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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Letter to the Editor

Loneliness that destroys and upsets: A lesson from and beyond COVID-19

"I've often come up against the bad part about living". A famous poem by the great poet Eugenio Montale represents well the situation of elderly patients admitted to our hospitals in recent months.

The review by Smorenberg et al. illustrates very accurately the serious consequences of Coronavirus Disease 2019 (COVID-19) in elderly patients [1]. In addition, we believe that factors such as forced isolation and the breakdown of relationship-based systems, which we are accustomed to, play a part in further worsening the situations of these patients. Below we briefly present the significant case of GB which we believe is representative of the crisis.

When GB arrived in our COVID department at the height of the second wave of the pandemic, we assumed that his end was near. What chance would an 81-year-old man with severe kidney failure have in the face of such a terrible virus?

GB experienced a fall at home, where he was living in a delicate balance with his beloved wife.

The CT scan in the emergency room showed a collapsed lumbar vertebra and interstitial pneumonia. GB had to go through the difficulty of undergoing CPAP but he overcame it, with the hope of soon returning home to his wife who supported him every day through phone calls. His strength was so great that once the pneumonia had been treated, he underwent a vertebroplasty and began physiotherapy with few muscles in good condition after days of bed rest. He was aided by his legs that were strengthened through extensive exercise in his youth as a farmer and mountaineer. Only one problem stood between him and returning home: a swab test for SARS-CoV-2 that was still positive more than two weeks after admission and the fear of returning home and infecting his wife, who was also elderly and at risk.

GB, although deeply saddened, did not give up for days, until one morning when he told me: "Doctor, I can't take it anymore, I just want to die. I heard my wife telling me that I might not be able to go home because she and my son don't feel like taking me back". I told him "You'll see, it'll only be a matter of days and you'll be able to go back home to your relatives". I lied to him: I knew he might not be able to go home because I knew the truth.

His wife had been in the room next to his for a week. She had also tested positive for SARS-CoV-2, she had pneumonia and her breathing was very bad. They spoke on the phone every evening and GB did not know that she was about one and a half metres away from him because she had expressly asked us non to inform him: she was afraid that knowing that she was so ill, he would not be able to cope, thinking he was the one who infected her.

The situation of profound isolation, the loss of structure of the family system, made worse by the measures of isolation and the fear of contagion, have profoundly altered the history of our patients, particularly for people suffering from frailty [2]. In the management of COVID-19, we have observed the ineffectiveness of certain drugs and in some cases their danger. Potentially equally deleterious for our patients is the loss of stimuli for recovery, such as the lack of objectives like the desire to return home. Cold conversations over the phone cannot satisfy their tired ears and eyes and the result is often a feeling of abandonment too heavy to accept. This can generate, together with a sense of guilt for having been a source of contagion, a state of deep depression that can undoubtedly affect their prognosis and their relationship with health professionals.

As a generation of doctors and nurses in the new millennium, we have never had to deal with such a potentially catastrophic mix of clinical, social and relational complexity. We used to deal with patients who, despite the despair of their illness, maintained the hope of a last embrace, of a last word of comfort from their loved ones. This fundamental component of the end of life has been profoundly damaged, and for us, healthcare professionals, the acceptance of pain and suffering cannot take place as it did before.

If it is true that *'all real living is meeting'*, as suggested by philosopher M. Buber at the end of the World War II, another serious historical context marked by broken human relationship, then it is important to provide operators with the tools they need to strengthen their resilience [3]. This cannot be left to chance, but can potentially be achieved through dedicated training courses, creation of stimuli for our human and professional growth and the identification of dedicated resources. In this regard, it is desirable to create a network which, through unifying the strength of scientific societies, can better identify difficulties and put forward proposals for improvement on a large scale, ones that would not only help us to deal with COVID-19, but that would also strengthen our structure so that we are able to better respond to any such crisis in the future.

Declaration of Competing Interest

The authors of the manuscript declare they have no conflict of interest.

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Christian Bracco*, Remo Melchio, Elena Migliore, Chiara Marrale, Luigi Fenoglio

Internal Medicine, S.Croce and Carle Hospital, Cuneo, Italy

* Corresponding author.

E-mail address: bracco.c@ospedale.cuneo.it (C. Bracco).

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