Re: Maternal transmission of SARS-CoV-2 to the neonate, and possible routes for such transmission: a systematic review and critical analysis

Sir,

We read with interest the article by Kate F. Walker and colleagues entitled ‘Maternal transmission of SARS-COV-2 to the neonate, and possible routes for such transmission: a systematic review and critical analysis’.1

In the article, the authors systematically analysed the mode of delivery on the infection rates of COVID-19 in the newborn. Despite the limitations, especially the retrospective nature of studies examined, this study provided important information about the selection of mode of delivery of women with COVID-19. It suggests that neonatal infection rates are not different after caesarean birth or vaginal delivery.

However, the severity of the COVID-19 infection of the mothers was not considered. Clinically, pregnant women with the more severe COVID-19 infection appear to prefer delivery by caesarean birth rather than vaginal birth. Therefore, it is possible that any beneficial effects of caesarean birth in reducing transmission of COVID-19 might not be apparent because the severity of COVID-19 infection was greater in these women. This selective bias would weaken the conclusions of current studies.

We feel that prospective evaluation of the safety of mode of delivery with COVID-19 is required.

References
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Re: Reflex cytology for triage of high-risk human papillomavirus positive self-sampled material in cervical cancer screening: a prospective cohort study

Sir,

We read with interest the recent study by Loopik et al. that evaluated cytology testing on high-risk human papillomavirus (hrHPV)-positive self samples.1 This study addressed an increasingly relevant issue in triaging women with hrHPV-positive self samples for immediate colposcopy in order to decrease loss to follow-up. Nevertheless, we would like to raise some concerns and potential solutions.

As the authors showed, cytology on self samples (CS) as triage for HPV-positive self samples had an extremely low sensitivity of only 29.4% (95% CI 22.5–37.1%) for detecting cervical intraepithelial neoplasia grade 2 or worse (CIN2+). This was much lower than the sensitivity of cytology (74.8%) recorded in our recent study (Table 1), where CS and clinician samples were collected at a single visit.2 The sensitivity of CS was also inferior to partial genotyping (HPV16 or HPV16/18) for triage (29.4% versus 49.6% and 52.6%, Table 1) for detecting CIN2+, as reported by Song et al.2 Unfortunately, HPV genotyping and its performance in the triage of HPV-positive CS was not included in this study.

Besides accuracy, the cost-effectiveness of CS should be considered. The authors suggested that the 15% of hrHPV-positive women with abnormal CS could be referred directly, but 85% would need CS and an additional cytology test.1 It is not clear that cost savings from avoiding cytology on clinician samples for limited cases (15%) would outweigh the substantial burden from the collection and reading of two cytology tests for most (85%) cases.

Cytology triage on CS is limited by low sensitivity and the need for substantial repeat testing.3 The main site of hrHPV infection is at the transformation zone of the cervix, but self samples contain a mixture of vaginal and exfoliated cervical cells, often lacking endocervical cells and thereby lowering the sensitivity of the test. Likewise, as a result of low sensitivity (confirmed in a