Sir,

The coronavirus disease 2019 has spread with alarming speed in northern Italy, especially in Bergamo and its province (1,116,248 residents), which represented the epicenter of the crisis. The number of confirmed cases rose to 11,002, with 2918 deaths (195,351 in Italy with 26,384 deaths).1

Between the end of February and the first week of March, the outbreak manifested with a quick increase of cases. On March 8, 2020, the Italian government decided on a suspension of all nonurgent healthcare activities, asking public and private hospitals to face the outbreak and to expand their intensive care units.2–4

Many colleagues, especially those specializing in cosmetic surgery, complained about this stop, believing that the measure was excessive, and concerned about a complete stop of their business. We report our experience about difficult management of a surgical case during the coronavirus disease 2019 outbreak.

Five days before the lockdown, we performed a postbariatric abdominoplasty on a 59-year-old woman, a nonsmoker, who previously underwent a sleeve gastrectomy. The patient was discharged 2 days after surgery without complications, and after a week, the drains were removed. Meanwhile, all the hospitals in Bergamo province were closed to the public and only postoperative visits were allowed.

Twelve days postoperatively, the patient developed fever, asthenia, and loss of taste and smell. An oropharyngeal swab was performed, showing positivity for severe acute respiratory syndrome coronavirus 2 infection, and a chest computed tomography scan outlined ground glass opacifications in the lungs.

According to Italian law, the patient was quarantined. The only possible way for her to leave home was for a medical emergency, calling the Italian emergency telephone number (112).2

A few days after, the patient developed an abdominal seroma. The emergency departments were overwhelmed by infected patients with severe respiratory failure, and no ambulance was available for the transport of a nonurgent patient.3

In such a complex situation, because there was no possibility of transporting the patient to the hospital, we opted for monitoring the patient at home, asking her to report her condition to surgeons with calls and pictures every day.

The seroma worsened, causing clear enlargement of the abdomen (Fig. 1) and great concern of the patient. Luckily, she did not have respiratory distress or thromboembolism. Three weeks after the diagnosis, 2 consecutive oropharyngeal swabs in 24 hours showed absence of severe acute respiratory syndrome coronavirus 2. After that, it was possible to admit the patient to the hospital and percutaneously drain the seroma, collecting >1400 mL of fluid. The patient recovered well but suffered greatly, both for the fear about worsening of the pneumonia and for the large seroma which caused pain, discomfort, and a poor aesthetic outcome.

Our experience suggests that all nonurgent procedures, especially the cosmetic ones, should be avoided or rescheduled, not only for the risk of disease transmission among patients and healthcare professionals, but also because the management of the natural complications of these procedures could be difficult and stressful during healthcare system stress. In addition, performing surgeries despite these issues could be considered malpractice in case of medicolegal consequences.

Carlo Guardo Ghilardi, MD
Department of Plastic Surgery
Humanitas Gavazzeni
Via Zambianchi 10
Bergamo, Italy
E-mail: carloghilardi@hotmail.com
DISCLOSURE
The authors have no financial interest to declare in relation to the content of this article.

REFERENCES

