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Supporting Information

Additional supporting information may be found online in the Supporting Information section at the end of the article.

Fig S1. The three zones of the COVID-19 floor: (1) The West Wing for critical care of confirmed cases of COVID-19: one allocated elevator was used only for confirmed patients (red line); (2) East Wing–Zone A with buffer room for asymptomatic patients with epidemiological risk factors (Group B-2); and (3) East Wing–Zone B with buffer room for suspicious patients in need of further monitoring of signs/symptoms related to COVID-19 (Group C-2).

Data S1. Screening Questionnaire for COVID-19.

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First COVID-19 maternal mortality in the UK associated with thrombotic complications

We report the first maternal death of a 29-year woman of Pakistani origin at Birmingham Heartlands Hospital (BHH), UK on 8 April 2020.

She had a body mass index (BMI) of 35, type 2 diabetes mellitus (T2DM) treated with metformin and insulin, renal tubular acidosis, asthma and vitamin D deficiency. In her first pregnancy, she had a stillborn baby. At her first antenatal (booking) visit, her glycated haemoglobin (HbA1c) was 9.7%. She also had a high albumin creatinine ratio but with normal kidney function (Fig 1).

She was admitted in mid-January 2020 due to poor diabetes control and low serum bicarbonate levels. An ultrasound scan at 26 weeks gestation showed a big baby with increased amniotic fluid volume (polyhydramnios).

She had more than 20 hospital attendances in March 2020 due to the baby's reduced movements. She received corticosteroids for fetal lung maturity. Fetal surveillance was normal.

She was admitted to the BHH delivery suite on 24 March 2020 (~29 weeks gestation) with fever. She was started on amoxicillin and enoxaparin for venous thromboembolism (VTE) prophylaxis and was tested positive for SARS-CoV-2. Her chest X-ray (CXR) was normal. Her temperature settled and she was discharged the following day.

She attended BHH on 1 April 2020 with severe breathlessness requiring 100% oxygen and was admitted to the High Dependency Unit of the delivery suite. Investigations revealed diabetic ketoacidosis and treatment started.

Next day, her respiratory function worsened and following a multidisciplinary meeting, delivery (~31 weeks gestation) by caesarean section under general anaesthesia was performed. She was transferred to the intensive care unit (ICU). Upon delivery her baby was immediately intubated and transferred to the neonatal ICU. Baby has been extubated

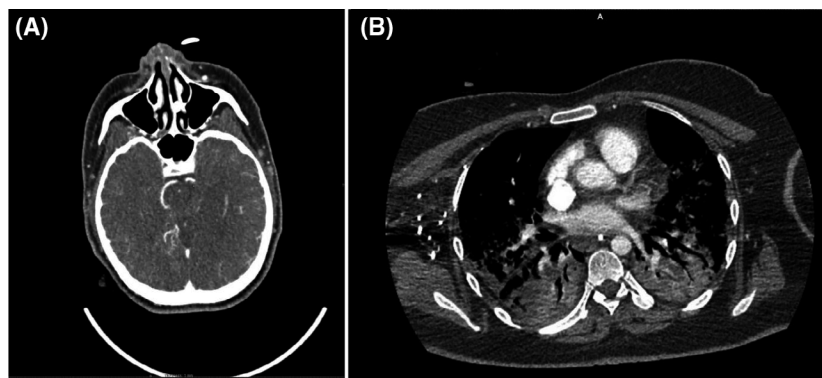


Fig 1. (A) Non-contrasted CT scan of the head with intracranial angiogram showing established acute infarcts in the PCA territories bilaterally extending to the left hippocampus and left and midbrain; hyperdense clots in the basilar artery and P1 segment of the left PCA on the non-contrasted CT brain which are confirmed with cessation of contrast in the angiogram. (B) CT scan of the chest with pulmonary angiogram showing right lower lobar pulmonary embolism; extensive bilateral ground-glass and patchy solid consolidation in keeping with established Covid-19 infection.

and is doing well. Subsequent SARS-CoV-2 testing of the baby was negative.

She improved and was extubated onto intermittent continuous positive airway pressure (CPAP) on 3 April 2020. However, on 7 April 2020, she complained of blurring of vision and was reintubated due to deteriorating respiratory function. A computed tomography (CT) pulmonary angiogram revealed right lower lobar pulmonary embolism, extensive bilateral ground glass opacities and patchy solid consolidation consistent with COVID-19 pneumonia; a head CT revealed basilar artery thrombosis. After discussions with the neurosurgeons it was concluded that no further treatment could be offered. On the following day, care was withdrawn, and she passed away.

Both pregnancy and COVID-19 increase the risk of thrombosis.^{1,2} This case has highlighted the synergy of these factors in increasing the risk of thrombotic complications in pregnant women with COVID-19, especially those admitted to ICU.² Moreover, she had T2DM, which has been reported to increase the morbidity and mortality associated with COVID-19.³


In summary, clinicians and carers need to be extra vigilant for the thrombotic complications in pregnant women with COVID-19.

Author Contribution

IA, AAZ and NE collected the data for the manuscript. BKT wrote the manuscript. All the authors reviewed, edited and approved submission of the manuscript.

Conflict of interest

The authors have no competing interests.

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