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Indirect casualties of COVID-19: perspectives from an American vascular surgery practice at a tertiary care centre

Editor

The COVID-19 pandemic has significantly altered the practice of medicine. The first case in USA was confirmed on 19 January 2020, and social-distancing recommendations and 'stay-at-home' orders have been implemented to delay hospital saturation, as is the case everywhere^{1,2}. This has also forced a change in specialized practices such as vascular surgery, leaving referring providers unsure of when to place consultations. To make matters more confusing, the situation varies based on location. Although the experiences of locations such as New York have been broadcast widely, there are few reports detailing experiences from the rest of the USA.

On 23 March, we instituted drastic changes to our practice in accordance with recommendations from the American College of Surgeons³. This involved postponing all elective cases, with the exception of those for immediately life- or limb-threatening processes.

Outpatient visits have largely transitioned to 'virtual' appointments, utilizing phone conversations, chart review and essential diagnostic testing only.

We had a total of 63 outpatient consultations between 23 March and 1 April compared with more than 200 new consultations per month in 2019. There were 42 surgical consultations, and all were performed 'virtually'; 13 patients (31 per cent) with venous disease, 11 (26 per cent) with peripheral artery disease (PAD), five (12 per cent) with aortic pathology, four (10 per cent) requiring surgical exposure for other procedures, and four (10 per cent) with cerebrovascular disease. Ninety-one procedures were electively scheduled to occur during the same period, with 88 cases (97 per cent) being postponed. To ensure these patients are not overlooked in the future, they were entered into a prospective database at the time of rescheduling. Nineteen procedures have been performed during the practice change so far; this includes eight non-hospitalized (42 per cent) patients. Indications for these patients were PAD with infection/gangrene in 2 (25 per cent), wound complications in 2 (25 per cent), and one case each for aortic graft infection, ruptured abdominal aortic aneurysm, symptomatic carotid artery stenosis and subacute arm ischaemia.

The indirect morbidity of this pandemic will lie with those patients whose care has to be postponed. We currently maintain the capacity to perform urgent/emergent procedures and

evaluate outpatient consultations 'virtually'. Proactive review of consultations may reduce unnecessary exposure of vascular patients by limiting diagnostics and traditional visits. 'Virtual' visits have thus far permitted timely evaluation for new consultations, while eliminating risk of viral exposure. Our capacity to continue with the current practice model may change as the pandemic evolves locally, making strategies such as patient databases all the more important to mitigate the indirect morbidity of COVID-19 on vascular patients.

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- 2 COVIDSurg Collaborative. Global guidance for surgical care during the COVID-19 pandemic. *Br J Surg* 2020; <https://doi.org/10.1002/bjs.11646> [Epub ahead of print].
- 3 American College of Surgeons. *COVID-19: Recommendations for Management of Elective Surgical Procedures*; 2020. <https://www.facs.org/covid-19/clinical-guidance/elective-surgery> [accessed 12 April 2020].