Question 1:
How do you propose ob-gyns should tackle the development of antimicrobial resistance to known standard agents? Are there common prescribing practices within obstetrics and gynecology that you feel have contributed to antimicrobial resistance?

Response from Dr. Beigi:
Ob-gyns should continue to practice judicious use of antibiotics and follow guidelines for the diagnosis and management of conditions that they manage. More research on the value and safety of potential for shorter antibiotic courses, as have been done in some other disciplines, would be beneficial. Some of the older antibiotics may again become priority choices going forward.

Ob-gyns should also follow their hospital’s antimicrobial stewardship programs to the extent possible. These programs have been effective at directing appropriate use of antibiotics from both clinical and cost-effective perspectives.

Question 2:
As more patients decline vaccinations, how do you suggest health care providers counsel pregnant patients who decline vaccinations for themselves and/or their children? Are there specific vaccines you feel should be mandatory?

Response from Dr. Beigi:
Clear statements and open discussions about the risks and benefits of vaccination are always justified. In these discussions it is also important to consider and discuss with the patients the risks of not immunizing (ie, severe disease). Previous and mounting evidence continues to demonstrate clear safety of recommended
vaccinations in pregnancy. Additionally, mounting evidence continues to validate the efficacy of vaccinations given during pregnancy in terms of offering protection to both mothers and neonates. This is very important because mothers have unique susceptibilities to some infectious diseases and neonates are also uniquely at very high risk for poor outcomes from various vaccine preventable diseases such as influenza, pertussis, and others.

**Question 3:**

During the severe acute respiratory syndrome (SARS) outbreak, traditional nonpharmaceutical countermeasures were very effective in curbing disease spread. You mentioned that global control was achieved within 5 months of the first notification. Do you believe that these nonpharmaceutical countermeasures you described should be employed at all times or do you feel that health care workers should only employ them during times of outbreak?

**Response from Dr. Beigi:**

*Standard precautions and vigilance to proper infection prevention recommendations are always important. These become increasingly critical when we have unique outbreaks of highly pathogenic infectious diseases, sometimes without any available pharmaceutical countermeasures. This was the case with SARS. The power and importance of the time-tested measures can’t be overemphasized and remain a cornerstone of effective identification and response.*

**Question 4:**

In terms of influenza preparation, do you suggest a specific month in which pregnant women should receive the influenza vaccine? Do you suggest that ob-gyn offices stock rapid flu tests? Is there any situation where you would prescribe oseltamivir in a woman who does not test positive for influenza?

**Response from Dr. Beigi:**

*Pregnant women should get the influenza vaccine each year as soon the vaccine is available. The onset of influenza season is somewhat unpredictable from year to year, so the earlier in the flu season women receive it, the better. It is safe to give in all trimesters of pregnancy.*

*Currently widely available rapid flu tests do not have a reliably high sensitivity, thus producing frequent false negative results. This is problematic in high-risk populations, such as pregnant women, where it is better to err on the side of safety. Because of this shortcoming, currently available rapid flu tests are not widely recommended. This may change with the advent of highly sensitive rapid flu tests becoming widely available.*

*I would consider prescribing oseltamivir (and do so) during flu season in a pregnant woman with a suggestive clinical scenario for influenza when no highly reliable test has been done. Continuing data confirm that oseltamivir is safe and effective for use in pregnancy and is recommended by the Centers for Disease Control and Prevention (CDC) and the American College of Obstetricians and Gynecologists.*

**Question 5:**

In terms of the Ebola virus, which specific cultural practices and caregiver roles contribute to women being more likely than men to contract Ebola infection?

**Response from Dr. Beigi:**

*It appears that women are more likely to be primary caregivers to others with clinical illness, thus placing them at higher risk for exposure to the highly transmissible virus.*
Question 6:

In the last 40 years, no Ebola-specific therapy has been identified. What do you feel is the biggest barrier to identifying such a therapy?

Response from Dr. Beigi:

There are many barriers. To name a few, it appears that the challenges of testing products and the sporadic nature of the outbreaks have contributed to an overall lack of therapies. This most recent outbreak seems to have stimulated increased interest and focus on countermeasure development in a positive and productive manner.

Question 7:

Do you think the Zika virus has garnered too much attention and resources, or do you feel that the response has been appropriate?

Response from Dr. Beigi:

The response and resources are absolutely appropriate from my perspective. Society has not seen a teratogenic viral outbreak in over 40 years, and we have never seen one with dual transmission capabilities (vector-borne and sexual transmission). These varied transmission capabilities raise many questions about global health as well as sexual health that affect large segments of the population. Given the devastating teratogenic nature of the outbreak, its associated impact(s) (which is still being fully delineated), and the relative lack of knowledge about this pathogen, the attention is justified.