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LETTER TO THE EDITOR

Effect of SARS-CoV-2 infection on trauma throughput to alternative elective care approaches

Beuy Joob, Viroj Wiwanitkit

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Abstract

In response to the paper on coronavirus disease 2019's effects on trauma throughput, elective care models should be modified. Concerns about the relevant factors and their potential therapeutic applications are brought up and looked into.

Key Words: Trauma; Model; Adaptive care; COVID-19

Core Tip: This letter to the editor is in reaction to the article: The influence of coronavirus disease 2019 (COVID-19) on trauma throughput and the adaptation of elective care paradigms. Concerns are raised and examined concerning the factors involved and their therapeutic application. The model's influence may be limited to the COVID-19 pandemic phase and may not be applicable to the post-COVID-19 period.

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TO THE EDITOR

We read with interest a case report on "Utilising the impact of COVID-19 on trauma throughput to adapt elective care models for more efficient trauma care" by Kulkarni *et al*[1]. Kulkarni *et al*[1] investigated the effect of severe acute respiratory syndrome

coronavirus 2 infection on service delivery. A comparison between throughput and productivity parameters during the pandemic with those observed in the previous years was performed in order to search for successful, cost-effective, and long-term differences in practice[1]. Coronavirus disease 2019 (COVID-19) has resulted in a practical change in the delivery and access to care, according to Kulkarni *et al*[1], with many changes and adaptations anticipated to affect healthcare services in the future.

We all believe that coronavirus disease 2019 (COVID-19) necessitates medical care adjustments. During an emergency, adjustments may be made, but it should be recognized that the standards of care must still be met. Kulkarni *et al*'s recent report may reflect their experience during the pandemic[1]. However, if the models are to be employed in the post-crisis period, they must be carefully considered. In the absence of an emergency, resuming full-scale normal treatment may be necessary. Some options, such as delayed case management and telemedicine management, may be avoided. While some studies have demonstrated that different orthopaedic surgeries may be considered elective, medically required surgery must continue in areas with minimal medical care[2]. This could be the fundamental medical notion of first doing no harm to the patient. Furthermore, the COVID-19 period's epidemiological pattern of the medical problem may differ from the pre-COVID-19 period. The model's effect may differ depending on the disease pattern[3]. The model's influence may be limited to the COVID-19 pandemic phase and may not be applicable to the post-COVID-19 period. In order to assess the exact effect of adapting elective care models, there should be a long term follow-up, and the relationship with the changing background situation should also be assessed. Finally, in addition to the present clinical outcome measurement, it should place a greater emphasis on the patient's perspective on the change. This is a point that is frequently overlooked in many investigations.

FOOTNOTES

Author contributions: Joob B wrote the letter; revised the letter and approved final submission; Wiwanitkit V wrote the letter; revised the letter and approved final submission.

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