

A Short Note on COVID-19 in Pregnant Patient

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Perspective

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INTRODUCTION

New beta coronavirus, known as severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), is the cause of COVID-19, and has spread rapidly around the world, reaching more than 200 countries, around 364 million people and causing more than 5 million deaths according to the World Health Organization. Some cases of severe acute respiratory syndrome were reported in Wuhan, Hubei province, in early December 2019. This respiratory infection spread quickly around the world, causing widespread public concern. The World Health Organization (WHO) has named this illness Coronavirus Disease 2019 (COVID-19), as well as the virus that caused it, SARS-CoV-2. The symptomatic patient exhibits a wide range of symptoms, including cough, fever, and fatigue, loss of smell and taste, and shortness of breath. The COVID-19 pandemic has had a significant impact on the health-care system, particularly specialised maternal services, because the availability of structures, medicines, and health professionals has been directed to the treatment of COVID-19, putting maternal health services on the back burner^[1-5].

DESCRIPTION

Many questions have been raised about SARS-CoV-2 transmission since the spread of the COVID-19 pandemic. This article discusses a case of premature labour caused by severe COVID-19 illness without vertical transmission. During her 28th week of pregnancy, the mother, a young woman with heart disease and mitral valve replacement, received a confirmed diagnosis of COVID-19, necessitating an emergency delivery. The mother did not respond to the treatment due to COVID-19 clinical complications, which led to her death 12 days after giving birth. The baby developed normally, with no evidence of vertical transmission and negative SARS-CoV-2 results. This case report exemplifies some aspects of this emerging viral outbreak that are still not fully understood, particularly mother-to-child transmission. Pregnant women with cardiomyopathy are a special risk group, with little scientific evidence about the likelihood of vertical transmission. The majority of pregnant women are asymptomatic or have only minor symptoms. Only a small number of pregnant women infected with SARS-CoV-2 required ICU admission and IVM. There were no reports of vertical transmissions during the analysis of these studies. There is currently no clear information on how immune regulation is related to pregnancy, how it affects the course of COVID-19, or how the mother's immune system prevents virus transmission to the foetus.

CONCLUSION

Vertical transmission is still a risk that is poorly understood. There has been no firm support for this type of transmission up to this point. A significant finding was that the nasopharyngeal swab sample was collected within the first 24 hours of the new-born's life and tested negative for SARS-CoV-2. It is thought that, in addition to the maternal immune system, pre- and trans-operative care in caesarean sections, such as the mother wearing masks, disinfection of the surgical environment, and isolation measures implemented immediately after birth, reduces the chances of new-born contagion. Because of her previous clinically extremely vulnerable comorbidities, the young pregnant woman in this study died from SARS-CoV-2 infection. This case includes a pregnancy and cardiomyopathy combination, which differs from other cases described in the literature that include a healthy female population. Aside from the severe and acute COVID-19 course, the baby was delivered via emergency caesarean and showed no signs of early or late SARS-CoV-2 infection. It is consistent with the lower probability of SARS-CoV-2 vertical transmission. More research is needed to understand how this protection works.

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