# Impact of COVID-19 in Orthopaedic Practice: What we Must Know

"COVID-19" was first noticed at Wuhan in China in December 2019. Within a very short period, it became pandemic, and as of April 19, 2020, >2.38 million cases have been reported in 185 countries and territories, resulting in >165,000 deaths.[1] It is characterized by strong infectivity with rapid transmission ability that ultimately caused the lockdown of the entire world for the first time in human history. The WHO has clearly narrated its impact on health and world economy and declared the outbreak to be a Public Health Emergency of International Concern.[2] Once the disease has entered the stage of community transmission, chances of being infected by lots of asymptomatic patients or health-care providers (HCP) are higher because they might harbor the disease. Therefore, precaution must be taken for limiting further dissemination of the disease as well as to protect the HCP and patient itself.

In the current scenario, the good thing is that emergency admissions either due to road traffic injury or other reasons have reduced drastically. For example, approximately 150 emergency admissions with nearly 100 emergency operations were carried out per day on a usual occasion in the NITOR (National Institute of Traumatology and Orthopedic Rehabilitation), the largest Orthopaedic and Trauma institute in Bangladesh, which has sloped down to only 25–30 emergency admissions with only 15–20 emergency operations daily. Almost a similar scenario is seen in the outpatient department (OPD), where 6–8 folds decline in patient-turnover is observed nowadays. However, in this context, three Orthopedic Surgeons have already been detected as COVID-19 positive that constitutes a total of 8% of the affecting physicians in Bangladesh, as evident in other parts of the world.[3]

Hence, proper planning is mandatory. First, a guideline should be built up for the management of the patients. Unless strictly indicated, routine checkup and consultation in OPD for all new patients should be avoided, and rather they should be encouraged and advised for online consultation. All elective surgeries, including spinal pathology or fractures having >4 weeks should be suspended. Only emergency procedures such as open fractures, acute fracture-dislocation of joints, acute knee injuries, major limb fractures, femoral neck and periprosthetic fractures, cauda equina syndrome, Spinal cord injuries with instability or neuro deficit, cord compression with progressive neurological deterioration, acute infections, and rapidly progressing malignancies should be given priority.

Whatever in emergency or OPD set up, a triage should be strictly followed. Patients should be categorized into two groups. One with suspected signs and symptoms (Group I), another with normal individuals (Group II). Group I should be attended in a designated febrile corner and their examination should be ensured by wearing a full set of comprehensive PPE. Thereafter, they should be referred to as the isolation corner of the hospital for further evaluation. Once the evaluation is completed, all positive cases should be transferred to the Referral Hospitals or as per the protocol of respective country. For ensuring an efficient service as well as protecting the HCP, a thorough plan should be taken to distribute the HCP in a routine, disciplined, and rational way. Depending on the available resources, logistics and HCP, try to utilize the HCP as less as possible at a time to lessen the chance of being infected. The strategy should be to reserve the HCP as much as possible. Keeping in mind, HCP should be categorized into different groups and subgroups so that all of them are not exposed at a time. Instead, it would be better to involve one or two groups for 14 days at a time that will be replaced by the next group and subgroup.

During routine rounds, always try to maintain at least 1 m distance and limit unnecessary contact. Consultation schedules in OPD should be given with an adequate time interval, sitting arrangement of patients should also be placed in every alternate chair. Visitor entry should be strictly maintained. More than one visitor per patient should not be allowed and none of them should be permitted to go outside the hospital premises during the entire period unless strictly indicated. During dealing with COVID-19 positive cases (if needed), precaution must be taken, especially in aerosol-generating procedures. Conservative treatment should be considered first unless there is an absolute indication for operative treatment. Try to limit the number of surgeons and staff during operation with special emphasis on wearing appropriate PPE, including an N95 mask. Once the operation is completed, shift the patient in an isolation ward. On completion of the procedure, all attending staff must be quarantined and should be screened for COVID 19.

Apart from this, this is a unique opportunity to build ourselves physically, mentally and academically. We now

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have enough time in our hands. Hence at least one or 2 h should be spent on physical exercise and for fulfilling our hobby that will refresh the mind. Attending online courses or webinars, reading books and journals as well as writing academic or nonacademic things might boost up the state of mind. Taking into account this horrible period as an asset, it is better to utilize it in the best possible way, like spending quality time with family. Try to stay safe and active.

In a nutshell, as none of us have any idea about the duration of this pandemic or the consistency of virulence, we must be prepared for living with coexisting COVID-19. All steps should be aimed at defeating this global enemy. Probably, there will be a time when COVID-19 will no longer exist; however, lots of problems might be waiting for us. Be prepared and protect thyself as well as our patients.

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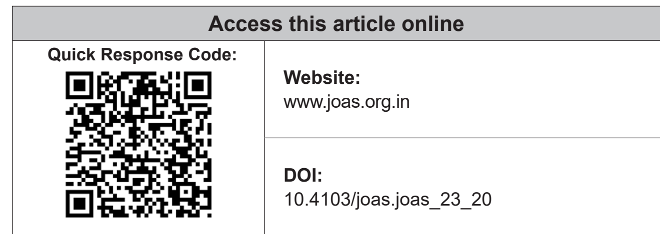
|  | **Website:** www.joas.org.in |
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