Birjand University of Medical Sciences

Journal of Surgery and Trauma

Letter to Editor

Acute care surgery and COVID-19 pandemic: the voice of emergency surgical services

Marcela Arzayus-Lozano[1], John Fredys Bello-Cordero[2], Juan Sebastián Quijano[2], Juan Manuel Sanchez[3], Iveth Fernanda Sánchez-Ortiz[4], Moshiur Rahman[5]✉

[1] Department of Medicine, School of Medicine, Universidad Santiago de Cali, Cali, Colombia
[2] Department of Medicine, School of Medicine, Fundación Universitaria de Ciencias de la Salud, Bogotá, Colombia
[3] Department of Medicine, School of Medicine, Fundacion Universitaria Sanitas, Bogotá, Colombia
[4] Department of Medicine, School of Medicine, Universidad Católica de Santa María, Arequipa, Perú
[5] Assistant Professor Department of Medicine, School of Medicine, Universidad Católica de Santa María, Arequipa, Perú

Corresponding Author:
Tel: +01713365274
Email: dr.tutul@yahoo.com

Dear Editor,

During the course of the COVID-19 pandemic, surgical services around the world were greatly affected by the need for organizational and infrastructure modifications, accelerated training of primary teams, and strategies to allow for patient flow due to the confinement and disruption of economic activities (1). Acute care surgery departments are one of the departments that presented the greatest number of questions and concerns, due to the limited availability of supplies, technological equipment, trained and healthy personnel, among other aspects (2-3). Many of these modifications focused on strengthening emergency and critical care services, leaving aside the functionality of other services. However, this is a fatal mistake, since acute surgical illnesses cannot wait (2).

A study carried out in the USA showed that although there was a decrease in the attendance to acute care surgery services during the first two months of the pandemic (57%), there was an increase in the severity of the symptoms presented (64%) (2). Therefore, the authors concluded that acute care surgery during public health disasters is an essential health service (2). Similarly, the perception of specialists and health professionals working in this area complained about the conditions of risk of infection due to the absence of biosafety elements and administrative neglect (3).

Some of the responses quickly proposed by the surgical departments were to maximize available surgical capacity through the separation of infected vs. uninfected patients with surgical pathology, internal and independent coordination with local health system networks, staff, and patient safety through the massive use of biosafety equipment and patient testing (however, in third world countries there are zones 0, which is where the patient is first admitted with respiratory symptoms, regardless of whether the reason for consultation was a surgical condition or not), and the performance of some surgical procedures in a specific manner (4). However,

Citation: Arzayus-Lozano M, Fredys Bello-Cordero J, Quijano J.S, Manuel Sanchez J, Sánchez-Ortiz I.F, Rahman M. Acute care surgery and COVID-19 pandemic: the voice of emergency surgical services. J Surg Trauma.2022;10(2):45-47.

Received: October 20, 2021 ***Revised: December 26, 2021*** ***Accepted: December 29, 2021***

the potential benefit of this response was not known due to the lack of evidence at the beginning of the pandemic. Currently, emerging evidence has allowed the creation of clinical guidelines and practical and reproducible programs for this type of situation, which can even be adapted to each of the contexts of different countries; a considerable advance (4).

A point to highlight that serves as justification for the investment in specialized training, purchase of equipment, and infrastructure reform, is the need to implement laparoscopy as a standard technique in both first and third-world countries (5).

During the pandemic, any intervention that decreased body invasion and reduced the risk of infection was critical. Probably the behavior given by several peaks from 2020 to the end of 2021 in low-income countries is represented by the use of traditional surgical techniques. Although it is reported that the mortality and complication rate was not very different compared to the pre-pandemic time (5-6).

it cannot be accurately established whether the infection, severity of COVID-19, and death occurred during the performance of the intervention with close contact with the infected patient, with or without symptoms. If an adjustment is made according to the above, then there is an underreporting of mortality in those professionals who have died from SARS-Cov-2 infection.

Multidisciplinary work, institutional collaboration, and governmental support are the pillars for the construction of practical and reproducible policies and strategies (7-8).

Gaps in evidence and public policies in the face of crises such as pandemics were evident. In this order of ideas, it is necessary to design and implement better strategies at the moment of a local, regional or global public health crisis. Equity in health care services, both for health care providers and patients, must be adequate and correspond to biomedical principles that guarantee favorable outcomes. Quality training of students and primary care physicians is also an indispensable aspect to ensure adequate patient flow, early diagnosis, and time management.

Conflict of interest

There is no conflict of interest.

References

1. Maiguel-Lapeira JD, Ortega-Sierra MG, Domínguez-Gutiérrez CC, González-Pérez E, Delgado-López NJ, Robles-Murgas LÁ, Lozada-Martínez ID. Letter to the Editor Regarding "The COVID-19 Pandemic and Global Neurosurgery: The Situation in Japan and the Philippines". World Neurosurg. 2021; 151:337.

2. Bugaev N, Hojman HM, Breeze JL, Nasraway SA, Arabian SS, Holewinski S, Johnson BP. Acute Care Surgery Service Is Essential During a Nonsurgical Catastrophic Event, the COVID-19 Pandemic. Am Surg. 2020; 86(12):1629-1635.

3. Fontenelle Ribeiro Junior MA, de-Campos T, Souza Lima D, Marttos-Jr AC, Pereira BM. The trauma and acute care surgeon in the COVID-19 pandemic era. Rev Col Bras Cir. 2020; 47:1-6.

4. Klein MJ, Frangos SG, Krowsoski L, Tandon M, Bukur M, Parikh M, Cohen SM, Carter J, Link RN, Uppal A, Pachter HL. Acute Care Surgeons' Response to the COVID-19 Pandemic: Observations and Strategies From the Epicenter of the American Crisis. Ann Surg. 2020; 272(2):66-71.

5. Cano-Valderrama O, Morales X, Ferrigni CJ, Martín-Antona E, Turrado V, García A, Cuñarro-López Y, Zarain-Obrador L, Duran-Poveda M, Balibrea JM, Torres AJ. Acute Care Surgery during the COVID-19 pandemic in Spain: Changes in volume, causes and complications. A multicentre retrospective cohort study. Int J Surg. 2020;80:157-161.

6. Krutsri C, Singhatas P, Sumpritpradit P, Thampongsa T, Phuwapraisirisan S, Gesprasert G. Impact of the COVID-19 pandemic on the outcome, morbidity, and mortality of acute care surgery patients: A retrospective cohort study. Int J Surg Open. 2021; 28;50-55.

7. Dancer SJ. Reducing the risk of COVID-19 transmission in hospitals: focus on additional infection control strategies. Surgery (Oxf). 2021; 1;39(11):752-758.

8. Lozada-Martínez I, Maiguel-Lapeira J, Torres-

Llinás D, Moscote-Salazar L, Rahman MM, Pacheco-Hernández A. Letter: Need and Impact of the Development of Robotic Neurosurgery in Latin America. Neurosurgery. 2021; 88(6):580-581.