

Dear Editor,


Acute care surgery and post-operative COVID-19 care: a comment

We found the study by Lepre *et al.* to be very interesting.¹ Lepre *et al.* concluded that 'active surveillance with a liberal use of reverse transcriptase-polymerase chain reaction test and thoracic computed tomography scan is required in this setting, to rule out coronavirus disease 2019 (COVID-19) infection, in an effort to offer prompt treatment to infected patients and to protect other patients and health workers'.¹ We agree that it is necessary to have a good preparedness for any surgery during the present COVID-19 outbreak. In our setting, Thailand, the second country in the timeline of COVID-19 pandemic,² the surgeon's COVID-19 infection is already recorded by local Center of Disease Control. In addition, the asymptomatic COVID-19 patient who received the first diagnosis of disease after the surgical procedure was completed has already been reported.³ An interesting consideration is whether the present prevention is sufficient.

Lepre *et al.* recommended the method based on the case with respiratory symptoms. Nevertheless, the asymptomatic COVID-19 patient might undergo surgery and can transmit the disease to the surgeon. How to manage the asymptomatic case is a challenge. It is questionable whether we have to use preoperational COVID-19 test for all patients. Nevertheless, a simple method according to universal precautions should be used in the clinical care of any patient in the present situation of COVID-19 outbreak.

References

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Dear Editor,

Re: Comparative study of outcomes for elderly hip fractures presenting directly to a referral hospital versus those transferred from peripheral centres

Butler *et al.*'s retrospective review of hip fracture patients at a rural referral hospital compares outcomes of patients who presented directly to the referral hospital with those who were transferred.¹ Clinical care standards aim for surgery within 48 h of presentation. Transfer delayed time to surgery from 36.9 to 54.2 h, and this delay was associated with higher mortality. This aligns with the Australian and New Zealand Hip Fracture Registry data where time to theatre is 31 h, but extends to 53 h if transfer is required.² Patients who had preoperative transthoracic echocardiography (TTE) were also more likely to be delayed. The authors conclude that as echo delayed time to theatre and did not change mortality rate in their study, it should be used more judiciously.

There is an ongoing tension between the risk of delaying anaesthesia for TTE and the risk of proceeding without the information it provides. TTE identifies cardiac structural abnormalities and haemodynamic status, with information used to modify anaesthetic management. Significant aortic stenosis is present in 8% of fractured neck of femur patients but one-third have no audible murmur.³ Instead of less TTE, we should advocate for increased availability and address the other modifiable causes of delay including a 'no-refusal' transfer protocol as recommended by the authors.

The Australian and New Zealand Hip Fracture Registry report that the main delays to surgery are theatre availability (38%), patient medically unfit (24%), anticoagulation (17%) and surgeon availability (2%). Life expectancy decreases with increasing remoteness from major cities, in part due to access to health services.⁴ We should continue to advocate for improved access to TTE, timely transfer and dedicated theatre time in order to improve equity. Elderly patients with neck of femur fracture are at high risk and need full and timely multidisciplinary care, particularly those in our regional and rural communities.

References

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