What are we learning during the COVID-19 pandemic

Qué estamos aprendiendo durante la pandemia COVID-19

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Dear colleagues,

I wish to tell you about an interesting activity that members from CACI had with friends and colleagues of different countries regarding their experiences during the COVID-19 pandemic. We conducted a webinar with Dr. Juan Granada of New York City (United States), Dr. Miguel Montero Baker of the city of Houston (United States), and Dr. Eduardo Aptecar of Paris (France).

We discussed the importance of keeping the strategies of cardiovascular healthcare in large cities and the management of acute coronary syndrome during the COVID-19 pandemic. Several doctors from Argentina and Latin America shared their thoughts with us.

Dr. Granada started by describing his experience in New York, a city that had a sudden and high rate of infection where the healthcare system collapsed immediately after to the huge number of cases reported. He said it was almost impossible to implement any strategies to reduce cardiovascular mortality following this collapse. In this context, he said it was important to use thrombolytic agents to treat the infarctions of critically ill patients with COVID-19 (+) to stop these coronary presentations right away as long as there were beds available since the cath labs remained closed in some cases. Dr. Granada insisted that during the peak of the pandemic it was impossible to access a cath lab in New York City and that patients simply did not seek medical attention with infarction-like symptoms.

On the other hand, those who actually sought medical attention did not receive proper care in the cath lab since the performance of primary angioplasties became almost nonexistent at one time or another during the pandemic.

Dr. Montero Baker said that in the City of Houston and the state of Texas this was never the case. The impact of COVID-19 was lower regarding health centers and had nothing to do with the situation lived in New York. However, the citizens of Houston also experienced massive hysteria, fear, and uncertainty that played a significant role causing delays when seeking medical attention, increasing mortality, and reducing the rate of success of these procedures.

Dr. Aptecar made a comparison between Paris and the city of BuenosAires. Paris and its surroundings extend over 12000 square kilometers. Two million people live in the city and another 12 million live in the suburbs. The BuenosAires metropolitan area extends over 14000 square kilometers with 2.7million people living in CABA and 13million people living in the Greater Buenos Aires conurbation. During the pandemic, in Paris it was necessary to double the number of beds from 1100 to 2600 by April 8. Even patients with non-COVID-19 related conditions were transferred by train to other regions to receive medical attention. He said that the French Group of Atheroma and Interventional Cardiology (GACI) conducted a survey that showed that angioplasty procedures for the management of infarctions reduced 50% in 2020 compared to the same three months of 2019.

In our country, data published by CACI and Stent-Savea Life show similar numbers with drops between 50% and 60% in the number of primary angioplasties performed over the months of April, May, and June and increases between 70% and 80% in July and August. However, this increase in the number of primary angioplasties performed was followed by consultation time delays, which translated into a higher mortality rate (from 5.5% to 11%), basically due to Killip-Kimball Classification C and D myocardial infarctions, cardiac ruptures, ISR, and severe arrhythmias. All these are conditions associated with time delays when seeking medical attention on fear of going to the health center.

Finally, on coadjuvant schemes or the management of myocardial infarction, the primary angioplasty remained as the standard of care and all panelists suggested continuing with the usual management of this condition as long as the healthcare system would allow it. Similarly, they discarded making big changes in the use of peri-

procedural drugs. Under uncertain conditions like the ones posed by this pandemic, it does NOT seem appropriate to change routines and treatments that have proven effective in the management of myocardial infarction.

For this reason, our own best judgment as physician and that of each health center should be used during the current COVID-19 pandemic. And when we start seeing light at the end of the tunnel, we'll have to raise our hopes. Nothing will be the same, but it will be the right time to rebuild. A better patient-doctor relation will be essential as well as clearer information to the people, more discipline, respect among colleagues at all time, and keeping a very cautious attitude about the information that is disclosed and the way it is exposed in the social media.

We should stress out that the cardiovascular mortality rate is still higher compared to the COVID-19 related mortality rate, which is why the population needs to know about the importance of seeking medical attention in the presence of infarction or stroke-like symptoms. Also, they should still go see their cardiologists to learn how to control their risk factors.

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