Letter to the Editor

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‘Getting to zero’ cross transmission of SARS-CoV-2 in obstetric ultrasound during COVID-19 pandemic

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To the Editor,

We are pleased that our viewpoint article has generated interest in the infection control community [1, 2]. The matter of preventing cross contamination of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) deserves further discussion as the pandemic still develops. We agree that prevention of healthcare-associated SARS-CoV-2 infection in pregnant women should not be limited only in the obstetric ultrasound suite. Proper disposal of face masks, personal protective equipment, and other medical waste (i.e. plastic probe covers and condoms) during the pandemic deserves significant attention by the concerned authorities [3]. The main assertion is that “zero-error” concept should be adopted for SARS-CoV-2, as well as all hospital-acquired infection [2]. Isolated reports of infection prevention campaigns resulting in zero hospital-acquired infections exist [4]. In reality, however, only 55–70% of hospital-acquired infections are potentially preventable [5].

Primary transmission of SARS-CoV-2 is human-to-human via oral and respiratory droplets with the virus-laden environment play a lesser role in the propagation of disease [6]. The main reason for cautioning the zero-error concept is our limited understanding of the physiopathology of SARS-CoV-2 infection. We still do not know why some individuals do, and others do not, develop coronavirus disease of 2019 (COVID-19), even after compliance with good practice guidelines and workflow policies [7]. Most people would consider that a “mistake” has been

made somewhere along the line, but nobody knows if this is really the case [8]. The clinically compatible risk management concept should therefore include blame-free reporting, collective use of reported events for root-cause analysis, and continuous quality improvement. “Getting-to-zero” concept may be an alternative policy framework for the elimination of hospital-associated infections [9].

Our described protocol is subjected for adaptation for various levels of clinical settings [1]. Minimizing risk is a challenge that has to be met jointly by medical teams, hospital managers, and patients’ associations in a climate of transparency. Additional preventative measures should be implemented and explained when risks escalate, but these measures will not reduce the risk to zero [7].

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