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Breaking the habit in the Covid Era: how is changed the routine of a surgeon in mostly affected italian province, Piacenza, Emilia Romagna

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To the Editor,

The Sars-Cov2 Pandemic in Italy gave rise in Piacenza, northern Emilia, to one of the most extensive contagions ever recorded in Italy, the area being hit from the beginning of February, with all its dramatic force and enormous impact in terms of human lives, upsetting social lives and wiping out an entire generation. Piacenza is only 15 km away from what was identified as the first known outbreak in the Western world, registered in Codogno, a small town in the province of Lodi, where the first verified Italian case of the infection Covid– 19 was isolated.

Right from the following morning to the closure of the Codogno hospital for the "unexpected" and "fortuitous" diagnosis of the first Covid-19 case, it was clear to us physicians of Piacenza that we would have undergone the effects of the flow into our province of the population affected in the "bassa lodigiana" with a predictable increase in the risk of infection for our population. The main cause for this being in our geographical features which favour movement, people relationships and trade between the territories of "basso lodigiano" and Piacenza.

The load of such contamination in the province of Piacenza is explained by the data here below (Table 1). In this scenario, in just a few days, our hospital had to suspend selected surgical procedures continuing to guarantee only general emergency surgery.

The outplacing of surgeons took place from the beginning, supporting the internists, in the newborn "Covid" ward, assigned to the hospitalization of patients with low to medium complexity management clinical cases.

Our hospital's selected surgery and emergency procedures were carried out by a deployed task unit at the peripheral two hospitals where small to medium sized surgeries were performed. Due to the advancement of the contagion and the exponential increase of Covid cases which required hospitalization, these peripheral hospitals were converted into real "Covid Hospitals" with relative suspension of surgical procedures. In short, all the surgical wards, except for the Emergency Surgery of the Hospital's central hub "Guglielmo da Saliceto" of Piacenza, were converted into Covid wards with various degrees of management care on behalf of the personnel, as also the operating theatres became new ICU units. Consequently, the professional life habits of the surgeons in general have radically changed: the surgeons have been working for about 70% of their working hours in internist support activities for the management of Covid-correlated pneumonia patients during the daytime, while the management of these wards was entrusted to them in complete autonomy during the night hours with the possibility of consultancy on behalf of critical care physicians and anaesthetists.

Since then however, many questions have arisen during our daily reflections regarding the need for future planning of our surgery procedures: how much longer can we delay the planning of our selected surgery? Which epidemiological parameters, and other, should we identify in order to start up selected general

Table 1. In Italy 189.973 cases have been confirmed (2) and in Emilia Romagna 20.983 contagions equivalent to 13.2% of the total with an incidence of 470,53 per 100.000 inhabitants (3); in Piacenza the incidence rate has been > 500 out of 100.000 inhabitants (4), with a mortality rate of 258,57 out of 100.000, the highest in Italy (5)

	Italy	Emilia Romagna	Piacenza
Incidence infection/100.000 inhabitants	310	470,53	>500
Deaths /100.000 inhabitants	42,97	69,97	258,59
Mortality % (deaths/ill)	13.5	13.7	22.3
Total Contagions*	192.994	23.970	3.635
Total Deaths*	25.969	3.303	811

surgery? Will it be sufficient, in this severely hit contagion reality, to subject patients to screenings whilst waiting for operations, also considering the high percentage of false negative results which can come from nasopharyngeal swab testing? (about 30%) *(5)*. When will we be able to reasonably start giving responses to our selected surgery patients without increasing too much the risk of contagion? Will it be necessary and possible to create or identify special Covid hospitals for performing surgery? Should we restrict to creating truly or partially “clean” Covid – 19 surgical environments? For how long can selected surgery be deferred without compromising outcomes and mid to long term mortality in oncological patients in our province, considering also the diagnostic-therapeutic delays in these exceptional months of the Covid era?

Conflict of interest: Each author declares that he or she has no commercial associations (e.g. consultancies, stock ownership, equity interest, patent/licensing arrangement etc.) that might pose a conflict of interest in connection with the submitted article

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