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Correspondences

A practical approach for the management of obstetric and infertile women during the phase two of the novel coronavirus disease 2019 (COVID -19) pandemic



Dear Editor,

Since December 2019, the outbreak of the novel coronavirus disease 2019 (COVID-19) has rapidly spread from China worldwide until to be declared a pandemic. To date, worldwide, almost 5 million confirmed cases of COVID-19 have been reported.

It is urgent to address the impact of this pandemic on the obstetric and reproductive medicine, seeking for reorganization strategies of daily practice [1,2].

Although professional bodies and experts have provided specific guidance [2], based on current limited evidences, data on obstetric, neonatal and reproductive outcomes are still partial [3]. In many countries after national lockdown, a Phase 2 started relaxing restrictions. To manage this phase, we recommend adopting rigorous preventive measures. Global lockdown has significantly impacted on new births, especially on those obtained with assisted reproductive technology (ART).

Obstetrics patients

- Outpatient management. Avoid unnecessary inpatient monitoring.
- Routine antenatal care should be organized by a triaging procedure. For suspected patients, visits should be deferred; if it cannot be delayed, they should be performed in a dedicated outpatient clinical setting, as for symptomatic or positive patients.
- Telemedicine is encouraged to minimize number of visits.
- Testing for COVID-19 before any obstetric invasive procedure patients is recommended.
- Fetal therapy (for life-saving procedures) should continue to be offered with appropriate consent on risks and benefits.
- For inpatient monitoring, suspected/symptomatic women must be isolated and admitted after a detailed assessment by a multidisciplinary team. Timing and mode of delivery should be patient-tailored based on maternal and fetal status. There is minimal evidence for intrauterine vertical transmission of COVID-19 infection [4].
- Breastfeeding and rooming in may be allowed

Infertility patients

Given that ART babies represent about 0.3 % of the total live birth rate every year and the increasing population decline registered in industrialized countries, a worldwide restart of fertility treatment is necessary. Recently, an international panel of expert identified which patients should be prioritized for fertility care [5]. Advanced age women (i.e. age \geq 35 years) with low prognosis to ART, tend to lose their fertility potential faster than other infertile women. Other subgroups of women who should be prioritized are those who need urgent fertility preservation, including women affected by systemic autoimmune disorders who presented a restricted timeframe during which fertility preservation is possible. Progressively, once the risk of COVID-19 infection is decreasing, other ART treatment could restart following local regulations. The key principle in ART treatment during Phase II is that COVID-19 symptoms should be excluded before and during ART treatment in patients, staff and anyone attending ART centers.

In conclusion, management of obstetric and infertile women should be carefully performed in countries who are progressively relaxing restrictive measures using strict triaging. Outcome record and data sharing are encouraged to improve our knowledge and address the further phases of COVID-19 pandemic.

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Declaration of Competing Interest

The authors report no conflict of interest

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Covid-19 in pregnant women: General data from a French National Survey



To the Editor

The Covid-19 pandemic is responsible for almost 3 million cases and more than 200,000 deaths worldwide. The risks of Covid-19 on pregnancy are poorly known and to date, the only available data come from women admitted to the hospital.

Di Mascio reported 41 Covid-19 infections during pregnancy [1]. The rates of preterm birth, preterm premature rupture of membranes (pprom) and preeclampsia were enhanced. Cesarean section was performed in 91 %, without any vertical transmission. Della Marca reviewed 51 cases [2]. Symptoms presented were fever, cough, sore throat, dyspnea, fatigue, myalgia, malaise, diarrhea and cholecystitis. Pprom occurred in 26 %. Cesarean section rate was 96 %. In a retrospective cohort study, Chen et al. described 118 cases [3]. Rate of severe form was 8 %. Among the 68 women who delivered 21 % were premature, 93 % underwent Cesarean section and no baby had neonatal asphyxia. The 8 newborn who were tested for SRAS-Cov-2 were negative. Finally, another cohort study [4] reported severe pneumonia in 6.9 % of the 116 cases. Symptoms were fever, cough and fatigue. Preterm birth occurred in 21.2 % cases, including 6 cases with pprom. No vertical transmission was reported.

Here, we present results of a national French survey which collected a “real life” data of pregnant women that were confirmed positive for Covid-19 and who were either treated by their family doctor or required hospitalization. We used an internet platform targeting more than 900,000 French viewers of a television show focusing on pregnancy (“la Maison des Maternelles”). Women were invited to answer an anonymous survey asking if they were pregnant and had been suffering from Covid-19 disease. They gave digital consent to share and publish this data.

Out of 194 pregnant women who had Covid 19 compatible symptoms, 88 were tested positive for the SRAS-Cov-2, either by RT-PCR (n = 84), serologies (n = 10) and/or lung CT-scanner (n = 6) (Fig. 1). Their median age was 31 years old (IQR 28–34) and their median BMI was 22.7 kg/m² (IQR 21–28) (Table 1). Only 3 women were smokers (3.4 %). Seven women had diabetes mellitus before pregnancy (n = 2) or developed gestational diabetes (n = 5). The most frequent symptoms were fatigue

(80 %), ageusia and/or anosmia (76 %), cough (63 %), muscle aches (57 %) and fever (50 %).

Among these women, 18 were admitted to the hospital (20 %) and 6 (7%) required oxygen therapy and were considered as having severe disease. Women with severe disease were older (34 vs 31 years; p = 0.009), with higher BMI (29.2 vs 22.6 kg/m²; p = 0.002) and were more likely to have a history of diabetes (50 % vs 4.9 %; p = 0.006) than pregnant women without severe disease. Clinical presentation of women with severe disease was also different. They had more gastrointestinal symptoms, such as diarrhea (83 % vs 28 %; p = 0.011), nausea (67 % vs 22 %; p = 0.03) and vomiting (67 % vs 2 %; p = 0.005) (Table 1). The median gestational age at the time of Covid-19 was 27 weeks (ranges 4–34). Women had no maternal and/or fetal adverse obstetrical incidents, with moderate uterine contractions in 17 % of all cases. Among the 88 women, 14 gave birth to a live birth baby between 28 and 41 weeks, with cesarean sections in 5 cases (36 %).

The main limit of this study is the recruitment bias. Women decided by themselves whether to answer the survey and we

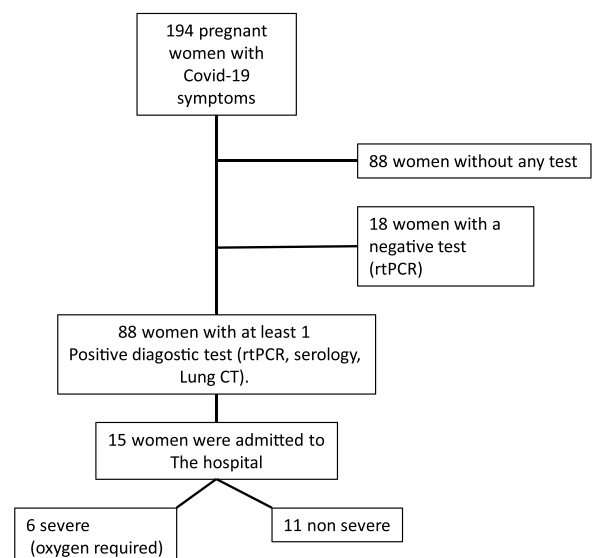


Fig. 1. Flow chart of the survey.