## Key Considerations

There is current guidance from the Centers for Disease Control and Prevention, the American College of Obstetricians and Gynecologists, and the Society for Maternal-Fetal Medicine on the management of pregnant patients with COVID-19. This section of the COVID-19 Treatment Guidelines complements that guidance. The following are key considerations regarding the management of COVID-19 in pregnancy:

- Pregnant people should be counseled about the increased risk for severe disease from SARS-CoV-2 infection and receive recommendations on ways to protect themselves and their families from infection.
- If hospitalization for COVID-19 is indicated for a pregnant patient, care should be provided in a facility that can conduct maternal and fetal monitoring, when appropriate.
- Management of COVID-19 in pregnant patients should include:
  - Fetal and uterine contraction monitoring based on gestational age, when appropriate
  - Individualized delivery planning
  - A multispecialty, team-based approach that may include consultation with obstetric, maternal-fetal medicine, infectious disease, pulmonary-critical care, and pediatric specialists, as appropriate
  - In general, the therapeutic management of pregnant patients with COVID-19 should be the same as for nonpregnant patients. The COVID-19 Treatment Guidelines Panel recommends against withholding treatment for COVID-19 and SARS-CoV-2 vaccination from pregnant or lactating individuals because of theoretical safety concerns (AIII). For details regarding therapeutic recommendations and pregnancy considerations, see General Management of Nonhospitalized Patients With Acute COVID-19 and the individual drug sections.
  - Pregnant or lactating patients with COVID-19 and their clinical teams should discuss the use of investigational drugs or drugs that are approved for other indications as treatments for COVID-19. During this shared decision-making process, the patient and the clinical team should consider the safety of the medication for the pregnant or lactating individual and the fetus and the severity of maternal disease. For detailed guidance on using COVID-19 therapeutic agents during pregnancy, please refer to the pregnancy considerations subsections found in the Antiviral Therapy and Immunomodulators sections of these Guidelines.
  - The decision to feed the infant breast milk while the patient is receiving therapeutic agents for COVID-19 should be a collaborative effort between the patient and the clinical team, including infant care providers. The patient and the clinical team should discuss the potential benefits of the therapeutic agent and evaluate the potential impact of pausing lactation on the future of breast milk delivery to the infant.

### Rating of Recommendations:

A = Strong; B = Moderate; C = Weak

### Rating of Evidence:

I = One or more randomized trials without major limitations; Iia = Other randomized trials or subgroup analyses of randomized trials; IIb = Nonrandomized trials or observational cohort studies; III = Expert opinion

## Epidemiology of COVID-19 in Pregnancy

Early in the pandemic, reports of COVID-19 disease acquired during pregnancy were limited to case series or studies that did not compare pregnant patients to age-matched, nonpregnant controls, and these reports were largely reassuring. Subsequent data have indicated that while the overall risk of severe illness is low, COVID-19 is associated with more severe disease in pregnant people than in nonpregnant people." There is also an increased risk of poor obstetric outcomes among pregnant people with COVID-19, such as preterm birth."3

In November 2020, the Centers for Disease Control and Prevention (CDC) released surveillance data on outcomes in approximately 400,000 reproductive-aged women with symptomatic, laboratory-confirmed COVID-19.
COVID-19. After adjusting for age, race/ethnicity, and underlying medical conditions, pregnant women had significantly higher rates of intensive care unit (ICU) admission (10.5 vs. 3.9 cases per 1,000 cases; adjusted risk ratio [aRR] 3.0; 95% CI, 2.6–3.4), mechanical ventilation (2.9 vs. 1.1 cases per 1,000 cases; aRR 2.9; 95% CI, 2.2–3.8), extracorporeal membrane oxygenation (0.7 vs. 0.3 cases per 1,000 cases; aRR 2.4; 95% CI, 1.5–4.0), and death (1.5 vs. 1.2 cases per 1,000 cases; aRR 1.7; 95% CI, 1.2–2.4). The increased risk for severe disease was most significant in women aged 35 to 44 years, who were almost four times as likely to be mechanically ventilated and twice as likely to die as nonpregnant women of the same age.

Notably, among Hispanic women, pregnancy was associated with a risk of death that was 2.4 times higher (95% CI, 1.3–4.3) than the risk observed in nonpregnant Hispanic women. Racial and ethnic disparities were also seen in other reports. Among 8,207 pregnant women with COVID-19 who were reported to CDC, the proportion of those who were reported to be Hispanic (46%) and Black (22%) was higher than the proportion of Hispanic and Black women who gave birth in 2019 (24% and 15%, respectively), suggesting that pregnant people who are Hispanic or Black may be disproportionately affected by SARS-CoV-2 infection.4

In an ongoing systematic review that includes 192 studies to date, maternal factors that were associated with severe disease included increased maternal age (OR 1.83; 95% CI, 1.27–2.63; 3,561 women from 7 studies); a high body mass index (OR 2.37; 95% CI, 1.83–3.07; 3,367 women from 5 studies); any pre-existing maternal comorbidity, including chronic hypertension and diabetes (OR 1.81; 95% CI, 1.49–2.20; 2,634 women from 3 studies); pre-eclampsia (OR 4.21; 95% CI, 1.27–14.0; 274 women from 4 studies); and pre-existing diabetes (OR 2.12; 95% CI, 1.62–2.78; 3,333 women from 3 studies).5 Compared with pregnant women and recently pregnant women without COVID-19, pregnant women with COVID-19 were at a higher risk of any instance of preterm birth (OR 1.47; 95% CI, 1.14–1.91; 8,549 women from 18 studies) and stillbirth (OR 2.84; 95% CI, 1.25–6.45; 5,794 women from 9 studies).

An observational cohort study of all pregnant patients at 33 U.S. hospitals with a singleton gestation and a positive result on a SARS-CoV-2 virologic test evaluated maternal characteristics and outcomes across disease severity.6 The data suggested that adverse perinatal outcomes were more common in patients with severe or critical disease than in asymptomatic patients with SARS-CoV-2 infection, including an increased incidence of cesarean delivery (59.6% vs. 34.0% of patients; aRR 1.57; 95% CI, 1.30–1.90), hypertensive disorders of pregnancy (40.4% vs. 18.8%; aRR 1.61; 95% CI, 1.18–2.20), and preterm birth (41.8% vs. 11.9%; aRR 3.53; 95% CI, 2.42–5.14). The perinatal outcomes for those with mild to moderate illness were similar to those observed among asymptomatic patients with SARS-CoV-2 infection.

Although vertical transmission of SARS-CoV-2 is possible, current data suggest that it is rare.7 A review of 101 infants born to 100 women with SARS-CoV-2 infection at a single U.S. academic medical center found that 2 infants (2%) had indeterminate SARS-CoV-2 polymerase chain reaction (PCR) results, which were presumed to be positive; however, the infants exhibited no evidence of clinical disease. It is reassuring that the majority of the infants received negative PCR results after rooming with their mothers and breastfeeding directly (the mothers in this study practiced appropriate hand and breast hygiene).

Managing COVID-19 in Pregnancy

Pregnant people should be counseled about the increased risk for severe disease from SARS-CoV-2 and the measures they can take to protect themselves and their families from infection. These measures include practicing physical distancing, washing their hands regularly, and wearing a face covering (if indicated). If the patient is not vaccinated, they should be counseled about wearing a face covering and getting vaccinated against SARS-CoV-2 infection. CDC, the American College of Obstetricians and Gynecologists (ACOG), and the Society for Maternal-Fetal Medicine highlight the importance of
accessing prenatal care. ACOG provides a list of frequently asked questions on using telehealth to deliver antenatal care, when appropriate.

ACOG has developed an algorithm to evaluate and manage pregnant outpatients with suspected or laboratory-confirmed SARS-CoV-2 infection. As in nonpregnant patients, SARS-CoV-2 infection in pregnant patients can present as asymptomatic/presymptomatic disease or with a wide range of clinical manifestations, from mild symptoms that can be managed with supportive care at home to severe disease and respiratory failure that requires ICU admission. As in other patients, the illness severity, underlying comorbidities, and clinical status of pregnant patients with symptoms that are compatible with COVID-19 should be assessed to determine whether in-person evaluation for potential hospitalization is needed.

If hospitalization is indicated, care should be provided in a facility that can conduct maternal and fetal monitoring, when appropriate. The management of COVID-19 in the pregnant patient may include:

- Fetal and uterine contraction monitoring based on gestational age, when appropriate
- Individualized delivery planning
- A multispecialty, team-based approach that may include consultation with obstetric, maternal-fetal medicine, infectious disease, pulmonary-critical care, and pediatric specialists, as appropriate.

In general, the recommendations for managing COVID-19 in nonpregnant patients also apply to pregnant patients.

**Therapeutic Management of COVID-19 in the Setting of Pregnancy**

Potentially effective treatments for COVID-19 should not be withheld from pregnant people because of theoretical concerns related to the safety of using those therapeutic agents in pregnancy (AIII).

Pregnant or lactating patients with COVID-19 and their clinical teams should discuss the use of investigational drugs or drugs that are approved for other indications as treatments for COVID-19. During this shared decision-making process, the patient and the clinical team should consider the safety of the medication for the pregnant or lactating individual and the fetus and the severity of maternal disease. For detailed guidance on the use of COVID-19 therapeutic agents during pregnancy, please refer to the pregnancy considerations subsections found in the Antiviral Therapy and Immunomodulators sections of these Guidelines.

The use of anti-SARS-CoV-2 monoclonal antibodies can be considered in pregnant people with COVID-19, especially in those who have additional risk factors for severe disease. There is no pregnancy-specific data on the use of monoclonal antibodies; however, other immunoglobulin G products have been safely used in pregnancy when their use is indicated. Therefore, these products should not be withheld in the setting of pregnancy.

To date, most SARS-CoV-2-related clinical trials have excluded individuals who are pregnant and lactating; in cases where lactating and pregnant individuals have been included in studies, only a small number have been enrolled. This limitation makes it difficult to make evidence-based recommendations on the use of SARS-CoV-2 therapies in these vulnerable patients and potentially limits their COVID-19 treatment options. When possible, pregnant and lactating individuals should not be excluded from clinical trials of therapeutic agents or vaccines for SARS-CoV-2 infection.

**Timing of Delivery**

ACOG provides detailed guidance on the timing of delivery and the risk of vertical transmission of SARS-CoV-2.
In most cases, the timing of delivery should be dictated by obstetric indications rather than maternal diagnosis of COVID-19. For women who had suspected or confirmed COVID-19 early in pregnancy who recover, no alteration to the usual timing of delivery is indicated.

**Post-Delivery**

The majority of studies have not demonstrated the presence of SARS-CoV-2 in breast milk; therefore, breastfeeding is not contraindicated for people with laboratory-confirmed or suspected SARS-CoV-2 infection. Precautions should be taken to avoid transmission to the infant, including practicing good hand hygiene, wearing face coverings, and performing proper pump cleaning before and after breast milk expression.

The decision to feed the infant breast milk while the patient is receiving therapeutic agents for COVID-19 should be a joint effort between the patient and the clinical team, including infant care providers. The patient and the clinical team should discuss the potential benefits of the therapeutic agent and evaluate the potential impact of pausing lactation on the future of breast milk delivery to the infant.

Specific guidance on the post-delivery management of infants born to mothers with known or suspected SARS-CoV-2 infection, including breastfeeding recommendations, is provided by CDC and the American Academy of Pediatrics, as well as the Special Considerations in Children section in these Guidelines.

**SARS-CoV-2 Vaccine in Pregnancy**

A study that used data from three vaccine safety reporting systems in the United States reported that the frequency of adverse events among 35,691 vaccine recipients who identified as pregnant was similar to the frequency observed among nonpregnant patients. Local injection site pain, nausea, and vomiting were reported slightly more frequently in pregnant people than in nonpregnant people. Other systemic reactions were reported more frequently among nonpregnant vaccine recipients, but the overall reactogenicity profile was similar for pregnant and nonpregnant patients. Surveillance data from 3,958 pregnant patients who were enrolled in CDC’s v-safe Vaccine Pregnancy Registry showed that, among 827 people who completed their pregnancies, there were no obvious safety signals among obstetric or neonatal outcomes when rates of pregnancy loss (spontaneous abortion or stillbirth), preterm birth, congenital anomalies, infants who were small for gestational age, and neonatal death were compared to historic incidences in the peer-reviewed literature. ACOG has published practice guidance on using COVID-19 vaccines in pregnant and lactating people, including a guide to assist clinicians during risk and benefit conversations with pregnant patients.

**References**


