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COVID-19 diffusion capability is its worst, unpredictable characteristic. How to visit a patient from a distance

Editor

Italy has implemented severe restrictions to avoid the spread of COVID-19. The major problem we face is the extreme, unpredictable diffusion capability of the virus^{1–3}. In this context, health workers may represent an involuntary, unexpected major transmission vector.

In Italy, doctors and nurses, and cleaners have done an extraordinary job, even working more than 100 hours a week. There has been and remains a shortage of doctors and nurses. Many doctors and nurses have been contaminated and have had to stop working. To date, 120 doctors (mainly family doctors), 30 nurses and 10 pharmacists have died from COVID-19. In this pandemic, the most important preventive measure is to avoid medical facilities. In Italy, too many medical facilities were contaminated from the beginning when

patients with respiratory symptoms asked for advice. The best solution is for dedicated and experienced health workers to follow a patient *via* e-mail and video-conferencing. If symptoms worsen, the patient can have a swab for COVID-19, and if positive the patient can be taken directly by ambulance to a dedicated COVID-19 hospital.

The most common initial attitude in all countries has been to underestimate the contamination rate. Often, COVID-19 patients are admitted *via* the emergency room to general wards before a diagnosis has been made and they are isolated. During this period, diffuse contamination of hospital workers is highly probable. The best solution is to have dedicated hospitals for COVID-19 patients.

In this extreme situation, patients should not be seen in medical facilities. New appointments and outpatient visits should not take place unless absolutely necessary. A system should be established in which patients are issued with a simple three-digit number that enables them to access a 'video-conference visit'. Patient history can be easily taken and recorded for comparison in the future control of disease progression. Physical examination may be performed in a video-conference. Patients can be examined by video, with health workers looking for signs of respiratory distress or cyanosis. Chest auscultation can be

performed by asking the patient or their relative to place the microphone of the phone on the different chest regions.

The clinical data may indicate the need or otherwise to swab for COVID-19. If needed, dedicated health workers can take the swab from a distance, giving the patient a O₂ oximeter. Operations that can be deferred should be not performed. The fewer people move around medical facilities, the better.

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- 1 Spinelli A, Pellino G. COVID-19 pandemic: perspectives on an unfolding crisis. *Br J Surg* 2020; <https://doi.org/10.1002/bjs.11627> [Epub ahead of print].
- 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 Søreide K, Hallett J, Matthews JB, Schnitzbauer AA, Line PD, Lai PBS. Immediate and long-term impact of the COVID-19 pandemic on delivery of surgical services. *Br J Surg* 2020; <https://doi.org/10.1002/bjs.11670> [Epub ahead of print].