Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Caring for patients with venous insufficiency during the COVID-19 pandemic at a tertiary care center

In December 2019, coronavirus disease 2019 (COVID-19) was identified as the cause of a cluster of pneumonia cases in Wuhan, China. It rapidly spread and has resulted in a global pandemic.

With the current recommendations of social distancing and stay-at-home orders, the pandemic has significantly affected medical practice. Although most venous insufficiency cases will be considered elective, delaying care can result in complications such as deep vein thrombosis or stasis ulcer. Furthermore, it has been confirmed that early endovenous ablation of superficial venous reflux will result in faster wound healing.¹ Consequently, it is crucial to weigh the risk of delaying these cases to reduce viral transmission with the benefit of reducing venous disease-related complications. In accordance with state, federal, and medical society recommendations, our institution has instituted drastic practice changes. These involved rescheduling of all elective procedures, including venous cases, and postponing all venous insufficiency ultrasound studies. Patients with suspected venous stasis ulcers or deep vein thrombosis are allowed to undergo appropriate testing and, in some cases, to be seen in the clinic. All postponed office visits, vascular laboratory studies, and procedures have been recorded in a database to allow for rescheduling once the COVID-19–related restrictions have been lifted. In accordance with the recent modifications of the Health Insurance Portability and Accountability Act rules to accommodate the COVID-19–related healthcare changes,² we have instituted additional steps to accommodate nonurgent venous cases. First, patients are asked to e-mail us photographs showing their area of concern. Second, for a select group of patients with access to compatible social media services, we have allowed for video calls to providers. Third, we began incorporating secured video conference call services provided by EPIC, which has facilitated live evaluation of patients'

concerns. All nonurgent patients are treated conservatively with compression, elevation, and exercise. Since the peak in Minnesota is projected to be in July 2020, our leadership has asked proceduralists to review all rescheduled and pending cases and provide insight regarding their urgency.² Cases with venous insufficiency–related intractable stasis ulcers will be considered on a case-by-case basis.

During the first month of the COVID-19–related practice changes, 29 vein procedures were rescheduled and 15 new consultations were performed using telehealth methods. Four patients with stasis ulcers have been monitored for progression, three of whom have been approved for procedures. Although venous insufficiency is not an immediately limb-threatening disease, the COVID-19–related delay in care will certainly affect patients' quality of life. We believe that our measures will help mitigate the effects of COVID-19 on the care of patients with venous disease.

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Problems related with anticoagulant usage during COVID-19 outbreak

The current COVID-19 pandemic has led to many countries asking or requiring their citizens to stay home to

avoid potentially contacting the disease or exposing others to the disease. Older patients with comorbidities are at particular risk of developing severe infection with COVID-19. Many people on anticoagulation are older and have significant comorbidities.¹

In many countries, including Turkey, governments have imposed restrictions on travel from home to limit the spread of COVID-19. Although so-called "sheltering in place" is proving to be an effective way to decrease community transmission, patients receiving vitamin K antagonist (VKA) treatment, like warfarin, may be harmed by such policies. Routine reporting of patients to outpatient clinics of hospitals or laboratories for checking their international normalized ratio (INR) places them at risk for community-acquired infection from COVID-19, whereas not traveling for INR checks places them at risk for a complication of over- or under-anticoagulation as INR levels can be labile in many patients on VKAs.

According to the current national and international guidelines, although therapy with novel oral anticoagulants (NOACs) is suggested over VKAs, due to reimbursement problems, many people with deep vein thrombosis of the leg or pulmonary embolism are still receiving VKA therapy.^{2,3} VKAs are also used after venous stenting procedures in patients with chronic venous occlusion syndromes to avoid stent thrombosis. Although there are no definite recommendations about anticoagulation after venous stenting, many patients are receiving VKAs.

Patients with mechanical heart valve replacement also need to use VKAs for long-term anticoagulant therapy to avoid thrombosis. Current guidelines for the management of valvular heart diseases favor VKAs for long-term therapy after valve replacement surgery.⁴

Therefore, many patients need to travel to hospitals or laboratories to screen their INR levels, and it makes them more susceptible to the COVID-19 infection.

If possible during the current COVID-19 pandemic, patients requiring anticoagulant therapy for deep vein thrombosis, venous stent therapy, and nonvalvular atrial fibrillation should be converted to NOACs for decreasing their need to travel from home to avoid COVID-19 transmission without increasing their risk for anticoagulant therapy-related complications.

For patients with mechanical heart valves or who are unable to be treated with an NOAC therapy, INR in-home testing machines can be a convenient alternative method and allow patients to check their INR levels without a need for frequent visits to hospitals or laboratories. Thus, a decrease in hospital visits leads to minimizing COVID-19 transmission. Patients need to consult their doctors for interval of tests and results for adjusting VKAs.

As a result, considering that COVID-19 is transmitted by inhalation and close contact, the in-home INR test method and consulting the results by phone may be favorable. For those who are suitable for NOACs should

be converted from a VKA to an NOAC. Such measures are important precautions to prevent the spread and inevitable consequences of disease in patients under anticoagulant therapies.

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Stenting procedure of nonthrombotic femoral or iliac vein stenotic lesions

We read with interest the article by Aurshina et al.¹ Chronic venous insufficiency of the lower extremities is a common vascular problem. Iliac venous system obstruction and superficial venous reflux are known as the main etiologic reasons.² Stenting of iliac venous obstruction with guidance of intravascular ultrasound is a promising treatment modality in recent years.³

We have some doubts concerning the manuscript. In the Results, 16 patients' Clinical, Etiology, Anatomy, and Pathophysiology classification is C5 and C6. There are no clear data about these patients' ulcer diameter regression during the follow-up period. Was there any benefit to the ulcers after stenting of culprit stenotic lesions?

In this study, percutaneous access was obtained in the ipsilateral femoral or common femoral vein with 10F sheath for all patients. The length of this sheath may extend to the common femoral vein stenosis. If the authors used a distal segment venous access (popliteal vein, saphenous vein) site, would it be an easier procedure for patients with common femoral vein stenosis?