



the second stage of labor and delivery until the test result became available.

During this study period, all patients and their support persons were given procedure masks on arrival and asked to wear them during their hospitalization as a means of source control. One support person was allowed to join women admitted for delivery; these support people were screened for COVID-19 infection using symptom assessment, but testing for support persons was not performed.

## RESULTS

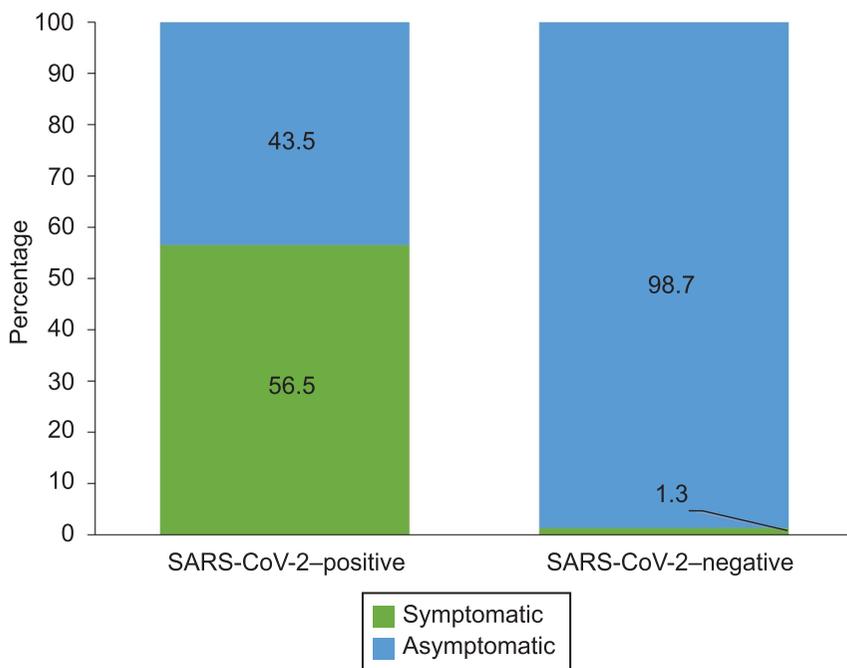
Over the first 20 days of universal testing, 635 pregnant women were admitted to Northwestern Memorial Hospital, of whom 23 (3.6%) tested positive for SARS-CoV-2 infection. Of the 23 who tested positive, 10 (43.5%) were asymptomatic on initial presentation. Twenty-one (3.3%) pregnant women who were admitted reported symptoms of COVID-19 infection. Of these 21 women who exhibited symptoms, 13 (61.9%) tested positive for SARS-CoV-2 infection. Of the 614 women who were asymptomatic, 10 (1.6%) tested positive for SARS-CoV-2. The distribution of women who reported symptoms, stratified by their SARS-CoV-2 test results, is depicted in Figure 1.

## DISCUSSION

Comparison of these data with the data reported from New York City (Sutton D et al. *New Engl J Med* 2020 Apr 13 [Epub ahead of print].) provides some

interesting insights. First, our data corroborate the observation that pregnant women with SARS-CoV-2 infection on admission do not seem to be reliably identified using symptom screening alone. This finding has important implications for policies to mitigate exposure to other parturients, newborns, and health care workers.

Second, testing within the general community across the United States is typically reserved for individuals with moderate to severe symptoms, given the limited availability of testing supplies. Our observed SARS-CoV-2 infection prevalence identified with universal screening (3.6%, 95% CI 2.3–5.4%) is sixfold higher than prevalence rates based on reported rates for our county (0.6%) during this period.<sup>3</sup> Comparing the observed SARS-CoV-2 infection prevalence obtained with universal testing (15.4%) at Columbia University Irving Medical Center (Sutton D et al. *New Engl J Med* 2020 Apr 13 [Epub ahead of print].) with the reported prevalence in New York City at that time<sup>4</sup> (0.7%) generates a 21-fold higher prevalence identified with universal testing on the labor and delivery unit. These ratios stand in contrast to data published from Iceland,<sup>5</sup> wherein universal testing resulted in an identified prevalence that was merely 1.6-fold higher than the reported country-wide prevalence.<sup>6</sup> The possibility remains that pregnant women may not be a representative sample of the entire community or that asymptomatic viremia



**Fig. 1.** Percentage of women with symptoms of coronavirus disease 2019 (COVID-19), stratified by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) test result.

Miller. *Universal SARS-CoV-2 Testing in Pregnancy. Obstet Gynecol* 2020.



may be increased in pregnancy compared with the nonpregnant state. However, data being produced by labor and delivery units across the United States that have implemented universal testing point to the strong possibility that community infection prevalence may far exceed what is currently being reported and may reflect the community prevalence of SARS-CoV-2 infection.

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## PEER REVIEW HISTORY

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