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## Missed diagnosis in the COVID-19 era: Are we losing ourselves?

### To the Editor

The current pandemic of coronavirus disease 2019 (COVID-19) has taken a toll on our already overburdened healthcare system [1]. Doctors are scarce in public hospitals, and with the current scenario, the emergency departments (ED) are expected to cater to a large number of patients presenting with respiratory complaints [2]. This has led to less emphasis on clinical examination as it is difficult to perform while wearing personal protective equipment, including face shields. This may lead to missed common diagnoses by overtime working resident doctors in emergencies but may be life-threatening unless managed in time [3, 4]. We need to encourage the medical fraternity to continue using clinical acumen while dealing with the current pandemic. Herein we present a patient, who could have been easily diagnosed if it was not a pandemic situation, but the diagnosis was missed due to COVID-19 panic in emergencies.

A 22-year-old male presented to the Emergency Department with the complaints of high-grade fever, shortness of breath, and dry cough for three days associated with abdominal pain for two days. He was a non-smoker and had no previous medical history of significance. On evaluation in the emergency, he was conscious and oriented. He was febrile with a heart rate of 132 beats per minute, respiratory rate of 24 per minute, blood pressure of 86/56 mm Hg and a pulse oxygen saturation of 83% while breathing room air. A chest ultrasound performed in emergency demonstrated bilateral lung sliding along with the presence of B lines and no pleural or pericardial effusion. Blood investigations revealed haemoglobin of

13 g/dL, total leucocyte count of 5200 cells/mm<sup>3</sup>, and platelet count of 76,000 cells/cu.mm. Given the above presentation and symptoms, the patient was suspected of having COVID-19, and an oro-nasopharyngeal swab was sent for RT-PCR for SARS-CoV-2. The patient was managed with intravenous fluids and amoxicillin-clavulanate. After 8 hours, the RT-PCR report came negative, and the patient was shifted to the Pulmonary Medicine ward in view of the respiratory complaints. When received in the ward, the man had gross abdominal distention. On history taking, it was noted that he had not passed stools for three days. The chest radiograph performed revealed air under the left diaphragm (Figure 1), and erect



**Figure 1.** The chest radiograph demonstrating clear lung fields with air under left side of diaphragm suggesting pneumoperitoneum

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abdomen radiograph showed dilated bowel loops and multiple air-fluid levels. The patient was immediately taken up for emergency exploratory laparotomy. Intraoperatively, he was found to have an ileal perforation around 30 cm proximal to the ileocecal junction with perforation peritonitis. Peritoneal lavage and a diversion loop ileostomy were performed. Post-procedure period was uneventful, and the patient was discharged after five days.

This case brings us to the issue of learning, teaching and practising the basic clinical skills during the pandemic time. We all need to make efforts to alleviate panic in the emergencies and encourage resident doctors working in emergencies to continue using clinical judgements while deciding plan for the patients with respiratory symptoms. Minimum essential history in the form of the review of all major body systems should form part of the initial assessment. Let us

not forget our basics, and we all will succeed in overcoming these hard times.

#### Conflict of interest

None declared.

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