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LETTER TO EDITOR

Comment on Hospital care in Departments defined as COVID-free: A proposal for a safe hospitalization protecting healthcare professionals and patients not affected by COVID-19

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To the Editor

The COVID-19 outbreak dramatically changed hospital everyday life, impairing the course of previous routine activity, also in urology (1, 2). In the next months, together with keeping the focus on the prevention of contagion recrudescence, the health care system will face another stringent issue, i.e. to restore all the services not COVID-related.
Leonardi et al. in their paper (3) report an equilibrate overview on the incoming "Phase 2", in order to set up so-called COVID-free hospitals and departments. The authors offer an insight from a practical point of view, detailing protocols for any of the steps of the path of care, from the outpatient visit to surgery. The aim is to ensure a safe healthcare flow, based on the early identification of the positive subjects and the rigorous protection of the negative ones. The cornerstones of this framework are: microbiological and instrumental COVID screening for patients but also for healthcare workers; furniture of personal protective equipment to the medical and administrative staff; re-definition of outpatient and inpatient scheduling to guarantee distancing; regulation of operating theaters by general protocols (as intubation in dedicated rooms, adoption of filters and smoke evacuation devices, etc), but also others dedicated to specific procedure (endoscopic, open, minimally-invasive).
Although these actions will undoubtedly be pivotal to prevent virus contagion, to date no solid evidence is available on the safety of contemporarily hospitalization (4). Furthermore, the feasibility and sustainability of such measures have still to be established, first of all concerning economical resources. Secondly, many hospitals will be required to engage structural works in order to create appropriate spaces for distancing patients and personnel. Thirdly, the dilution of scheduling and increasing intervals between procedures will result in a significant extension of sessions and need for additional personnel, otherwise posing conflicts with the regulatory on shift and rest. Similarly, restricting surgical teams to a few operators periodically screened for COVID will result in the escalation of workload. Fourthly, academic institutions shall conjugate safety requirements with their educational mission; this objective will become even more challenging considering the emerging calls to increase the number of residency positions, already initiated before the COVID emergency. Besides these considerations there are several issues related to the patient side, mainly due to the withdrawal of procedures and consequent delay in execution of adequate new diagnostical examination (5) and in choice of best treatments occurred in this emergency period (6), with consequent repercussions on the quality of life of the patients (7).
All these points should be read taking into account the peculiarities of Italian scenario, where marked differences in the epidemiology and effects of the pandemic have occurred (8). Additionally, our universalistic health systems, articulated in independent regional subsystems, count on institutions of various nature (academic, public, private), with different facilities, delivery capacity and attractiveness towards patients and investors. Such disparities have been already dramatically highlighted by the COVID emergency, but could be more and more emphasized if further phases will be managed on a local basis. Reasonably, supra-regional and, hopefully, supra-national coordination are needed to control such heterogeneity, sharing protocols and regulating funding allocation, in order to ensure that each institution could handle with both COVID and non-COVID patients.

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