Letter to the Editor

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Comment on "Proposed measures to be taken by ophthalmologists during the coronavirus disease 2019 pandemic: Experience from Chang Gung Memorial Hospital, Linkou, Taiwan"

Dear Editor,

We are all aware that the coronavirus pandemic has affected the regular patient flow and practice patterns in all the specialties worldwide including ophthalmology. Since SARS-CoV-2 is highly contagious, we as ophthalmologists are at the highest risk of contracting this virulent infection, due to the close contact with patients during ocular examinations, and are also facing high patient volume in both the outpatient clinics and emergency consultations.[1] We read the interesting article by Lin *et al*.[2] and we were deeply impressed by the measures taken by the team for combating the coronavirus pandemic. We must congratulate the authors for highlighting all the measures during the past 9 months. However, we have a few important observations and suggestions to make and we would like the authors to share their experience with the readers.

First, in the hospital policy, the authors mention that "all visitors were screened by infra-red thermometers and were requested to put on masks before entering our hospital." Did all the patients were also instructed for handwashing and sanitation before entering the hospital, as coronavirus is known to spread through the contact?[3] This needs clarification as this is missing.

Second, the authors mention that "patients with nonurgent ocular conditions or examinations will also be rescheduled and postponed to at least 1 month later." It will be interesting to know that did these patients were initially teleconsulted[4] or based on history alone they were rescheduled for the next appointment. This also needs clarification.

Third, for "segregating patients and medical staffs" what strategy did the authors employ for examining pediatric patients as they are always accompanied by the parents? Were both parents allowed or single parent? This will be interesting to know. Moreover, since the patient volume was low, in a majority of the ophthalmology hospitals in our country, the doctors and nurses were segregated in 2–3 teams to reduce the contact and exposure time. The teams worked for 2–3 days a week during the pandemic.

Fourth, how did the authors manage to disinfect the fundoscopy, indirect ophthalmoscopy, and gonioscopy lenses after each examination? Did they use alcohol-based hand rub? Were these lenses washed after each examination? Were they also covered with disposable plastic wrap? These are very important questions in this context to know.

Next, before surgical intervention, did the high-risk patients underwent COVID-19 testing for antibodies or polymerase chain reaction as there is a high risk of spread in the operating room through aerosols? Moreover, did only the senior ophthalmologist perform the surgeries? This strategy is employed at the majority of the centers in our country to date to reduce patient table time and complication rate and it has proven beneficial during this pandemic.[5]

Finally, how did the authors manage the large corneal perforations and nonresolving corneal ulcers during the pandemic lockdown as there was an acute shortage of donor buttons? These patients were at high risk due to the risk of secondary glaucoma, phthisis bulbi, and endophthalmitis, and saving the globe was a challenge.

In the end, we want to add a few important points. Conjunctivitis cubicles can be set up separately as there is recent evidence of SARS-CoV-2 in the tear fluid. Patients with nonurgent conditions can be managed with teleconsultation and the doctors and nurses can be split up in alternate day teams to reduce contact and exposure.

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Conflicts of interest

The authors declare that there are no conflicts of interests of this paper.

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