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Disruption in Medical Care of Non-COVID Patients in COVID-19 Pandemic

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In December 2019, a novel coronavirus (COVID-19) was detected in Wuhan Hubei province, China. The virus has caused a global concern because of its high potential for transmission, high morbidity and mortality. COVID-19 spreads so rapidly across an increasing number of countries worldwide that it has been found in more than 200 countries so far. The World Health Organization (WHO) has declared COVID-19 a pandemic and public health threat [1-3]. In general, COVID-19 is an infectious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). A case fatality rate of approximately 2.3% has been reported for COVID-19. New fever, cough, lymphopenia and bilateral lung infiltrations are characteristic but not diagnostic for COVID-19. Sore throat, dyspnea, myalgia, diarrhea, and abdominal pain are other presentations of COVID-19. We should also be attentive to the probability of atypical presentations in patients who are immunocompromised. While the majority of cases result in mild respiratory tract symptoms like acute bronchitis, severe cases might end in severe pneumonia, acute respiratory distress syndrome (ARDS), septic shock and death due to multiorgan damage, so early recognition of patients with suspected COVID-19 infection is crucial. The burden of the virus is not limited to physical damage, but it also has a significant impact on the mental health of the public. It can lead to generalized anxiety disorders and depression during COVID-19 pandemic [1, 4, 5]. Now many countries are in a state of crisis worldwide. Whenever the living environment changes, people feel unsafe. People's fear of COVID-19 makes them refrain from going to medical centers, which significantly impacts their access to medical care while they require acute treatment. COVID-19 outbreak in countries has pulled essential medical resources away from regular procedures. This has caused complications for patients who need treatment for other medical conditions that require timely and appropriate care. Cancer patients especially still require attention in curative or palliative settings, and women will still be delivering their infants. How can we care for these patients without exposing them to COVID-19? Now many patients try to avoid going to the emergency room which is filled with patients suspected of COVID-19. For example, in our center, Imam Khomeini Hospital Complex, which admitted an average of 50 patients to emergency wards on a daily basis, this number has decreased to 3 patients daily. Furthermore, when many of these patients finally arrive, their clinical conditions are more severe [2, 5]. For example, a 57-year-old man came to our emergency ward with a history of abdominal pain and vomiting from 10 days ago. He was ill and toxic, and had high grade fever, tachycardia and hypotension, oliguria from 12 hours before coming to the hospital. His laboratory tests showed elevated levels of amylase, lipase and creatinine and leukocytosis. He was admitted with impression of necrotizing pancreatitis. We visited more than 20 patients with chronic liver failure with the impression of decompensated cirrhosis who came to us with sever ascites, hyperkalemia, hepatorenal syndrome or encephalopathy. We encountered with patients with chronic kidney disease who did not oblige to their dialysis program regularly and came to us with uremic status. There were many diabetic patients that came to clinics with poorly controlled diabetes (Hemoglobin A_1C>8%) and also diabetic ketoacidosis which postponed their routine diabetes care. A 22-year-old woman with a history of cholecystectomy (4 years ago) came to us with abdominal pain from 15 days ago, fever and jaundice. Her blood pressure was 60/40 mmHg, her pulse rate was 140/min, and she had tachypnea and high temperature upon admission to the emergency room. On sonography, radiologists reported dilated common bile duct, and the patient was admitted with impression of severe cholangitis and septic shock. Indeed, they all postponed receiving care. There will still be patients in outpatient, elective and non-elective

settings requiring care. Furthermore, some patients need diagnostic services (e.g. a young woman with a breast mass) or they may also need ongoing therapy for a chronic medical condition such as solid organ transplants, malignancies, rheumatologic disease. Non-elective patients such as those with heart attack, stroke, pancreatitis, gastrointestinal bleeding, fulminant hepatitis, cholangitis, acute leukemia, multiple trauma and other infections requiring medical care should be managed to avoid delays in treatment. There are some diagnostic procedures such as angiography gasteroesophagoscoy and biopsies that the patients may need in the course of treatment. Therefore, we need to meet the medical needs of patients with chronic diseases such as cancer, chronic kidney disease and those who need long-term maintenance treatment. The day to day medical service of some groups of people, such as pregnant women and older adults are also very important [6].

Recommendations

All of us as physicians have responsibilities in the era of COVID-19 and we should ensure that critical and essential care continues for non-COVID-19 patients. We should try to continue the appropriate management of non-COVID patients while saving resources for responding to COVID-19, for example:

- Many hospitals have been converted into facilities for treating only patients with COVID-19. We should dedicate some hospitals specifically for patients with illnesses other than COVID-19.
- We can also provide wards and clinics specific for non-COVID patients in our hospitals. Separation of hospital emergency wards for admission of patient suspected of acute respiratory symptoms due to COVID-19 and non-COVID-19 patients with other medical conditions, is another solution.
- We can consider preadmission triage to prevent unnecessary admissions, and reduce patient's exposure to the hospital environment. Before hospitalization of non-COVID-19 patients in different wards, they should be examined for any related signs and symptoms of COVID-19 (e.g. fever, O2 saturation %).
- As a rule, reduction in elective work and appropriate outpatient care may reduce the burden on the non-elective care. To this end, hospitals can use Telemedicine in the COVID-19 Outbreak by designing a website for non-COVID-19 patients that had been hospitalized in their centers or visited their clinics. These patients can send messages if they have any medical problems and communicate with their medical teams and physicians through the website.
- In order to reduce transmission rate from healthcare workers to patients with other medical problems, it is crucial that physicians and nurses who visit COVID-19 patient not visit patients that come to emergency wards with medical conditions other than COVID-19. It is necessary for all the physicians and nurses who visit non-COVID-19 patients to use masks (preferably N95) and gloves while working.

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CONFLICT OF INTEREST

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