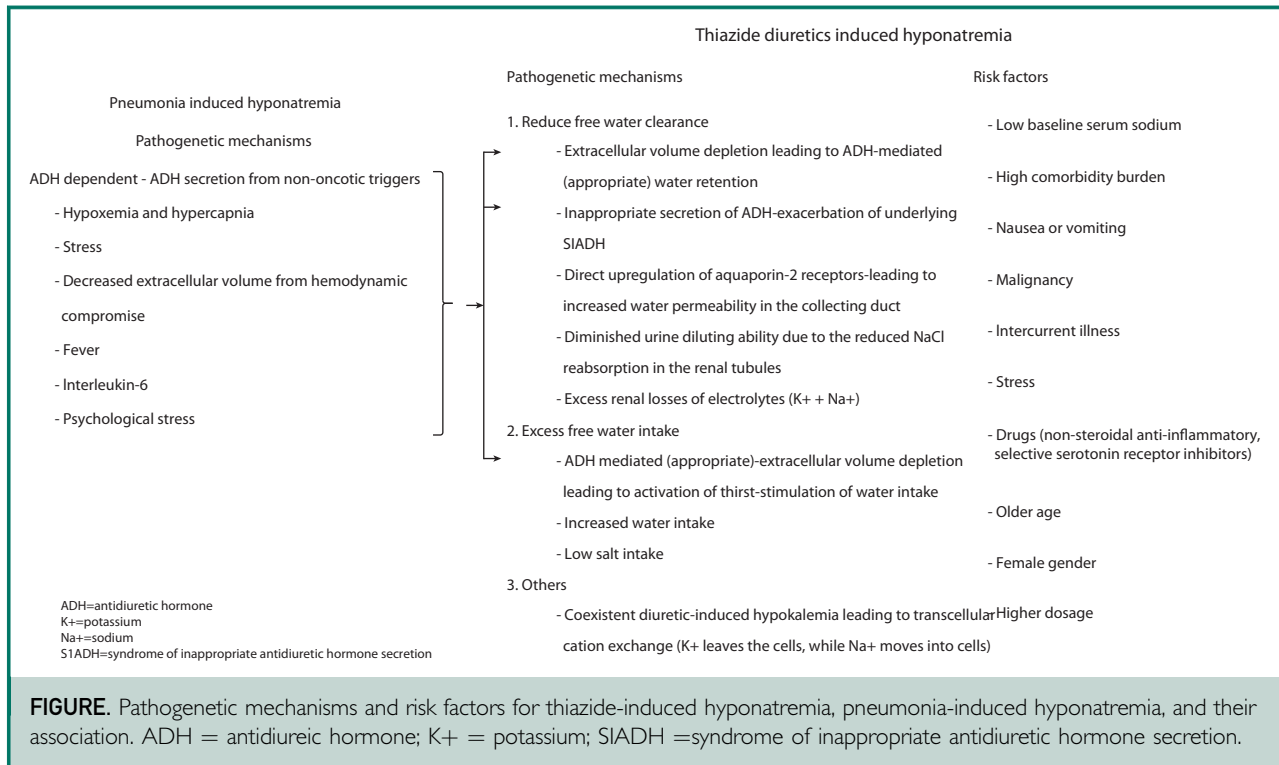




Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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estimated 30 million hypertensive patients were taking thiazides.⁵ Approximately 30% of patients on thiazides develop hyponatremia.¹ Viral pneumonia via ADH-dependent pathways can facilitate the development of hyponatremia in patients on long-term thiazide therapy, as observed in our patient. Remarkably, our patient had no respiratory manifestations from COVID-19 pneumonia. Rather, she presented with encephalopathy from hyponatremia, a consequence of viral pneumonia for patients on long-term thiazide therapy.

According to estimation models from the Imperial College of London, ~81% of the US population will be afflicted with COVID-19. This places the 30 million people on thiazides at risk for COVID-19-induced hyponatremia.⁵ It is imperative that primary care physicians be aware of this mostly unrecognized effect of the current pandemic and be

prepared to adjust accordingly. We recommend the cautious use of thiazide in the management of high blood pressure during the current COVID-19 pandemic. Closer monitoring of symptoms and laboratory values might be warranted.

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1. Leung AA, Wright A, Pazo V, Karson A, Bates DW. Risk of thiazide-induced hyponatremia in patients with hypertension. *Am J Med.* 2011;124(11):1064-1072.
2. Sharabi Y, Illan R, Kamari Y, et al. Diuretic induced hyponatremia in elderly hypertensive women. *J Hum Hypertens.* 2002;16(9):631-635.

3. Anderson RJ. Hospital-associated hyponatremia. *Kidney Int.* 1986;29(6):1237-1247.
4. Liamis G, Filippatos TD, Elisaf MS. Thiazide-associated hyponatremia in the elderly: what the clinician needs to know. *J Geriatr Cardiol.* 2016;13(2):175-182.
5. Kantor ED, Rehm CD, Haas JS, Chan AT, Giovannucci EL. Trends in prescription drug use among adults in the United States from 1999–2012. *JAMA.* 2015;314(17):1818-1831.

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Dying Without
COVID-19: End-of-Life
Care for an Uninfected
Incarcerated Patient



To the Editor: In March, the relative beginning of the COVID-19 pandemic on the East Coast, we cared for a middle-aged woman with end-stage chronic hepatic and renal failure. This medically complex patient was matched by an equally complex social situation, wherein she had been taken to the

hospital directly from our local jail a month previously. As with all hospitalized patients in criminal custody, she was allowed no in-person or phone communication with family. Her closest contacts were the ever-present pair of correctional officers stationed in the corner of her room. Through the lens of a single uninfected yet vulnerable patient, we examine the unforeseen consequences of institutional policies related to COVID-19.

With the eruption of COVID-19 in the United States as policies were rapidly being rewritten and staff schedules reimaged, our patient remained physically and physiologically restrained, shackled to the bed. A blockade on nonemergent endoscopic procedures limited potential therapeutic options and muddled medical decision making. She began to decline precipitously with multiorgan failure and profound encephalopathy. The patient's poor prognosis was discussed with her family, who supported her transition to hospice. We sent a letter to the medical directors of the jail, petitioning for the compassionate dismissal of her charges, and, within 24 hours, a judge ordered her released from custody. Late Friday evening, her handcuffs were removed, and correctional detail retracted. Now absent any criminal justice-related restrictions, hospital administration authorized an hour-long visit with her mother, who was grateful for the opportunity. Our patient was discharged the following day to her mother's home under hospice care.

Despite numerous barriers to receiving appropriate care—an active pandemic, criminal charges, complex multimorbidity—our patient's case was ultimately a successful one. When medical care was determined to be futile, the justice system approved her compassionate release,

and she survived to discharge with home hospice. Yet certain aspects of her hospitalization were negatively affected by COVID-19: namely, her visitor restriction and deferred endoscopy. The rigidity of these hospital policies, although well intentioned and necessary, stands in contrast to the swiftness and flexibility of the criminal justice system in mobilizing her release. What motivates this differing response?

When infected patient numbers surged, our institution, like so many others, enacted a strict visitation policy.¹ The epidemiologic basis for upholding this CDC-supported policy is unquestionably sound.² Any exceptions to this standard policy, as were made in this patient's case, require compelling justification because of the potential harms. For our patient, this translated to having 2 full-time correctional personnel by her bedside for weeks but only 1 hour of family visitation upon being declared terminally ill.

Prisons and custodial settings have received significant media attention because of concerns that they may not be able to implement social distancing, and some have advocated for decarceration.³ The speed at which our patient was released from charges was remarkable. Although it is possible that this was motivated in part by self-interest—that is, the desire to limit medical costs and redeploy her correctional officer detail—the justice system and its health care directors showed marked compassion. We received frequent updates late in the day as they worked on our patient's behalf. The effectiveness and efficiency of this collaboration between the justice and medical systems was refreshing.

Health care providers play key roles in navigating and potentially challenging hospital policies that

are affecting their patients negatively, especially those who are most vulnerable. In our patient's case, the rapid timetable for hospice release made it logistically challenging to petition the limited visitation policy. As patients are transferred to medical centers for the management of severe COVID-19–related illness, providers should be mindful of the complexities involved in caring for dying incarcerated patients: lower average rates of health literacy and less previous opportunity for advance directive completion.⁴ At the administrative level, to lessen the negative impact of these policies, it is essential that streamlined processes be in place to adjudicate appeals promptly.


The COVID-19 infection spreads far beyond the bodies in which SARS-CoV-2 takes hold. Those who test negative for the virus are uninfected in name only. They remain vulnerable to sweeping policy shifts from the justice and medical systems. As with the movement to release inmates from jails and prisons, some of these changes may be recognized as positive, even long overdue.⁵ Other efforts to mitigate the damage from COVID-19 can be harmful to patients and morally distressing to providers. Although we can take some comfort knowing these policies serve the greater good, we must recognize and strive to mitigate the significant toll on the uninfected.

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1. Hafner K. A heart-wrenching thing: hospital bans on visits devastate families. *The New York Times*. March 29, 2020.
2. Centers for Disease Control and Prevention. Interim infection prevention and control recommendations for patients with suspected or confirmed coronavirus disease 2019 (COVID-19) in healthcare settings. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>. Published 2020. Accessed April 9, 2020.
3. Akiyama MJ, Spaulding AC, Rich JD. Flattening the curve for incarcerated populations: Covid-19 in jails and prisons. *N Engl J Med*. 2020;382(22):2075-2077.
4. Linder JF, Meyers FJ. Palliative care for prison inmates: "Don't Let Me Die in Prison". *JAMA*. 2007; 298(8):894-901.
5. James N, Foster MA. Federal prisoners and COVID-19: background and authorities to grant release. *CRS Report*. April 23, 2020.

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The Pandemic of Publications: Are We Sacrificing Quality for Quantity?



To The Editor: The coronavirus disease 2019 (COVID-19) pandemic has sparked an explosion in biological and medical research worldwide, with more than 30,000 COVID-19 PubMed-indexed publications and 6200 medRxiv and bioRxiv preprints this year as of July 9th, 2020.^{1,2} However, while immediate access to the latest research is undoubtedly crucial in combating this pandemic, the scientific community must be wary of the potential tradeoff between quantity and quality. In this letter, we discuss the implications of this surge in the rate of publications and suggest measures to minimize undesirable consequences.

During the first week of June 2020, the editors of *The Lancet* and *The New England Journal of Medicine* (NEJM), 2 premiere medical journals, both published expressions of concern regarding the questionable

quality and reliability of data presented in articles published in their respective journals.^{3,4} Both of the articles in question were published using data from the Surgical Outcomes Collaborative (Surgisphere Corporation, Chicago, IL). In addition, a third article, first uploaded as a preprint in the Social Science Research Network, also used data from Surgisphere.⁵ All 3 articles concerned drug therapy in COVID-19 and findings reported in these publications had a major impact on both ongoing clinical patient management and the direction of several clinical trials. The World Health Organization chose to err on the side of caution and suspended the hydroxychloroquine arm of the Solidarity Trial (an ongoing international clinical trial exploring treatments for COVID-19), thus delaying the provision of evidence-based guidelines to practitioners worldwide. The consequences of this occurrence can be exceedingly harmful, and the significant doubts raised regarding these papers has called into question the publishing behavior of both researchers and journals.

With the eagerness to publish COVID-19 research, there is a looming potential for errors on the part of both the researchers and the journals. For the researcher, this may involve publishing research of subpar methodological quality or doubtful ethical considerations, or publishing in predatory medical journals.^{6,7} In addition, researchers are rushing to upload their work as preprints, opening the floodgates to a "preprint surge." While preprints do offer a legitimate platform to share and gain quick feedback on novel results, the haste to preprint articles invites an inherent tradeoff between speed and accuracy.^{8,9} The non-peer-reviewed nature of preprints may often promote the spread of inaccurate information, with flawed data

often finding itself under the public spotlight through social media and news outlets.^{8,9} As the death toll from the pandemic surges, desperation may force clinicians to turn to insufficiently peer-reviewed research for decision-making purposes. However, even peer-reviewed research published by legitimate journals may be called into question. With many highly reputable journals offering fast-tracked services for COVID-19 publications, the robustness of the methodological examination and critical appraisal within the peer review of submissions may be compromised.⁹ This is evident in the redundancy of COVID-19 research, which in addition to being repetitive, may also be inaccurate, inconsistent, biased, and biologically implausible.¹⁰ The torrent of exaggerated or subpar research being published may lead to dangerous consequences and threaten the evidence-based response to COVID-19 globally.

With this pandemic leaving health care systems in disarray, healthcare professionals on the frontline face many challenges, ranging from the lack of protective equipment to the overwhelming patient load. It is the collective responsibility of the academic community to make sure that accessing accurate information does not become another challenge. Much of the responsibility for ensuring high quality research lies with the researchers themselves. While one would like to believe that global health and advancing science are the sole motivators to conduct and publish research, some of the COVID-19 research may be due to researchers wanting to jump on the bandwagon for personal gain, such as improving one's resume or attracting media and public attention. This behavior must be countered by a paradigm cultural shift within the academic community,