guidelines for management.

Outcomes: Cases reported from Asia suggest that maternal and fetal outcomes are worsened by SARS during pregnancy.

Evidence: Medline was searched for relevant articles published in English from 2000 to 2007. Case reports were reviewed and expert opinion sought.

Values: Recommendations were made according to the guidelines developed by the Canadian Task Force on Preventive Health Care.

Sponsors: The Society of Obstetricians and Gynaecologists of Canada.

Recommendations

1. All hospitals should have infection control systems in place to ensure that alerts regarding changes in exposure risk factors for

SARS or other potentially serious communicable diseases are conveyed promptly to clinical units, including the labour and delivery unit (III-C).

2. At times of SARS outbreaks, all pregnant patients being assessed or admitted to the hospital should be screened for symptoms of and risk factors for SARS (III-C).
3. Upon arrival in the labour triage unit, pregnant patients with suspected and probable SARS should be placed in a negative pressure isolation room with at least 6 air exchanges per hour. All labour and delivery units caring for suspected and probable SARS should have available at least one room in which patients can safely labour and deliver while in need of airborne isolation (III-C).
4. If possible, labour and delivery (including operative delivery or Caesarean section) should be managed in a designated negative pressure isolation room, by designated personnel with specialized infection control preparation and protective gear (III-C).
5. Either regional or general anaesthesia may be appropriate for delivery of patients with SARS (III-C).
6. Neonates of mothers with SARS should be isolated in a designated unit until the infant has been well for 10 days, or until the mother's period of isolation is complete. The mother should not breastfeed during this period (III-C).
7. A multidisciplinary team, consisting of obstetricians, nurses, pediatricians, infection control specialists, respiratory therapists, and anaesthesiologists, should be identified in each unit and be responsible for the unit organization and implementation of SARS management protocols (III-C).
8. Staff caring for pregnant SARS patients should not care for other pregnant patients. Staff caring for pregnant SARS patients should be actively monitored for fever and other symptoms of SARS. Such individuals should not work in the presence of any SARS symptoms within 10 days of exposure to a SARS patient (III-C).
9. All health care personnel, trainees, and support staff should be trained in infection control management and containment to prevent spread of the SARS virus (III-A).
10. Regional health authorities in conjunction with hospital staff should consider designating specific facilities or health care units, including primary, secondary, or tertiary health care centres, to care for patients with SARS or similar illnesses (III-A).