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EDITORIAL

A Note from the Editor-in-Chief

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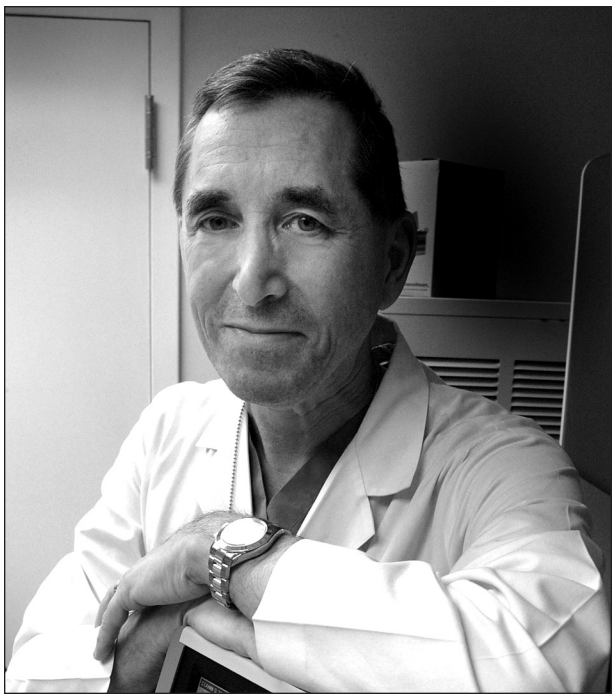
Welcome to the March-April 2020 Editor-in-Chief's page. This editorial column will focus on the major medical issue that is confronting most countries today—the COVID-19 pandemic—as it relates to vulnerable populations, which include pregnant women. At least for the moment, almost every other healthcare issue will take a back seat to this disease as it ravages global populations with no clear endpoint in sight.



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

As coronavirus has moved relentlessly, the numbers to date tell a grim story of more than 4 million identified cases and 300,000 recorded deaths.

When the first cases of coronavirus were identified in China, possibly as early as October 2019, little information about SARS-CoV-2's biological behavior was either known or promulgated to a worldwide medical community. The obvious questions that needed to be answered concerned how infectious it was, how likely an infected patient would become seriously ill or die, and the impact that it would have on pregnant women or their fetuses.

Although various advisories have been issued by professional societies such as the American College of Obstetrics and Gynecology, which has taken its lead from the Centers for Disease Control and Prevention, there is little substantive, evidence-based data on how to best deal with COVID-19 in the care of obstetric patients. A prepublication release of a study from two New York City hospitals reported on 43 pregnant patients with identified COVID-19 infection and suggested that the profile of this disease is similar to that of nonpregnant individuals, with 80% having mild or no symptoms, 15% having severe disease, and 5% having critical disease. There have also been pre-publications of algorithms for labor and deliv-

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ery management of COVID-19 patients and for prenatal care and antenatal surveillance.

As matters stand at present, much remains unknown or uncertain for COVID-19 patients in general and obstetric patients in specific. We still do not know how infectious this virus is in the nonpregnant population, but we do know that pregnancy alters the immune response to enable implantation in the first trimester and much later to participate in the onset of spontaneous labor at term. Seasonal influenza has been shown to be a more severe disease in pregnant women than in their nonpregnant counterparts. This has been attributed to an overexpression of the immune response rather than the opposite and may result in the type of cytokine storm also described in SARS-CoV-2 infections. However, Influenza A and B viruses are not coronaviruses, and, therefore, any inferences about their behavior may not be valid for COVID-19.

Currently, there is no effective treatment for COVID-19, and the availability of an effective vaccine may be a year or more away. For now, the best approaches to minimizing the risk of infection for pregnant women involve social distancing, frequent handwashing, and minimizing travel to essential functions like grocery shopping or—even better—using a grocery home delivery service if available. Pregnant women who work should explore the possibility of performing their jobs at home. Telemedicine is also being ramped up to deal with routine visits or minor complaints. Distance-learning for obstetric patients who are in school is becoming increasingly available. Many obstetric services are now performing COVID-19 screening on all of their patients whether or not they are symptomatic, but it should be remembered that genomic or serologic testing is simply a snapshot in time and may also render false positives and false negatives.

While we cannot know when this pandemic will end, valuable lessons will be learned about future preparations for the next one, developing models to better predict disease trends and discovering how to best protect our pregnant patients, their families, and their caregivers.