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on the latest information diminishes the fear of uncertainty and negative emotions associated with the virus [20]. This entails frequent information sessions on the specific details of the virus, practicing ethical decision making, and how to effectively use hospital resources [19]. By ensuring that the entire team maintains the same understanding of information and protocols, a certain amount of order can be maintained to curtail the negative impacts of this crisis. Additionally, establishing break time will allow for HCWs time to take care of themselves. Another recommendation centers on creating healthcare staff reserves to relieve those on duty before exhaustion and strain sets in resulting in anxiety and depression, affecting the quality of healthcare delivery. This can be done in several ways, including incorporating outside registered nurses into the hospital system, re-employing HCWs who recently retired, and adding in the newly matched fourth year medical students. As this crisis progresses it is imperative to continue to evaluate the well-being of our HCW and implement effective measures to care for their mental health.

This global crisis has fostered fear among healthcare workers. Healthcare workers are scared for their co-workers, their families, their friends, our communities and our country. Despite this fear, they continue to fight on the frontlines to execute their job while in a persistent state of survival mode in order to protect everyone around them. In order to win this war against COVID 19, we must come together on a united front to support those on the frontlines. While our healthcare workers continue to fight, we must help them fight off any potential short or long-term effects during and after the COVID19 pandemic. This requires the implementation of accessible counseling services and effective measures to care for their mental well-being in order to preserve their health.

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7 April 2020

<https://doi.org/10.1016/j.ajem.2020.04.024>

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Why India needs to extend the nationwide lockdown



The ongoing COVID-19 pandemic has afflicted almost the entire world. China and Italy have been some of the worst hit while the first world economic superpowers like United States of America and United Kingdom have had an onerous load on their respective healthcare systems. On January 30, 2020 India became part of this global carnage with the first COVID diagnosis [1]. The numbers have risen steadily since then, albeit at an alarming rate in the final days of March. Aiming to control community transmission, the Indian government took the step of declaring a 21 day nationwide lockdown starting on March 24th [1].

As we approach deeper into the lockdown, a steep rise in the number of confirmed cases has been noted. Despite this, as of now, the Central government has expressed no intention of extending the lockdown.

Epidemics are a numbers game and as far as numbers are concerned, India has its hands full.

India has the second largest population after China but India's population density far exceeds China's (455/km² vs 148/km²) [2]. This is should be an extremely pertinent factor while designing the epidemic response suited to the country. When we look at the rate which screening is being done, India ranks at the lower end of the spectrum. If the maximum number of people cannot be diagnosed, how can one expect them to be quarantined or treated.

Availability and cost of testing kits are valid concerns which perhaps cannot be dealt with at this juncture in a manner of urgency. What can be done is to contain the spread of the infection to as few individuals as possible before this becomes the wildfire that some countries have had the misfortune of being witness to.

The answer lies not in clinical medicine. This battle cannot be won inside the hospital. There are no evidence based treatment options and a vaccine does not seem to be in sight anytime soon. Healthcare systems across the resource rich countries have visibly crumbled under the case loads. The answer lies in the fundamentals of epidemiology.

Recently a predictive model of the way the infection could spread in India was published by Singh and Adhikari [3]. Emphasizing the importance of social distancing as the only effective tool against COVID for now, they have formulated various predictive models based on Bayesian imputational analysis.

Their recommendations are very clear. For the lockdown to be effective, there are only two approaches:

- 1) Extend the lockdown to a total of 49 days or
- 2) Phased lockdowns of 21, 28 and 18 days with intervening periods of 5 days of suspension.

Both the models seem to suggest effective control of spread of infection [3].

Even if mathematical models are not convincing enough, we need to look at the other side of the available statistics. At the time of writing this article, India has tested 114,015 people out of which 4616 have been reported to be positive [4]. Considering the strength of iceberg phenomena in India, one should not draw any delusive contentment from these statistics.

Seventeen cases and three fatalities [5] out of the largest slum dwelling in India-Dharavi, with a population density of a staggering 870,000/mile² (335,907/km²) [6], is a data set that should be a cause for serious concern.

India is yet to visualize the true impact of this pandemic. Using the current statistics to formulate epidemic control policy would be equitable to running in the blind. If the government decides to end the lockdown as planned, it could spell doom for the entire country. The mortality numbers in Italy and Spain would seem like specks of dust. As clinicians, we should be building surge capacities for the time when the lockdown is lifted. This lockdown is the dam holding back a flood. Once it breaks, our entire healthcare system, public and private, will drown in the torrent that follows.

The most pragmatic way to deal with this pandemic is what is being done right now—a lockdown. If implemented with integrity, it could prevent this disaster from engulfing a large section of the Indian diaspora.

We live in an extremely connected world. Considering that the Indian lockdown directly concerns approximately 18% of the world's population [7], its impact can go far beyond just the Indian borders.

In the recent years, Indians have taken great pride in the strength that they display in numbers. This population has been the cornerstone of India's phenomenal economic success.

COVID-19 threatens the very foundation of this triumph. A storm is coming. We better take shelter.

Disclosure of funding

No funding was given for this article.

Declaration of competing interest

There is no conflict of interest.

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6 April 2020

<https://doi.org/10.1016/j.ajem.2020.04.026>

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The use of personal protective equipment in the COVID-19 pandemic era



Sir,

In the times of SARS-CoV-2 pandemic, particular attention should be paid to personal protective equipment (PPE). Medical personnel protection is of particular importance because of the risk of infecting other members of medical teams, including not only physicians, nurses or paramedics, but also other support personnel necessary to maintain the continuity of care for patients [1,2]. Medical personnel protection is a priority as in their case, infection or even the need for quarantine may pose a real threat to patients.

The weaknesses of health care systems in many countries are now particularly highlighted. Even the highly developed countries with the highest level of health care systems cannot cope with a sudden increase in the number of patients in need of treatment, including, primarily, intensive care with endotracheal intubation and mechanical ventilation [3]. The need to limit therapy to survivors constitutes an enormous psychological burden and moral and ethical challenge; it also triggers a number of negative phenomena among the affected families and the medical personnel themselves [1,4].

The current pandemic is reducing medical resources and requires PPE adaptation to the circumstances and to the scale of the threat to medical personnel [5]. One should remember that it is the most important to follow the general recommendations on hand disinfection and the sequence of procedures when putting on and taking off PPE [6]. It is essential to use masks with a filter, but also goggles and visors to protect the face, as well as double or triple gloves (Fig. 1). Sterile surgical gloves are particularly useful as they are longer.

The optimal solution is to fully protect the entire body surface, isolate it from the environment, and breathe in air from a portable source, but this is not necessary in the case of SARS-CoV-2 [7]. At present, it is recommended to apply various types of equipment, including, in particular, partial protection of the environment through the use of surgical masks or ordinary face masks by persons with confirmed or potential SARS-CoV-2 infection; this may reduce the risk of infecting people in the environment, including medical personnel [3,7].

At present, performing a number of procedures in emergency medicine is associated with additional problems and risks for medical personnel. Emergency physicians, anesthesiologists and intensive care specialists, as well as the relevant scientific societies issue recommendations concerning endotracheal intubation or other procedures dangerous for the medical personnel [1,2]. It should be remembered that endotracheal intubation by using direct laryngoscopy without adequate protection presents a high risk of SARS-CoV-2 infection. The proposed modifications of endotracheal intubation include special preparation of the equipment and medical personnel, using a special protective box, foils applied to the upper half of the patient's body, and the use of indirect laryngoscopy methods, including video laryngoscopy and rapid sequence intubation [8,9]. In this context, it should be emphasized that attempts of prehospital endotracheal intubation by inexperienced personnel constitute a challenge, and supraglottic methods should be