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## Correspondence

## COVID-19: could CT provide the best population level biomarker? Incidental COVID-19 in major trauma patients suggests higher than predicted rates of infection in London



Sir—We read with great interest the paper by Dr Adam *et al.*<sup>1</sup> We would like to share some comments on this article based on our clinical experience.

As mentioned in the study's Materials and Methods section, all cases with a clinical history of major trauma were included in the study. The term “major trauma” needs to be defined clearly as it is not clear if this study included patients who were under a trauma activation system or anyone presenting to the hospital, including ambulatory patients, with any kind of traumatic injuries. For the study group in 2020, the months of January to April were included, but for the control group in 2019, only the months of January and March were included. Thus, the control group did not have the data from February and April in 2019. As a result, the study group had a higher number of patients than the control group. We are interested in knowing the reasoning behind not including the months of February and April for the control group in 2019.

According to Fig 2, the age range of the patients in the study group was from 1 to 100 years, whereas in the control group, the age range was from 16 to 99 years. We are not sure why the age distribution between the study and control group was not homogeneous. Was it intentional to include the paediatric population in the study group?

It would be very convenient to have a table with all demographic data and co-morbidities to better understand the baseline characteristics of both study groups. We struggled to understand Fig 3; there is a mention of a green line, but the graph is in black and white. Therefore, we are not sure if this green line refers to the solid line or the dotted line in the figure.

In the discussion section, the authors mentioned approximately 17% of the general London population tested positive for the COVID-19 antibody and concluded that computed tomography (CT) was better than the antibody test as a COVID-19 screening tool.<sup>2</sup> It is not clear at what

time did 17% of the general London population test positive for the antibody test and who exactly was tested.<sup>2</sup> For a better comparison between CT and the antibody test as a screening tool, we need to know if this antibody testing was done during the same time of this study. Additionally, in the provided reference number 19, we could not find if this antibody testing was done on the entire population or only on the asymptomatic people similar to this study. Moreover, this study only included asymptomatic COVID-19 patients, and thus cannot be compared to the antibody test results where patients were presumably tested regardless of the presence of symptoms.

We are not sure about the individual and institutional cost-effectiveness of implementing CT as a COVID-19 screening tool. Additionally, we are also concerned about the risk of radiation exposure, especially to the younger population. It is worthwhile to address these important issues in the discussion section.

### Conflict of interest

The authors declare no conflict of interest.

### References

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2. Testing for SARS-CoV-2 antibodies. *BMJ* 2020;**370**:m3325. <https://doi.org/10.1136/bmj.m3325>.

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