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EDITORIAL

A Note from the Editor-in-Chief

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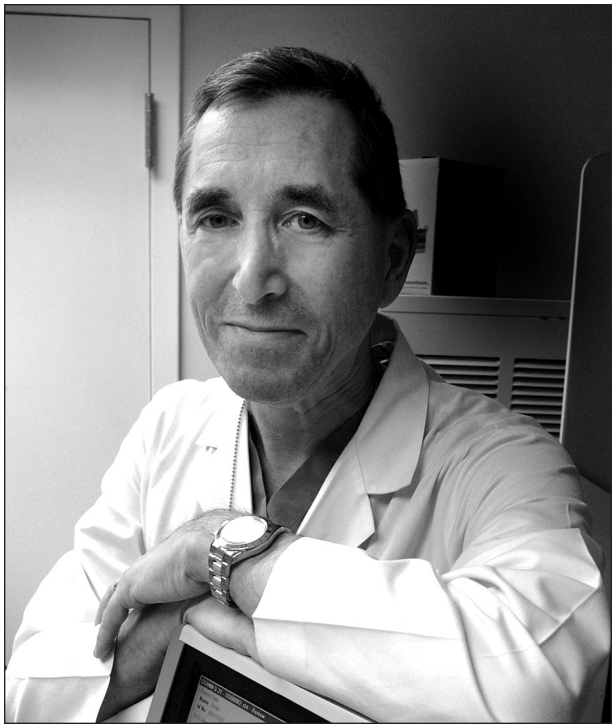
Welcome to the July-August 2020 Editor-in-Chief's page. Since the March-April 2020 issue that focused on the COVID-19 pandemic and pregnant women, there has been considerable new information that prompts this update for a medical phenomenon that is changing the way that we deliver care to this particularly vulnerable patient population. As I am writing this editorial, I am also anticipating my daily receipt of 30–40 COVID-19–related emails.



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

As COVID-19 testing in the United States as well as the rest of the world has ramped up, we are discovering that an increasing number of COVID-19 patients are asymptomatic, raising the realistic concerns regarding the carrier status of such individuals. The same has been found in pregnant woman, although the actual numbers reported vary considerably due to the limited sample sizes in the published reports. While the actual infection rate is still a moving target, fortunately it does seem to be quite low in pregnant women, hovering around 1% or less in some reports.

What is concerning, now that more data are available, is that, unlike earlier reports that seemed to indicate that COVID-19 was not a more severe disease in pregnant women than in their nonpregnant counterparts, this appears no longer to be the case. Most recent data as of July 2020 demonstrate a higher likelihood of ICU admission and need for mechanical ventilation in COVID-19–infected pregnant women, although, again, the actual numbers remain low, as does mortality associated with this disease in pregnancy.

Further studies have shown that the severity of COVID-19 not only increases with co-morbidities such as obesity, hypertension, and diabetes, similar to that of nonpregnant women, this is a disproportionately more serious illness for African-American and Hispanic pregnant women than it is

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for Caucasian gravidas. The causes for these findings are likely to be multifactorial as the former groups tend to have an increased burden of comorbid conditions, although even correcting for those, these disparities seem to persist.

In response to matters of safety for both pregnant patients and their healthcare providers, there have been numerous changes in obstetric practice. These include the consistent wearing of face masks for patients, personal protective equipment for doctors, midwives, and nurses, higher frequency of handwashing and surface wipe-downs, and social distancing. Other important practice modifications include COVID-19 testing for all patients presenting to labor and delivery units, the availability of negative-pressure rooms, and limitation of visitors and nonessential personnel. Planned elective procedures like repeat cesarean delivery are now preceded by interdisciplinary team reviews of known COVID-19 patients so that all bases are covered. The use of telemedicine for routine obstetric visits has burgeoned, another protective step that would minimize exposure for patients and providers.

Much remains uncertain. This includes the actual infection rate since the numbers are subject to continual change as more data are gathered. While there are robust tests for the COVID-19 virus, the reporting times can be as long as several days due to increased demands, raising the concern that a patient that has tested negative might then have been exposed during this interval. We also do not know how likely is vertical transmission of COVID-19 from mother to fetus since a paucity of documented cases have been reported so far. Studies of patients with known COVID-19 disease, whether symptomatic or not, have shown that there is a fairly rapid generation of specific antibodies. What remains unknown is whether there is a critical titer that confers immunity against reinfection and, if so, how long this immune state will endure.

There is some potentially good news out there. Currently there are a reported 150 COVID-19 vaccines in development worldwide, including a massive initiative by the World Health Organization with a goal to effect the delivery of two billion doses before the end of next year. While this is encouraging, it may be overly optimistic given the usual time for vaccine development, the following clinical trials demonstrating safety and efficacy, and production, which is often several years. In the same vein, COVID-19–specific antiviral medications for treating ill patients is somewhere off in the distance, and stop-gap measures like remdesivir are exactly that. So, it remains for those providing obstetric care to remain extremely vigilant, adhere to the best current preventative practices, and fully instruct their patients regarding signs and symptoms and proper procedures if they have had contact with someone who is COVID-19 positive.