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## Covid-19 簡介

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COVID-19 is caused by SARS-CoV-2. Severe illness occurs in 10%– 20% of patients with a mortality of 2%– 4%. The illness is reported to be mild in children and in pregnant women.

Common symptoms of COVID-19 include fever, cough, tachydyspnoea, headache, malaise, abnormal smelling/tasting, rhinorrhea, and gastrointestinal issues. Skin rashes and thrombotic phenomenon may be present. The clinical condition may be aggravated suddenly 1 week after the disease onset.

Typical chest film abnormalities include ground-glass opacities, patches, and consolidations. Although the image findings on chest computed tomography are quite characteristic, these findings are not very specific for COVID-19. A specific diagnosis of COVID-19 relies on polymerase chain reaction (PCR). Antibody and antigen tests may aid the diagnosis of COVID-19 with a purpose of epidemiological survey or mass screening.

Several antiviral agents that is active against SARS-Cov-2 virus in vitro have been tried to treat patients with COVID-19. The global COVID-19 vaccine research and development landscape includes more than 100 vaccine candidates. Control of the epidemic relies on the prevention of droplet and contact transmissions.

**葉國明**
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## 國內治療 Covid-19 經驗

2020 年 2 月至 5 月期間，本院收治 29 名新型冠狀病毒感染病患。平均年齡為 41 歲，大多為境外移入，有 14 名女性。咳嗽、發燒及流鼻水，為最常見症狀。有一位無症狀病患，有一位重度肺炎合併呼吸衰竭及敗血性休克。全員已康復，於 5 月底前出院，平均住院天數約 28 天。

本院治療新冠感染，主要是根據衛生福利部疾病管制署編製的感染臨床處置暫行指引。其中重點包括:一、篩檢與檢傷分類，及早辨識可能的感染患者；並將依據病情嚴重度分為無併發症的輕症、肺炎、嚴重肺炎、及急性呼吸窘迫症等。二、立即執行適當的感染管制措施，使用適當的個人防護裝備。三、盡早給予支持性治療與監控病情變化；立即對呼吸窘迫，低血氧症或休克的患者給予氧氣治療；若患者無休克證據，則採取保守性的輸液治療。四、當標準氧氣治療無效，患者出現嚴重的低血氧性呼吸衰竭時，及時介入給予進一步的呼吸支持。

關於相關藥物治療，本院未使用全身性類固醇、remdesivir 或抗凝血劑。部分病患使用 azithromycin、hydroxychloroquine 或人類免疫球蛋白(IVIG)。

指引中關於孕產婦的注意事項為: 一、孕婦感染的症狀和其他患者相似。二、目前無證據顯示孕婦感染後有更高的風險演變為重症或產生胎兒窘迫。三、若有妊娠周數介於 24 至 34 周確診孕婦有早產風險，為促進胎兒肺部成熟給予全身性類固醇對胎兒之益處可能大於對孕婦之風險。四、考量新生兒染病風險，建議將疑似或確診產婦暫時與新生兒隔離。

**張　裕**
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## 新冠肺炎之婦科處理原則

*張 裕 副教授*
*義大醫院婦產部*

因應新冠病毒 COVID19 的疫情，對於需接受婦科手術病人的安排建議如下：

**Emergency surgeries (no delay)**

- Ectopic pregnancy
- Spontaneous abortion
- Adnexal torsion
- Rupture tubal-ovarian abscess
- Tubal-ovarian abscess not responding to conservative therapy
- Acute and severe vaginal bleeding
- Cesarean section
- Emergency cerclage of the cervix based on pelvic exam/ultrasound findings

**Surgeries that if significantly delayed could cause significant harm**

- Cancer or Suspected cancer
  - o Ovarian, Tubal or Peritoneal cancer
  - o Ovarian masses cancer is suspected
  - o Endometrial cancer and endometrial intraepithelial neoplasia
- o Cervix cancer
  - o Vulvar cancer
  - o Vaginal cancer
  - o Gestational Trophoblastic Neoplasia
- Cerclage of the cervix to prevent premature delivery based on history
- Pregnancy termination (for medical indication or patient request)

**Surgeries that could be delayed for a few weeks**

- Chorionic villus sampling/amniocentesis (CVS is performed between 11 and 14 weeks of gestation; amniocentesis is performed 15-22 weeks of gestation)
- D&C with or without hysteroscopy for abnormal uterine bleeding (pre- or postmenopausal) when cancer is suspected
- Cervical conization or Loop Electro-Excision Procedure to exclude cancer
- Excision of precancerous or possible cancerous lesions of the vulva

**Surgeries that can be delayed several months**

- Sterilization procedures (eg, salpingectomy)
- Surgery for fibroids (sarcoma is not suspected)
  o Myomectomy
  o Hysterectomy
- Surgery for endometriosis, pelvic pain
- Surgery for adnexal masses that are most likely benign (eg, dermoid cyst)
- Surgery for pelvic floor prolapse
- Surgery for urinary and/or fecal incontinence
- Therapeutic D&C with or without hysteroscopy with or without endometrial ablation for abnormal uterine bleeding and cancer is not suspected
- Cervical conization or Loop Electro-Excision Procedure for high grade squamous intraepithelial lesions
- Infertility procedures (eg, hysterosalpingograms, most elective embryo transfers)
- Genital plastic surgery
- Excision of condyloma acuminata (if cancer is not suspected)

*Pisake Lumbiganon (Tailand)*
*SY11*

- 2019 - Present: President-Elect, AOFOG
- 2017 - 2019: Vice President, AOFOG
- 2016 - 2018: President, Royal Thai College of Obstetricians and Gynaecologists
- 2009 - 2013: Dean, Faculty of Medicine, Khon Kaen University, Thailand
- 2013 - Present: Director, WHO Collaborating Centre in Research Synthesis in Reproductive Health
- 2002 - Present: Convenor, Cochrane Thailand

## COVID-19 situation in AOFOG and Living systematic review of COVID-19 and pregnancy

*Pisake Lumbiganon, MD, MS, FRCOG (Hon)*

The pandemic of COVID-19 with the official name of Severe Acute Respiratory Syndrome coronavirus 2 (SARS-CoV-2) started in Wuhan, China in late December 2019. The first COVID-19 case outside China was reported in Thailand on 13th January 2020. As of 3rd July 2020, there were 11,163,949 reported coronavirus cases with 528,102 deaths affecting 215 countries or states globally, https://www.worldometers.info/coronavirus/.

Among 28 members of AOFOG, as of 3rd July 2020, five members with the highest number of COVID-19 cases are India (649,889), Pakistan (221,896), Saudi Arabia (201,801), Bangladesh (156,391) and China (83,542). Members of AOFOG that have reasonably well controlled COVID-19 situation include Cambodia, China, Fiji, Hong Kong, Laos People's Democratic Republic, Macau, Malaysia, Mongolia, Myanmar, New Zealand, Papua New Guinea, Sri Lanka, Taiwan, Thailand and Vietnam. Countries that are almost there include Australia and South Korea. Countries that still have to work hard are Bangladesh, Egypt, India, Indonesia, Israel, Japan, Nepal, Pakistan, Philippines, Saudi Arabia, and Singapore.

Department of Sexual and Reproductive Health and Research in collaboration with WHO Collaborating Centre for Global Women's Health, University of Birmingham, UK has undertaken living systematic reviews (LSR) involving pregnant and postnatal women at risk, suspected, and diagnosed to have COVID-19 and synthesize the relevant evidence on prevalence, risk factors, mother-to-child transmission, diagnosis, treatment of the disease. The findings will be continuously updated, by incorporating appropriate new evidence as it becomes available. This very interesting information is accessible at https://www.birmingham.ac.uk/research/who-collaborating-centre/pregcov/index.aspx.

As of 5th July, 2020, the main information available from this Living Systematic Review are:

- The prevalence of COVID-19 in pregnant women admitted to the hospitals was about 5% which appears to be similar or lower than the rates in the general population based on limited data.
- The common symptoms of COVID-19 in pregnancy and postpartum were cough (34%) and fever (42%). Breathlessness and muscle ache were reported in 10% of women with suspected or confirmed COVID-19.
- The common laboratory findings were lymphopaenia (43%), raised white cell count (35%), and low platelets (19%). Relatively small studies reported raised levels of IL-6 (57%) and procalcitonin (36%).
- The clinical manifestations of COVID-19 in pregnancy and postpartum appears to be broadly similar to the general population, but are less frequent.
- 5% of pregnant and recently pregnant women diagnosed with COVID-19 were admitted to the intensive care unit, 84% were diagnosed to have pneumonia, 2% needed invasive ventilation.
- 15% delivered preterm before 37 weeks, 5% had preterm premature rupture of membranes, and 60% were delivered by caesarean section.
- The rate of stillbirths and neonatal deaths in babies born to pregnant women with suspected or confirmed COVID-19 was 0.4% for both outcomes.
- Neonatal sepsis was diagnosed in 4% of babies; 43 % babies were admitted to the neonatal unit
- Existing evidence has not identified major risks of complications in babies born to mothers with COVID-19.

Note: These informations are evolving and will be updated in my presentation in the Congress.