Editorial

Pediatric and Adolescent Gynecology (PAG) in the Time of a Pandemic

Sometimes I struggle to decide what I will write about as a topic of editorials for the *Journal of Pediatric and Adolescent Gynecology* (JPAG). Other times, the news provides an easy choice of topics. Today, I am preoccupied with the topic at the forefront of discussions, news reports, and social media posts—the novel coronavirus COVID-19. As I write, on March 12, the situation in the United States is evolving—as it has been for the last few weeks, and will in the weeks to come in the United States and throughout the world. Admittedly, I am providing my perspective from the United States, and I recognize that your perspectives will be different. By the time you read this, we will have more information, and a different view of the situation. Currently I and my family are well, but colleagues at my institution have tested positive, in-person classes for undergraduate and medical students have been cancelled, new policies for hospital visitors have been instituted, national meetings have been cancelled, and we are all washing our hands and applying hand sanitizer gel even more than we had been previously—which was a lot.

My travel plans have changed. As I write this piece, the Annual Clinical and Research Meeting of the North American Society for Pediatric and Adolescent Gynecology (NASPAG) has not officially been cancelled, but this may well happen. I had made the decision that I could not responsibly attend the meeting in person, when my county is one in which there is community spread of the virus. I felt that I did not want to be responsible for being a possible vector, bringing the virus to friends and colleagues at the meeting. Not surprisingly, the Annual Clinical and Scientific meeting of the American College of Obstetricians and Gynecologists (ACOG), which was scheduled to meet in Seattle, another community where there is community spread, has been cancelled. After President Trump announced a travel ban on visitors from Europe last night, I received an e-mail from a colleague in Europe who was planning to attend the NASPAG meeting, indicating that she will be unable to attend. Each of us is making individual decisions that will affect not only our own health, but that of our family members (whether young kids or elderly parents), our colleagues, and our patients. Our decisions are increasing being determined by government decisions that, while they may feel coercive, are nevertheless increasingly necessary, and perhaps too little too late.

The pace with which I am receiving new information that I am being asked to process and act on is escalating. I heard a term on National Public Radio this morning that describes how I am feeling with the barrage of information: “shock and stress.” I suspect that you are experiencing some variant of this feeling, as we react to announcements and communications from our institutions; our president and vice president; the Centers for Disease Control and Prevention (CDC); our social groups; our professional organizations; our friends and our families. The World Health Organization (WHO) has declared just this week that we are experiencing a pandemic, a term that the organization had previously avoided. I searched for the definition of pandemic—and read about the highest level of public health emergency. I’m learning more about the previously identified coronaviruses as well as the novel COVID-19. I’m hearing and using terms that were not previously a part of my everyday vocabulary: epidemic, vectors of infection, isolation, quarantine, mitigation, incubation period. As physicians and clinicians, we are all expected to be knowledgeable about infectious diseases, and to be a source of accurate information to friends and to family; the stress of judging how much to emphasize to our neighbors that a pandemic means that we cannot proceed with business as usual vs how much to note that it is not necessary to stock up on toilet paper is tiring.

We are all being impacted in a variety of ways that we could not have imagined just last week. Yesterday I heard on the news that three Transportation Security Administration (TSA) workers at the nearby San Jose, California airport had tested positive. While this is not surprising, given that each TSA worker undoubtedly comes in contact with hundreds of travelers from all over the globe on a daily basis, it also means that these workers potentially exposed more individual travelers who were coming from and going to all parts of the globe. Some of you have children that you are both worrying about being exposed to the virus at school and worrying about how you will be able to work when the school is closed to prevent more infections. Some of you have elderly parents who are most at risk for succumbing to the infection and its pulmonary complications. Some of you have had to change your vacation plans for spring break. As the one source of information in the current administration whom I trust because he is a scientist, Dr. Anthony Fauci stated, “We can’t be doing the kinds of things we were doing a few months ago” (https://youtu.be/0jfD4xzrJtc).

But I, and most of you, are fortunate. We have jobs that allow us to have health insurance and sick leave. If this pandemic doesn’t teach us that universal health insurance is needed in the United States, I don’t know what will. Individuals who do not have health insurance are being faced with significant medical bills when they contract the virus and perhaps ultimately become ill with pneumonia and respiratory compromise and must be hospitalized. Not only

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does that individual and family suffer, but we all do when the virus spreads more widely because that individual must continue to work at a minimum wage job, as she has no health insurance, no paid sick leave, and thus no access to early testing or practical ability to self-quarantine without losing her job. We all suffer because our president disbanded the unit of the National Security Council that was established to coordinate a government-wide response to epidemics and left leaderless the Homeland Security Advisor position that was intended to manage complex transnational threats.[1] We all suffer when the government's response to providing early testing for COVID-19 is too little and too late, leading to the move from containment to mitigation.[2] Currently, while testing is more widely available, it is still difficult to prescribe or find a site where testing can be done. Specific and strong steps from the White House have been suggested and would help with mitigation, but we all are now involved on a local level, as well.[3]

As a groups of colleagues from adolescent medicine discussed these current events in clinic this week, we agreed that we were assuming that we would become infected. Not that we might get infected, but that we would. My biggest fear is not that I myself will have a severe infection, even though I am past the age of 60 and thus categorized as having a higher risk of complications. My fear is that when I get infected and before I become symptomatic, I will transmit the virus to friends, family, colleagues, and—importantly—to other patients, many of whom are immunocompromised or have multiple comorbidities. So, I am socially distancing myself to the extent possible, and washing my hands and using alcohol gel multiple times a day. Sometimes it's almost comical, as we struggle to find out what is appropriate in this new age. I sing in a choral group, and we had a rehearsal early this week, but rather than sitting close to one another in the church where we rehearse, we were spread out—three to a pew in every other row of pews. The rehearsal was videoed so that the singers who chose not to come to practice were able to view a private YouTube channel and sing along at home (I marvel at what technology can do). Somehow, the rehearsal worked, and we were able to sing together the choruses from Mendelssohn's wonderful oratorio, Elijah.

What about PAG in the time of a pandemic? My patients are mostly still coming to appointments, although the "no-show" rates to clinic have been higher than usual. Patients are being called and offered video telehealth visits if they have symptoms. There have been changes to inpatient visitor allowances, and limitations on who can accompany outpatients. Physicians are being encouraged to provide telehealth visits. In the end, we will continue to do what we have been doing: provide care to girls and adolescent young women with urgent gynecologic problems, as we always have.

And so, that brings me to this issue of JPAG, and as usual, I am delighted to tell you of some of the content. My Stanford adolescent medicine colleague Neville Golden has written an excellent review on bones and birth control.[4] For me, the biggest take-away message from this thorough and well-written review is that low-dose combined oral contraceptives (COCs), those with <30 μg ethinyl estradiol, are insufficient to support peak bone mass acquisition during adolescence. This is a message that I have observed is sometimes lost on the community of general pediatricians and obstetrician-gynecologists; we PAG clinicians can provide that educational message. Low-dose COCs can be too low for adolescents. With regard to bones and depot medroxyprogesterone acetate for contraception, the review notes that both the Society for Adolescent Health (SAHM) and ACOG recommend that the risks and benefits of "the shot" for contraception be discussed with adolescents. As for long-acting reversible contraceptives (LARC), these methods do not appear to affect peak bone mass acquisition or fracture risk, and remain the first-line contraceptive choice for teens.

Other important reports in this issue include a 2-part report on the unmet needs of both adolescent girls with heavy menstrual bleeding and dysmenorrhea and the unmet needs of their parents, from our colleagues in Australia.[5,6] These authors document what we see in our clinical practices: that menstrual problems can have a profound impact on physical and psychosocial health of adolescents, and that they and their parents have a real need for information and support. Drs. Dietrich and Hernandez provide a report from their institution on the gynecologic problems of adolescents with Ehlers-Danlos syndrome, which was helpful to me in the management of a patient I saw last week.[7] This issue also contains 2 reports on adolescents in juvenile detention facilities, an underserved and vulnerable population in general, with significant needs for reproductive healthcare.[8–10]

Stay healthy, and may JPAG inform your clinical care.

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