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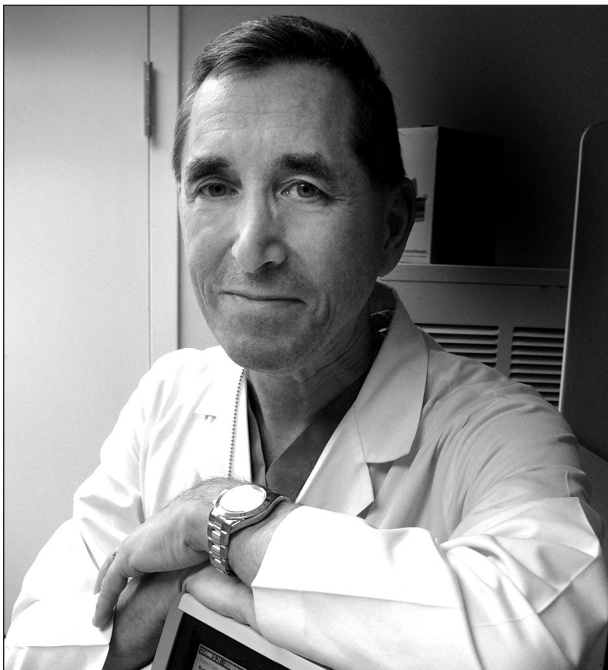
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## A Note from the Editor-in-Chief

Lawrence D. Devoe, M.D.

Welcome to the November-December 2020 Editor-in-Chief's page. This issue's editorial page is devoted to the ongoing COVID-19 pandemic and its impact on obstetric patients and their healthcare providers.



Lawrence D. Devoe, M.D., Editor-in-Chief

A lot has happened since I last wrote about this pandemic in the July-August issue. The number of COVID-19 cases has now reached 70 million worldwide, with the United States leading the pack with nearly 16 million cases. More than 1.5 million deaths have been reported around the globe, with the U.S. total approaching 300,000. Some of these numbers are the result of massive numbers of COVID-19 tests now being performed on a daily basis, but, from all recent reports that I have received (I get 30–40 COVID-19-related emails on a daily basis), the surge in COVID-related hospital admissions has stressed many of these institutions to the breaking point. This has resulted in difficult medical decision-making regarding who gets admitted, where patients get sent, regular ward versus intensive care unit, and how COVID-19 patients who are sent home get their conditions monitored.

To date, the number of pregnant women who have been diagnosed with this disease in the United States is approaching 500,000, with 8,500 hospitalized and nearly 60 deaths reported. Considering the fact that there are approximately 4 million births annually in the U.S., the infection rate in the obstetric population may hover around 12–14%, which is very close to the current overall infection rate reported by the Centers for Disease Control and Prevention (CDC). This is not surprising since, when broken down by age, this is a relatively young population, with cases peaking between the ages of

20 and 34. Further data on the numbers of pregnant women who have required invasive ventilation and have been admitted to the ICU are incomplete.

Healthcare workers who take care of pregnant women also tend to be younger and healthier individuals. They also wear personal protective equipment and, although they may be exposed to greater numbers of infected individuals, the latest reports suggest that the estimated rate of infection in this group is no higher than that of the population at large, and those that become infected typically have had more mild disease.

So much for the bad news. The great news is that the Food and Drug Administration has just voted to recommend that Pfizer's COVID-19 vaccine be granted emergency use authorization as early as the weekend of December 11, 2020. This vaccine has been shown to be 95% effective in the tested population with minimal side effects. The CDC has weighed in on the priorities of which groups should be the first to receive the vaccine. Currently, most pregnant women are not being included in this list because they were excluded from the clinical trials and, therefore, there are insufficient safety data. However, on December 15, 2020, the American College of Obstetricians and Gynecologists issued a new practice advisory to the effect that pregnant and lactating women who would otherwise qualify as priority patients for receiving the vaccine could be considered vaccine candidates after discussion with their clinical care provider. This recommendation could be taken to mean that such women who have comorbid conditions that would enhance their risk for COVID-19 infection could be offered the opportunity to receive the mRNA vaccine, which is not a live virus. Although this vaccine has not been tested in pregnant populations, the likelihood of adverse reaction to the mother or injury to the fetus is extremely low.

So, how will the availability of COVID-19 vaccines (and there are other such vaccines on the way) impact our obstetric populations? By conferring immunity to increasing numbers of non-

pregnant women and men, there is an increasing likelihood that a condition of "herd immunity" could be reached by some time next year. Varying estimates of the numbers needed to be vaccinated have been put forth, but, considering that somewhere between 10 and 15 percent of the population will have been infected already and a yet-to-be-determined number will have become immune to COVID-19, the most common estimates of the percent of the population that must be vaccinated, given a >90% effective immunization rate, hover around 70%. The real challenges will be distribution of the vaccines, educating individuals about its safety, and making it easier to vaccinate increasing numbers of people. Even if the safety of vaccinating pregnant women remains an unanswered question, when herd immunity is ultimately achieved, their risk of contracting COVID-19 will be greatly reduced.

In the meantime, all of us, pregnant women included, should be strongly encouraged to continue the behaviors intended to reduce exposure to COVID-19 that include wearing face masks in public, social distancing, frequent handwashing, and minimizing travel outside of the home as much as possible. Pregnant women are getting more COVID-19 tests when they present for urgent or emergent care, so the overall numbers of test-positive patients will probably increase. In the course of routine prenatal care, there has been increasing use of telemedicine visits for low-risk and asymptomatic patients, also reducing their risk of COVID-19 exposure. It is essential during prenatal care, whether in-person or virtual, to educate pregnant patients about the signs and symptoms of COVID-19 that should require a visit for testing and the steps to take if they are exposed to someone diagnosed with the disease.

The increasing availability of effective COVID-19 vaccines notwithstanding, we should all understand that this virus will be with us for the foreseeable future, and as healthcare providers we should continue to be vigilant and encourage the same kind of behavior in the patients we serve.