Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Table 2: Primary Outcomes: Cases of Superimposed Disease by Type of Antihypertensive Medication Prior to Pregnancy

Type of Antihypertensive	CHTN[a] no PEC[b] (N=185) n (%)	CHTN[a] early onset PEC[b] (N=45) n (%)	CHTN[a] late onset PEC[b] (N=92) n (%)	P value*
Labetalol	33 (17.8)	11 (24.4)	17 (18.5)	0.592
Nifedipine	9 (4.9)	3 (6.7)	2 (2.2)	0.396
Lisinopril	11 (5.9)	3 (6.7)	8 (8.7)	0.693
Amlodipine	10 (5.4)	2 (4.4)	5 (5.4)	1.000
Hydrochlorothiazide	26 (14.1)	7 (15.6)	12 (13.0)	0.923
Methyldopa	18 (9.7)	4 (8.9)	4 (4.3)	0.295
No medications	81 (43.8)	16 (35.6)	47 (51.1)	0.218

*Chi square or fisher exact test was used for categorical data
*Kruskal-Wallis test was used for continuous
a-Chronic Hypertension, b-Preeclampsia

150 Management of diabetes in pregnancy during the COVID-19 pandemic at a New York City hospital

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OBJECTIVE: To compare diabetic control and maternal and neonatal outcomes in pregnant women during the Coronavirus 2019 (COVID-19) pandemic to women managed one year prior.

STUDY DESIGN: This was a retrospective cohort study of pregnant women with diabetes managed either during the COVID-19 pandemic or one year earlier. Twenty-two gestational and pregestational diabetic subjects were identified in a city hospital clinic during the peak of the pandemic in New York City (NYC) from March 15, 2020 until May 31, 2020. Fifty-seven pregnant diabetic subjects were identified who were managed at this clinic during the same time-frame in 2019. Demographics and maternal and neonatal outcomes were collected and compared. Diabetic control was compared by measuring change in hemoglobin A1c and diabetic medication regimen at time of delivery. Outcomes documented included mode of delivery, gestational age at delivery, postpartum hemorrhage, maternal infection, birth weight, shoulder dystocia, APGAR score <7, fetal acidosis, NICU admission, neonatal glucose level and neonatal demise. Secondary outcomes included number of virtual or in person visits, COVID-19 status, and gestational age at time of the diabetes diagnosis.

RESULTS: Patients managed during the COVID-19 pandemic had significantly more telehealth visits and fewer in person visits compared to the year prior ($p<0.001$). However, no significant differences in maternal or neonatal outcomes or diabetic control were noted. There was no significant change in mode of delivery ($p>0.999$), shoulder dystocia ($p=0.075$), macrosomia ($p>0.999$), APGARs ($p=0.671$) or change in hemoglobin A1c during pregnancy ($p=0.342$).

CONCLUSION: There were no significant differences in maternal or neonatal outcomes or diabetic control for subjects managed during the COVID-19 pandemic in a NYC hospital. A decreased number of in person visits, substituted with telehealth visits, had no apparent negative effect on outcomes or diabetic control.

Table 1: Maternal Demographics

Variable		Managed during the pandemic (N=22) n (%)	Managed prior to the pandemic (N=57) n (%)	P value*
Maternal Age (years of age)		34 (30.0, 37.0)	34.0 (29.0, 36.0)	0.831
Maternal BMI[a] (kg/m^2)		32.5 (29.0, 34.0)	33.0 (30.0, 38.0)	0.146
Parity		1.5 (1.0, 2.0)	2.0 (1.0, 2.0)	0.888
Pregestational DM[b]		9 (40.9)	10 (17.5)	**0.041**
Gestational age at diagnosis of GDM[c] (weeks)		27.0 (22.0, 29.0)	27.0 (24.0, 30.0)	0.911
Prior Cesarean Delivery		10 (45.5)	20 (35.1)	0.114
Race and Ethnicity	Caucasian	1 (4.5)	3 (6.0)	<0.001
	Black/African American	4 (18.2)	12 (24.0)	
	Hispanic	17 (77.3)	14 (28.0)	
	Other	0 (0)	21 (42.0)	
Comorbidities	Thyroid	1 (4.5)	4 (7)	>0.999
	CKD[d]	0 (0)	1 (1.8)	>0.999
	Asthma	2 (9.1)	13 (22.8)	0.212
	Psychiatric	3 (13.6)	2 (3.5)	0.129
	Cardiac	4 (18.2)	6 (10.5)	0.452
	COVID-19[e]	2 (9.1)	NA	
Virtual prenatal visits		3.0 (2.0, 4.0)	0	**<0.001**
In-person prenatal visits		8.5 (6.0, 10.0)	13 (10.0, 16.0)	**<0.001**

Continuous data reported as medians (IQR) unless otherwise specified.
a-Body Mass Index, b-Diabetes mellitus, c-gestational diabetes, d-chronic kidney disease, e- Coronavirus disease 2019
*: Fisher's exact test was used for the categorical data and Wilcoxon two sample test was used for the continuous data.
†: Total data is <n.

Table 2: Outcomes

Variable	Managed during the pandemic (N=22) n (%)	Managed prior to the pandemic (N=57) n (%)	P value*
Maternal Outcomes			
Cesarean delivery†	6 (33.3)	21 (36.8)	>0.999
Gestational age at delivery (weeks of gestation)†	39.6 (38.4, 39.9)	39.0 (38.4, 39.7)	0.326
Diabetic ketoacidosis	0	0	
Shoulder dystocia	2 (11.1)	2 (3.5)	0.075
Postpartum hemorrhage†	1 (5.6)	1 (1.8)	0.425
Postpartum/intrapartum maternal infection†	0	11 (19.3)	0.056
Elevated blood pressure at delivery†	2 (11.1)	14 (24.6)	0.328
Preterm labcr/PPROM[a,†]	1 (5.6)	5 (8.8)	>0.999
Fetal Outcomes			
Fetal weight (grams)†	3380 (3115, 3985)	3460 (3145, 3840)	0.951
Macrosomia (weight >4000 grams)†	3 (16.7)	11 (19.3)	>0.999
APGARs <7 at 5 minutes of life†	2 (11.1)	5 (8.8)	0.671
Fetal Acidosis (Arterial pH<7.2)†	3 (17.6)	21 (38.9)	0.145
NICU Admission†	10 (55.6)	36 (64.3)	0.581
Neonatal demise†	0	0	
Neonatal glucose level†	50.5 (43.0, 65.0)	48.0 (39.0, 69.0)	0.857
Glycemic Control			
Change in HgbA1c[b,†]	0.2 (-0.4, 0.5)	0.2 (-0.2, 0.6)	0.342
On insulin at time of delivery†	10 (45.5)	20 (35.1)	0.444
On Metformin at time of delivery†	3 (13.6)	2 (3.5)	0.129

†: Total data is <n.
Continuous data reported as medians (IQR) unless otherwise specified.
*: Fisher's exact test was used for the categorical data and Wilcoxon two sample test was used for the continuous data.
a- Preterm Premature Rupture of Membranes, b- Hemoglobin A1c

151 Effect of implementation of a sepsis care pathway on maternal morbidity in obstetric patients

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OBJECTIVE: Sepsis is a leading cause of death worldwide, causing >10% of US maternal deaths. Early goal directed therapy (EGDT) - rapid evaluation, aggressive fluids, antibiotics, and source control - improves outcomes, but data on its efficacy in obstetrics are limited. Aggressive fluids in pregnancy raises concerns about volume overload and hypertension (HTN). In 10/2016, our center implemented an EGDT sepsis protocol (Code Sepsis) involving a rapid response team and an EMR bundle to guide providers through treatment