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Commentary: Echoes of war

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CENTRAL MESSAGE

Aggressive identification of COVID-19 surgical candidates is mandatory to avoid lethal postoperative complications and prevent exposing surgeons to the contagion.

Patients with coronavirus disease 2019 (COVID-19) experience 1 of 3 possible pathways—minimal symptoms (home rest), shortness of breath (hospital admission), and need for ventilatory support (intensive care unit admission)—variably combined and yielding different outcomes.¹ The article by Peng and colleagues published in this issue of the *Journal*² describes the postoperative onset of COVID-19 pneumonia in patients with ascertained exposure to the contagion before surgery. Once viral pneumonia is recognized, the outcome becomes unpredictable, irrespective of the type of surgery and the wide variety of treatment regimens used to control the infection.^{2,3} The lesson learned from Wuhan is that we need to strike a balance between the benefit of surgery and the risks of an undue exposure to the virus for both patients and surgeons by changing the principles of managed care.⁴ We hear from Europe, especially from Italy, of hospitalized patients developing COVID-19 after surgery, as well as thoracic surgeons intubated after heroically providing service to these patients. In addition, fewer and fewer thoracic surgical units are operative, with the majority converted to COVID-19 step-down wards.

In New York City, the new epicenter of the disease, we have just begun ramping up the curve of the contagion. The frightening 27% mortality risk reported by Peng and colleagues should make us rethink our strategies and reshape our approach to the patient.² The availability of

human resources will affect the ability to continue to perform cancer surgery—those resources need to be protected.⁵ The implementation of telemedicine to triage perspective new visits and provide follow-up of operated patients is rapidly becoming a necessity.⁵ Strict personal hygiene, social distancing, and avoidance of external visitors are effective preventative measures, especially considering the risk of spreading the contagion from asymptomatic patients.⁵ Accurate selection of candidates for endoscopic staging may avoid an unmeasurable exposure of clinicians and staff to a patient’s exhalates. Surgical procedures that can potentially increase length of stay must be carefully selected and, if possible, postponed if we want to be ready with bed availability when the COVID-19 pandemic hits with its maximum strength. The paper from Wuhan transfers the echoes of war from the initial epicenter of the contagion.² For the first time after the era of tuberculosis, an airborne pathogen can potentially harm both the patient and the surgeon in the perioperative phase. In the supreme interest of both patients and surgeons, aggressive screening for COVID-19 should be used with surgical candidates, and

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THOR

COVID-19 should enter the differential diagnosis of postoperative complications after thoracic surgery.

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Commentary: The double responsibility of the thoracic surgeon at the time of the pandemic: A perspective from the North of Italy

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The rapid spread of the coronavirus disease 2019 (COVID-19) pandemic in the north of Italy at the end of February 2020 has taken the local health care system by surprise because of the exponential increase in the number of daily cases and sheer number of those needing admission to intensive care units.¹ In the emergency, with hospitals' services being reconfigured, thoracic surgeons still tried to maintain a more or less regular operating schedule amid uncertainties regarding the safety of the patients and health care operators.^{2,3} Although China was ahead of us in terms of experience, there were no data available regarding thoracic surgery and the potential postoperative increase in morbidity and mortality.

The first meaningful evidence emerging from this study is the proportion of severe and critical disease between

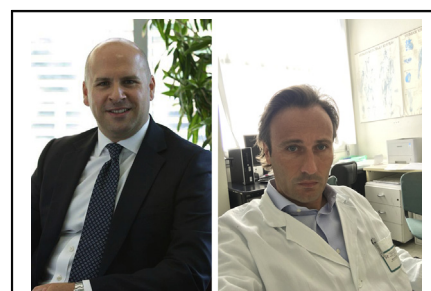
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CENTRAL MESSAGE

Insidious diagnosis and high fatality rate of COVID-19 require special management of patients referred to thoracic surgery. Maximum in clinical surveillance and preoperative selection are mandatory.

thoracic surgery patients and the whole COVID population, which was 27.3% and 36.4% versus 2% and 13.8%, respectively, strongly suggesting the possibility that surgery, in itself, can negatively affect outcomes. These data seem to be consistent with general surgery.^{4,5}

In the present issue of the *Journal*, Peng and colleagues⁶ are to be congratulated as they focus on identifying the diagnostic challenges in the early postoperative management of patients diagnosed with COVID-19. The most important alert is that, in addition to its variable incubation period, signs and symptoms of infection often coincide with normal postoperative ones, making realistic a delay of about 8 and 4 days for suspicion of viral pneumonia and confirmed diagnosis. It should be particularly emphasized that 5 of 11 cases had misdiagnosis at first