COVID Story; Pandemic Was A Universal Challenge

Ayesha Abbasi

Dear Sir,

The SARS-CoV-2 epidemic in recent years has fundamentally altered how people live. SARS-CoV-2 poses a significant hazard to healthcare workers, including doctors, nurses, and paramedics working as front-line personnel in emergency rooms, clinics, wards, and intensive care units in Pakistan due to the country's low middle-income status and restricted healthcare and resource availability.

In December 2019, it emerged from China's Wuhan region. On February 26, 2020, the first regional case in Pakistan was reported. From that point onwards, a growing tide of instances was seen with each passing day[1]. Rapid cross-border spread of SARS-CoV-2 has caused severe death and morbidity[2].

Over the years of experience, the emergency care providers have suggested to implement few changes in practices which can help to treat and control covid-19 transmission within the healthcare providers.

Table 1. Issues identified and lessons learnt

Delay in identification of suspected COVID-19 i-nfectio-n in patient with no travel history indicating the need for a better screening criteria.
Attendants substantially exposed to infected patient in-dicating lack of public health awareness and precau-tions.
Delay in defining hospital processes and implement-ation of admission policy for suspected COVID-19 pa-tient leading to mass exposure of healthcare workers.
Neglect in immediate Personal Protective Equ-ipment (PPE) safety measures taken by health care workers.
Nebulization being done on patient allowing aer-osolization.
Cardiopulmonary Resuscitation (CPR) done on such patient for 40 minutes further increasing risk of expo-sure to healthcare staff.
Screening and self-isolation of a large group of heal-thcare workers in the current crisis leading to an addi-tional burden to the healthcare system.

In addition to being crucial for the individual patient, a thorough history that includes contact tracing is also crucial for population-level conta-inment and control during a pandemic. In a perfect world, rigorous social segregation would already be in use to stop communal transmission[3], however this is often very difficult to achieve, particularly early on a pandemic, due to complex issues from social, cultural, religious, and econ-omic considerations to communication and mes-saging approaches from authorities and public health officials[4]. However, if a patient does arrive, rapid suspicion and prompt isolation of the patient are crucial owing to the possibility of transmission, not only to medical staff but also to other patients in the Emergency Room. To avoid contamination, patients should be confined in rooms with negative isolation. The low and middle income countries (LMIC) with a low to moderate income level already has a constrained healthcare system and few available medical experts. In the event that nume-rous emergency physicians and other medical professionals isolate themselves, patient care might be threatened, making it challenging to manage patients in crucial emergency department locations.

In conclusion, underlying comorbid disorders, particularly in individuals with impaired immune systems, can disguise SARS-CoV-2 infection dur-ing clinical and laboratory testing[5].In addition, infec

Department of Emergency Medicine, Aga Khan University Hospital

Correspondence: Dr. Ayesha abbasi
Department of Emergency Medicine,
Aga Khan University Hospital
Email: dr.ayeshaabbasi@gmail.com
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tions in these patients might advance quickly, necessitating the availability of critical care resources and the establishment of defined protocols to deal with a precipitous decline in clinical status[5]. All healthcare personnel should be required to exercise early suspicion with thorough screening procedures, awareness of asymptomatic transmission, and rigorous adherence to PPE.

To offer the greatest possible protection against contracting an illness, it was strongly advised to strictly abide by Personal Protective Equipment on a regular basis. Prioritizing and protecting the front Line Doctors as effectively from airborne infections as possible should be the primary goal of a strong healthcare facility.

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