Trauma care in the times of COVID

Editor

Trauma care is dynamic. While most elective and outpatient healthcare services were on hold in view of COVID 19 pandemic, trauma care services continued[1]. This pandemic created unique situations in low and middle-income countries. Road traffic injuries, a major shareholder of trauma burden reduced significantly due to lockdown, however there was a steep rise in interpersonal violence and fall cases. In most developed nations, new facilities were built to isolate COVID victims, however in low middle-income countries, many standalone trauma centers were converted to COVID facilities and so was our level I trauma centre. We present our experience in managing trauma victims in this peculiar situation.

In Emergency Department (ED), a COVID screening area was set up initially. However, as COVID 19 cases increased, all the patients are now treated as COVID suspects with health care personnel donning level III PPE[2]. Patients presenting to ED requiring urgent surgery for haemorrhage, contamination and threatened limb are operated with level III PPE in a dedicated COVID OR. In stable patients, procedures are done after COVID status is known. All patients planned for admission are tested for COVID[1]. Blood bank and radiology services have to be shared with other departments, leading to unexpected delays. Imaging studies are being used as per clinical judgement, the earlier practice of imaging all patients with dangerous mechanism of injury is on hold. Blood products availability is limited, thus transfusion triggers have been modified. Prophylactic transfusions are avoided. Patients with less severe injuries are shifted to smaller centres to avoid resource scarcity. There is a dedicated negative pressure COVID OR. Procedures are preferably done by senior surgeons. Nonessential staff is not allowed inside OR, especially during endotracheal intubation[2]. Aerosol generating devices such as electrocautery, ultrasonic scalpel are avoided. The evidence for use of laparoscopy is controversial, it is being used sparingly[3]. Postoperatively, the patient is shifted directly to ward after telephonic handover to keep the contact minimal. As there is a possibility of patients being in incubation period, new admissions are kept in a single cubicle in the ward for the first 7 days. ERAS protocol is followed to encourage early postoperative recovery and discharge. On discharge, patient is provided with information for teleconsultation, physical follow up is not encouraged unless essential[1,4]. Exposure of large number of staff to COVID at the same time may create a crisis situation. To avoid this, staggered rosters are being followed, with a few team members as backup, to be called when required[5]. All aspects of patient care are managed with the minimum number of Healthcare workers (HCW) required. All academic activities are being conducted via virtual platform[2].

COVID pandemic is here to stay, and so is trauma. We must continuously evolve and learn ways to ensure that either of them should not let the quality of care and human touch suffer.

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