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and serum thyroid stimulating hormone analysis was not available in all patients in the LICU-20 group.

In conclusion, we suggest routine assessment of thyroid function in patients with COVID-19 requiring high intensity care, because they frequently present with thyrotoxicosis due to a form of subacute thyroiditis related to SARS-CoV-2. Considering the currently ongoing pandemic emergency, future studies are encouraged to confirm, or counter, these results. Thyroid cytology or histology and longitudinal studies of thyroid (dys)function in these patients would be particularly informative.

We declare no competing interests.

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Bariatric and metabolic surgery during and after the COVID-19 pandemic

In *The Lancet Diabetes & Endocrinology*, Francesco Rubino and colleagues discussed the prioritisation of bariatric and metabolic surgery during and after the COVID-19 pandemic.¹ We congratulate the authors for bringing up this important discussion, since difficulties around future care of obesity and type 2 diabetes might be a major problem within this context.

We would like to point out, however, our disagreement with the algorithm for prioritisation for bariatric and metabolic surgery in patients with type 2 diabetes. Many diabetes characteristics the authors suggest be prioritised are associated with reduced long-term benefits (which we previously discussed in a review²), but we would like to focus on one point here: established cardiovascular disease. This suggestion goes against current evidence.

Although many good-quality observational data suggest that cardiovascular disease risk and mortality are reduced after bariatric and metabolic surgery, the number of patients evaluated that already had cardiovascular disease is very small, and even smaller if we consider those with type 2 diabetes.² In the large Swedish Obese Subjects study, although similar benefits were suggested, only 1.5% of patients had a history of cardiovascular

disease, and only 21 patients with cardiovascular disease were submitted to surgery.³

In randomised controlled trials of bariatric and metabolic surgery in diabetes, there are few mentions of patients with established cardiovascular disease, and in some of these studies, such as the large and highly cited STAMPEDE, previous cardiovascular disease was an exclusion criterion, according to the details registered on ClinicalTrials.gov (NCT 00432809). Early this year, in a retrospective study of nearly 7000 patients who had bariatric and metabolic surgery for obesity, only 3.6% had a history of cardiovascular disease, and the rates of post-operative complications in those patients were significantly higher than in patients without previous cardiovascular disease.⁴ The authors concluded that additional research is necessary to define the benefits of bariatric and metabolic surgery in this population. The exact number of patients with type 2 diabetes and a history of cardiovascular disease who have been submitted to bariatric and metabolic surgery and whose outcomes have been studied is unknown, yet is probably too small to draw any definitive conclusion to put such patients on a priority list.

Moreover, we should bear in mind that, on the contrary, this particular population with type 2 diabetes and a history of cardiovascular disease is the most studied regarding long-term safety and benefits in cardiovascular outcome trials with drugs (with more than 50 000 patients studied), and the known cardiovascular and renal benefits of both SGLT2 inhibitors and glucagon-like peptide-1 receptor agonists are clear.⁵

Therefore, we agree with most of Rubino and colleagues' work¹ and that much effort will have to be made regarding evidenced-based therapies, including bariatric and metabolic surgery for obesity and type 2 diabetes following the COVID-19 pandemic, but it is still unwise and incorrect to

prioritise this procedure over drug therapy in a population in whom almost no studies exist about the former treatment and several investigations do exist concerning the latter.

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We read the article by Francesco Rubino and colleagues with interest.¹ It represents the recommendations of 23 authors on a diverse range of topics around bariatric and metabolic surgery during and after the COVID-19 pandemic, the collation of which is a difficult task. The methodology used to reach this consensus of opinion and recommendations needs to be detailed; we did not come across the

use of any established instruments for this exercise, such as the Delphi or modified Delphi approach.²

The authors very correctly highlight that the remission rate of type 2 diabetes with surgery is higher for patients with shorter diabetes duration.¹ The overarching theme in these recommendations is about prioritising patients who are likely to benefit the most and where delays would be more likely put patients into a more disadvantageous category. We therefore find the authors' recommendation to prioritise patients with diabetes of more than 5 years' duration puzzling and is in direct contradiction to their priority statements.

We would also like to draw the readers' attention to a recent publication by Luigi Angrisani and colleagues,³ which took a different view from Rubino and colleagues. This article was co-authored by the president of International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO), along with the president-elect and at least seven other current or past presidents of IFSO chapters. Angrisani and colleagues state that patients with higher BMI and multiple comorbidities (with uncontrolled type 2 diabetes being one of the main areas of concern) are at risk of life-threatening COVID-19-related complications in the perioperative setting, thus concluding that surgery should be offered to patients who are more likely to recover from a possible infection.³ The eligibility criteria for surgery proposed by Angrisani and colleagues included, among others, BMI below 50 kg/m² and no or controlled comorbidities.³

Considering that obesity is a major risk factor for severe COVID-19 and its related mortality, obesity treatment could offer an opportunity to reduce the burden of COVID-19. Bariatric surgery, which is the most effective treatment in producing sustained, long-term weight loss, came to a standstill globally with the

COVID-19 pandemic. Hence, there is a lot of interest in restarting bariatric surgery safely. The two opposing views we highlight might only add to the confusion in the field. A wider consensus is needed to ensure this life-saving treatment is delivered to patients in a timely manner.

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The COVID-19 pandemic has caused serious disruptions to the health-care system and has revealed substantial racial, ethnic, socioeconomic, and other health-care disparities. The role of obesity has also been highlighted, as obesity severity appears to be related to higher rates of hospitalisation and poorer clinical outcomes of COVID-19.¹ Obesity treatment has been hugely affected by the pandemic, leaving millions of children, adolescents, and adults at high risk for worsening comorbidities, with less access to treatment and increased risk for poor outcomes from COVID-19.

We applaud Francesco Rubino and colleagues' recommendations for bariatric and metabolic surgery during and after the COVID-19 pandemic,