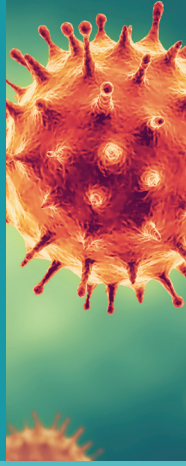


A perspective from Italy



Summary: COVID-19

27 March 2020

acem.org.au/covid-19

Italy's Dr Roberto Cosentini
with FACEMs Dr Martin Tham,
Dr Jan Bone and Dr John Bonning

Summary

- His hospital: in a town of 100,000, but serving a population of 1,000,000. 100,000 presentations pa to their ED, hospital 900 beds.
- They were far too late instituting community measures or population lockdown and social isolation, stating this was a 'big mistake' that they clearly now regret. They ran a large derby football match in March with devastating consequences of high transmission of COVID-19.
- The population didn't respond to numbers of cases until they started to see pictures of the devastation (patients dying in ICU)

“numbers don't speak to the heart, images speak to the heart”

- Early infections of healthcare workers (HCW) occurred when HCW were treating what were thought to be non-COVID-19 patients. There is no such thing as a non-COVID-19 patient just high risk and moderate & low risk COVID-19 patients. Surgical masks on all HCW and good hand hygiene
- The relationship between medical staff and patients changed, with patients becoming much more trusting and accepting of everything advised by their doctors.
- Dividing ED onto hot/dirty and cold/clean zones – only worked in initial phase, then rapidly swamped so whole dept hot/dirty
- Re-purposing redundant staff and beds. Turning surgical ward beds into COVID-19 beds to increase the no of available hospital COVID-19 beds. Re-training surgical staff in caring for COVID-19 patients on the ward. Each ward supervised by a Respiratory Physician or equivalent.
- Changing pattern of clinical presentation: initially sore throat and dry cough, fever that worsens, then pneumonia after the first (few) week(s)
- Surgical masks over all O2 delivery systems (Hudson masks, nasal prongs, HFNO)
- Surgical masks + good hand hygiene for all HCWs in direct patient contact regardless of risk status – understanding that face masks are not perfect.

- Relatives were not allowed to go to hospital so often their loved one would die alone in hospital, so people did not necessarily bring their sick elderly family member in so they would not die alone.
- Mortality terrible in age >80 yrs. ?Futility of intubation or NIV in any sick pt >80 yrs.

Clinical presentation

- **Phase 1:** sore throat and dry cough over 4-5/7, prolonged fever with rigors. Increasing fever signifies worsening disease
- **Phase 2:** Respiratory complications and hypoxia, NOT necessarily with respiratory distress, but did have hypoxia and tachypnoea. 80% of pneumonia pts needed oxygen
- Not so much circulatory collapse/sepsis, mainly just lung endothelial damage and vascular inflammation
- Thrombosis (peripheral, pulmonary) common so must give prophylaxis
- High risk factors: older age >60y but especially >80 yrs, hypertension, DM, presumably smokers and other co-morbidities
- As more and more COVID-19 pts – whole dept became "dirty"

Radiology

- a. CXR sometimes negative initially
- b. POCUS good (clean probes between patients)
- c. CT no added value to POCUS and high contamination risk

Staff wellbeing

- a. Prepare ahead of the surge
- b. Have specific staff/therapists/counsellors. It will be tough, plan for this.
- c. Mindfulness