Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

mutations and cCR to primary chemotherapy may be candidates who do not require surgery. Although IDS has been shown to be less morbid than primary cytoreductions, there are still inherent surgical risks.[4] Because examination, imaging, and CA-125 testing confirmed a cCR in our patients, these risks were believed to outweigh the benefits.

In addition, the availability of PARP inhibition offers patients with *BRCA* mutations a unique opportunity to benefit from maintenance therapy. Both of these patients underwent genetic testing during their primary chemotherapy as is standard at our institution. This allowed for early identification of the *BRCA* mutations and their candidacy for maintenance olaparib based on the Food and Drug Administration's approval of olaparib for frontline maintenance in patients with *BRCA1/2* mutations. This is based on the results of SOLO-1, which demonstrated a hazard ratio for disease progression or death of 0.30 (95% confidence interval, 0.23−0.41), favoring olaparib in patients with advanced-stage, high-grade EOC with response to primary platinum-based chemotherapy.[5]

Ultimately, this study presents an alternative management strategy for patients with EOC and *BRCA* mutations who have cCRs to platinum-based chemotherapy, especially with the excellent outcomes observed in SOLO-1. This strategy may now be even more relevant in the context of the current COVID-19 pandemic because it allowed both patients to avoid inpatient surgery and hospitalization, which in turn would have allowed for reduction in exposure to patients with COVID-19 and conservation of personal protective equipment. In addition, these patients would not have entered the growing queue of patients whose surgeries may have been further delayed because of some hospitals restricting surgeries during the COVID-19 pandemic. ■

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This communication has been published in the middle of the COVID-19 pandemic and is available via expedited publication to assist patients and healthcare providers.

REFERENCES

1. Liang W, Guan W, Chen R, et al. Cancer patients in SARS-CoV-2 infection: a nationwide analysis in China. Lancet Oncol 2020;21:335–7.
2. Society of Gynecologic Oncology. Gynecologic oncology considerations during the COVID-19 pandemic. Available at: https://www.sgo.org/clinical-practice/management/covid-19-resources-for-health-care-practitioners/gyn-onc-considerations-during-covid-19/. Accessed April 10, 2020.
3. Boffa DJ, Rosen JE, Mallin K, et al. Using the National Cancer Database for outcomes research: a review. JAMA Oncol 2017;3:1722–8.
4. Fagotti A, Ferrandina G, Vizzielli G, et al. Phase III randomised clinical trial comparing primary surgery versus neoadjuvant chemotherapy in advanced epithelial ovarian cancer with high tumour load (SCORPION trial): final analysis of peri-operative outcome. Eur J Cancer 2016;59:22–33.
5. Moore K, Colombo N, Scambia G, et al. Maintenance olaparib in patients with newly diagnosed advanced ovarian cancer. N Engl J Med 2018;379:2495–505.

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Screening all pregnant women admitted to labor and delivery for the virus responsible for coronavirus disease 2019

Check for updates

TO THE EDITORS: We read with great interest the study of Vintzileos et al and their call for universal obstetrical coronavirus disease 2019 (COVID-19) screening to conserve limited personal protective equipment (PPE) and to allow appropriate triage, adequate obstetrical and neonatal management, and safe patient transport in overcrowded hospitals.[1] However, we disagree with their call for universal COVID-19 testing of asymptomatic pregnant women, rather we suggest continued adherence to the public health guidelines for COVID-19 diagnostic testing.[2,3] The COVID-19 test is extremely specific because it identifies the viral RNA to which the individual has been exposed during the preceding 21 days. The viral load peaks between 7 to 10 days after onset of symptoms and declines throughout the next 3 weeks. Detection is performed by the highly specific (96% specificity) polymerase chain reaction.[4] The false-negative test rates for this test range from 30% to 3% in asymptomatic and symptomatic populations, respectively.[5] A positive COVID-19

test result provides no information regarding the individual's current or future ability to transmit the virus. We therefore recommend continued use of universal PPE during testing, limited to diagnosis in disease management, and as the foundation of a contact public health tracing program. We ask the authors whether there was any difference in the temperature upon admission between women who received positive test results for COVID-19 and women who received negative test results for COVID-19. ■

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REFERENCES

1. Vintzileos WS, Muscat J, Hoffmann E, et al. Screening all pregnant women admitted to labor and delivery for the virus responsible for COVID-19. Am J Obstet Gynecol 2020. [Epub ahead of print].
2. World Health Organization (WHO). Advice on the use of point-of-care immunodiagnostic tests for COVID-19. Available at: https://www.who.int/news-room/commentaries/detail/advice-on-the-use-of-point-of-care-immunodiagnostic-tests-for-covid-19. Accessed April 28, 2020.
3. Centers for Disease Control and Prevention (CDC). Testing for COVID-19. 2020. Available at: https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/testing.html. Accessed April 27, 2020.
4. Cheng PK, Wong DA, Tong LK, et al. Viral shedding patterns of coronavirus in patients with probable severe acute respiratory syndrome. Lancet 2004;363:1699–700.
5. Wang W, Xu Y, Gao R, et al. Detection of SARS-CoV-2 in different types of clinical specimens. JAMA 2020;323:1843–4.

 https://doi.org/10.1016/j.ajog.2020.05.040

REPLY

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We would like to thank Dr Henderson et al for their interest in our article and for raising some interesting points. Dr Henderson et al disagree with our proposal for universal coronavirus disease 2019 (COVID-19) testing of women admitted to labor and delivery. To support their position, they cited the Centers for Disease Control and Prevention (CDC) report produced in the early stages of the COVID-19 pandemic.1 However, at that time, testing capacity was limited, and the degree of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) transmission from asymptomatic patients was uncertain. In addition, the CDC guidelines on testing were not exclusive to symptomatic individuals; furthermore, the guidelines left the decision for testing to "state and local health departments or healthcare providers."[1] By the end of March 2020, testing capacity using rapid and accurate real-time polymerase chain reaction testing increased nationwide. At the same time, various reports, including recent studies cited by the CDC, suggested widespread viral transmission by both presymptomatic and asymptomatic patients who received positive test results for COVID-19.[2] We feel substantiated by these more recent findings that found strong epidemiologic evidence for transmission of the SARS-CoV-2 from presymptomatic and asymptomatic patients.[2] The aforementioned data, in conjunction with our study's finding that 66% of pregnant women who received positive test results for COVID-19 are asymptomatic, strongly support the logic of universal testing for SARS-CoV-2 among obstetrical patients admitted to the hospital.

The authors' second point about viral load peaking between 7 and 10 days after the onset of symptoms and declining in the next 3 weeks pertains to a study about symptomatic patients,[3] whereas the main focus of our study was the detection and prevention of viral spread and transmission among presymptomatic and asymptomatic patients. The authors' third point about a 30% false-negative rate in asymptomatic patients who received positive test results for COVID-19 could not be verified in their cited reference.[4] Finally, the authors' fourth point about temperature differences between mothers who received positive test results for COVID-19 and mothers who received negative test results for COVID-19 is not relevant because the main purpose of universal testing is not to detect symptomatic patients but to identify asymptomatic patients who may be transmitting the virus to others.

Universal testing ensures the correct cohorting of patients, the correct use of personal protective equipment, and the correct utilization of inpatient resources if the need arises. In addition, knowing who received positive test result increases the pool of people eligible for plasma donation, which is invaluable to those who are critically ill fighting COVID-19. ■

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