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Where Have All the Children Gone? Pediatric Perspectives on COVID-19 in New York City

Deborah A. Levine, MD; Susan Fraymovich, DO; Shari L. Platt, MD*

*Address for correspondence: . E-mail: slp9001@med.cornell.edu, Twitter: @slp1001.

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Where have all the flowers gone? Long time passing.

Where have all the flowers gone? Long time ago.
—Pete Seeger, 1955

It was early February. I walked into my overnight shift in our pediatric emergency department. The rooms were filled. Children with broken bones, vomiting babies, and adolescents with head injuries lined the hallways on stretchers. Parents and grandparents huddled by their side; siblings ate goldfish crackers and watched videos. The air was thick with the cacophony of crying, laughing, monitors beeping, and oxygen hissing; patients and providers exchanging stories, both medical and personal. I immediately felt the palpable pulse of our pediatric ER, buzzing with energy. My pulse heightened, adrenaline rushed, and I prepared to take over from my colleague, to receive "handoff," the proverbial baton.

More than 20 patients waiting to be seen. We opened our surge hallway to expand our space; more stretchers and more supplies were needed to care for the many children and babies. In emergency medicine we say, "The bus just rolled up," and it did, indeed, feel that way. Fever, cough, vomiting, rash, diabetes, asthma, headache, toothache, a coin swallowed, fall-on-outstretched-hand, ankle sprain, pinkeye, bead in the nose…an infinite list of maladies, the gamut of pediatric emergency medicine. Our patient flow was a never-ending revolving door, presenting with conditions that challenged our brains, spinning a web of medical uncertainty and discovery. I thrived in this element, the organized chaos, taking the time to console an anxious teen, to reassure a tearful mother, and to make a toddler belly laugh playing peekaboo.

On March 1st it all changed. The first reported case of COVID-19 hit the United States. It was a chilly Sunday with a rainy forecast. We started to plan. ER doctors are notorious for preparing. We think ahead, always ready for the worst. We have done this before. We know the drill. We prepared for crowding during the 2009 H1N1 pandemic, we prepared despite the eerie absence of patients after 9/11, and we prepared for the flood of decanted patients flowing into our hospital atrium following Hurricane Sandy. So, too, we prepared for COVID-19. We activated our disaster plan, identified space for expansion, and educated staff about personal protection. Throughout the planning, pediatric emergency medicine was there, in the room where it happens. How would we manage the surge of children with coronavirus while caring for the countless others?

Again, things changed; now in an unforeseen way. Runny noses and fingers caught in doors, painful throats and tummy aches, allergic reactions and accidental burns stopped coming. Everyone stopped coming. Children vanished from the ER.

Today, we only see a handful of children each day. The revolving door of the pediatric ER is still. The symphony of noise is muted; families are cordoned off at the door. Staff float in and out of our area with expressions hidden behind masks and goggles, unable to share a touch or a smile. Our surge hallway is hushed, with rows of white stretchers, barren and unused.

Are children not getting sick anymore? Is the shuttering of schools and daycare hindering the passage of winter viruses and strep throats? Is the closing of playgrounds and ball fields protecting our children from the usual broken bones and concussions we see on a typical day? Are the pediatricians' use of video visits successfully preventing emergency visits? Or most concerning, are parents avoiding the ER even when their child may need emergency care? *Where have all the children gone*?

This silent treatment is pervasive across our city. Inpatient pediatric and pediatric ICUs have closed at major institutions in New York City. Children who need admission are transferred to other hospitals or cohorted to make room for adult COVID-19 patients. Our once-thriving pediatric ER is now relegated to 3 stretchers in our waiting area.

We are so relieved that children are spared by this deadly virus, yet we feel unsettled. We mourn the loss of our specialty, our space, and our expertise. In an effort to help our adult emergency medicine colleagues, we care for patients of older ages. We are learning to manage adult chest pain and liver cirrhosis. Displaced and practicing in uncharted territory, the pediatric physician is an outsider in this pandemic. We welcome the unnerving silence yet await the unknown future with caution.

Yesterday, I took a walk in Central Park, mask on, appropriately distanced. The sun was beaming in a cloudless sky. The dogwoods and daffodils were brilliant in bloom. The flowers have not all gone; neither have the pediatric emergency physicians. We are here to suture the wounds and splint the breaks. When schools burst open their doors to welcome students, when the chains on our parks are unlocked, and when our world is connected again with physical touch, we will be there.

Author affiliations: From the Department of Emergency Medicine, Division of Pediatric Emergency Medicine, New York–Presbyterian Hospital and Weill Cornell Medicine, New York, NY.

IMAGES IN EMERGENCY MEDICINE

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DIAGNOSIS:

Abdominal aortic pseudoaneurysm. The pseudoaneurysm is a rare but critical condition that usually follows blunt or penetrating injury.[1] Clinical features are generally nonspecific (eg, abdominal distention/pain, back/flank pain, hypotension, tachycardia). A prompt diagnosis with advanced vascular imaging and an aggressive management approach potentially avoids catastrophic complications.[2,3]

Because of the bedside ultrasonography, the patient received CT angiography without delay and underwent endovascular repair and femorofemoral bypass. The patient was discharged 2 weeks later without any sequela.

Author affiliations: From the Department of Emergency Medicine, Tri-Service General Hospital, National Defense Medical Center, Taipei, Taiwan.

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