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About the scientific letter ‘Suspected acute abdomen as an extrapulmonary manifestation of COVID-19 infection’[☆]



A propósito de la carta científica «Sospecha de abdomen agudo como manifestación extrapulmonar de infección COVID-19»

To the Editor

We have read the article published in this journal by R. Blanco-Colino et al¹ about COVID-19 and its manifestation in the form of acute abdomen. Given the current pandemic situation we are in, we surgeons have been able to work as a team with different specialties and update our knowledge in different fields that we are not accustomed to. Much of the knowledge gained regarding the management of COVID-19 has unfortunately been improvised initially, and then later based on protocols that have been changed relatively frequently.

As, reported by the authors, it is known that an important percentage of COVID-19-positive patients present gastrointestinal symptoms, including anorexia, diarrhea, vomiting². However, it is true that the vast majority are accompanied by respiratory symptoms or fever, COVID- rarely presents as, an isolated gastrointestinal symptom³. Both manifestations can coexist without being dependent on one another. We must not forget that gastrointestinal symptoms were already described during the SARS outbreak in 2003⁴, so even though it is considered a new pandemic, we already had information available.

The title of the article can be misinterpreted if we understand acute abdomen to be sudden and intense abdominal pain that requires urgent medical or surgical action⁵. The authors' description of the clinical case does not fit this definition or standard practice. The etiological diagnosis of infectious colitis requires different diagnostic tests (stool culture, histological study, immunohistochemistry, etc) based on clinical suspicion^{6,7}. With the data provided in the case description and with the abdominal x-ray (see legend of Figure 1), such a diagnosis cannot be made. If suspected, we did not find the intention to perform any of the aforementioned diagnostic tests. Likewise, different concepts, such as lymphopenia or altered liver levels (in patients already treated) are introduced that are not related to the purpose of the article: to alert us to the alleged gastrointestinal manifestations caused by COVID-19.

Given that we do not know the absolute number of the infected population and that the estimates suggest they are

more cases than reported, it is logical to suspect that many of the patients we treat for other reasons will be COVID-19-positive. We feel it is positive that the authors highlight the need to conduct a thorough anamnesis about respiratory symptoms in order for precautions and isolation measures to be taken. However, regardless of the pandemic, a complete patient medical history should be compulsory for any surgeon.

In unknown scenarios, the reporting of clinical cases may be of general interest, but publishing practically everything related to COVID-19 can cause confusion, especially when the information does not provide solutions. As of today, four months after the initial outbreak, interactions and exchange of information between surgeons on social media is immediate; surveys and coordinated studies are being conducted among different surgery groups, which are of greater help and are more informative.

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Authors' response to: "About the scientific letter: Suspected acute abdomen as an extrapulmonary manifestation of Covid-19 infection"[☆]



Respuesta de autores a: A propósito de la carta científica «Sospecha de abdomen agudo como manifestación extrapulmonar de infección COVID-19»

To the Editor,

We have read with interest the comments made by Dr. F. Pardo Aranda in his Letter to the Editor. We appreciate the points made.

Firstly, we insist that our aim was to inform about the gastrointestinal involvement associated with COVID-19 in the context of patients requiring urgent surgery.

The original title of the accepted publication was *Abdominal bloating and gastrointestinal symptoms as an extrapulmonary manifestation in a COVID-19+ patient, which was later replaced with Suspected Acute Abdomen* (. . .), after review by the Editorial Committee.

In his letter, Dr. Pardo states that it does not conform to usual practice, but General Surgery specialists assess abdominal pain and/or gastrointestinal symptoms.¹ The patient was referred to our hospital from Primary Care in order to rule out acute abdomen, at which time the patient was triaged to our General Surgery Emergency Unit. This could also be the case of inadequate protection against patients presenting in the emergency department with gastrointestinal symptoms associated with COVID-19 and mild or no pulmonary symptoms; some 10% present chest radiographs without pneumonia, as in the case reported.²

At that moment, we believed that triage and treatment protocols should be followed for patients referred from the emergency room. Given the epidemiological suspicion, the patient presented signs that led us to consider the possibility of COVID-19, and this immediately allowed us to pursue the

diagnosis and isolate the patient. The presentation of lymphopenia and elevated PCR on the laboratory tests were signs to suspect a poor COVID-19 prognosis,³ requiring a differential diagnosis with other pathologies such as sepsis of abdominal origin.

Computed tomography (CT) scan of the abdomen ruled out urgent surgical pathology and showed sensitivity to rapidly identify pulmonary alterations due to COVID-19.^{4,5} Based on the findings, the differential diagnosis needed to be confirmed. In this specific case, the abdominal radiograph showed dilation of the loops, so the possible causes of acute abdomen to be ruled out included volvulus, intestinal obstruction, and colitis. It is important to guarantee early treatment of patients who initially consult for gastrointestinal signs, since they may later present respiratory symptoms.⁶ In addition, another reason for the need to identify early suspicion is to avoid dissemination among other patients who come to the Surgical Emergency Unit for other reasons and to avoid infection of healthcare workers, who are the gateway to the healthcare system and who are often unprotected.

In coming months, we will surely see the results of international cohort studies and clinical trials that will enable better protocols to be proposed based on scientific evidence.⁷ We have adapted the protocols according to the experience described. Furthermore, it will be necessary to consider whether the current system functioning in the emergency services of many hospitals is adequate. Properly trained multidisciplinary groups may also be required for triage in potentially surgical pathologies.¹

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