A New Presentation of Covid-19 in Pregnancy

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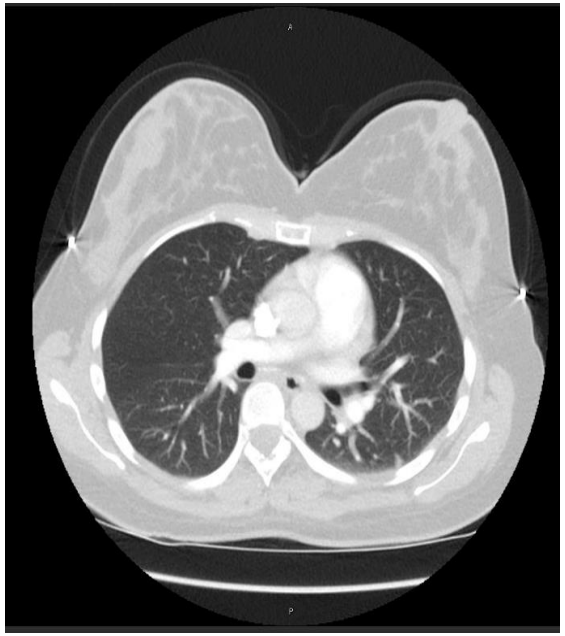
Patient consented to her case being presented

Background

Covid-19 is a new disease that we are all still learning about. I present a case of severe abdominal pain in pregnancy following Covid-19 transmission, which led to premature delivery of the baby. The findings at section were not typical of a pre-labour Caesarean section, and were thought to be due to abdominal Covid-19/

The case also prompted many discussions within the department about the likely diagnosis and management.



Case Report

The patient was a G4P2. She had a previous forceps at 40+5 in 2015 of 3430g baby. This baby had an unknown genetic condition. Her second delivery was a normal vaginal delivery in 2019 after an induction of labour at 37/40 due to worsening maternal asthma. This baby was 3260g.She had a booking BMI of 29.

Her past medical history included asthma and migraine. She took inhalers and montelukast.

She had low risk 1st trimester screening and an uncomplicated antenatal course until 33/40 when she was admitted under the medics with cough and SOB. **Covid-19 swab was positive**. CXR was NAD. She had a CTPA which showed LLL ground glass opacification and one area in the RLL likely due to **Covid pneumonia**. Negative for VTE *(pictured).*

7 days later she re-presented to maternity with worsening symptoms of cough, SOB and fever. Observations were normal other than a tachycardia of 107bpm. CTG was normal, CRP 27, WCC 9.8, Hb 114 and Plt 195. She was transferred to medicine and was discharged 6 days later.

She returned to A&E at **35+1** with central chest and back pain. Obs and bloods were unremarkable. Shortly later, she was seen by Obstetrics, and had generalised abdominal and back pain. She looked very **distressed**. She had been vomiting for 4-5 days. PV examination was normal.

She had a HR 120, RR 28 and an uncomplicated fetal tachycardia of 170bpm. The tachycardia settled with IV fluids and antibiotics. The following evening, the **CTG became abnormal** and she **looked unwell**. She was taken for a Category 2 Caesarean Section.

At Section, the tissue was very **oedematous** and there was at least **400mls** of yellow **ascitic fluid**. There were white **nodules** on the omentum and broad ligament. Surgical opinion was sought, and it was thought to be **abdominal Covid**. On day 1, there was a further 400mls of serous fluid in the drain. A CT abdomen showed inflamed bowel and post-op ileus. She went home on day 8 post-op. The baby was well throughout.

Discussion

This patient presented acutely, and was clear of the Covid-19 isolation period. Her management triggered lots of conversations within the department on the best course of action.

Her presentation was atypical compared to other Covid-19 patients that the department had managed. There were many differentials of her abdominal pain discussed, including appendicitis, hence why surgical opinion was sought. Her abdominal pain got better following delivery, and this possibly might have been because of the ascites that was there pre-delivery. It is important to consider an atypical presentation when a patient presents with symptoms that don't quite fit, and seek multi-disciplinary input if required.