Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

must not sacrifice our still fragile research standards in our efforts to help frightened patients. Expedited approval—which is established for research that is known not to put participants at risk—is inherently dangerous when the result is relaxed research accountability. One guard against serious therapeutic misconception would be to focus patient discussions on what is not known more than on what might result. We must not forget the failed polio vaccine and the thalidomide tragedies.

Disclosure Information: Nothing to disclose.

Beware of Time Delay and Differential Diagnosis when Screening for Symptoms of COVID-19 in Surgical Cancer Patients

Abdelilah Ghannam, MD, Amine Souadka, MD
Rabat, Morocco

We read with interest the original paper by Forrester and colleagues[1] and would like to congratulate the authors on producing an operational algorithm for operating room team members' protection. At the National Institute of Oncology of Rabat, we share the same guiding principles for team safety. However, we would like to draw attention to time-delay risk on screening symptoms for novel coronavirus (COVID-19), especially in cancer patients.

Indeed, we consider breast surgery a low-risk procedure. When surgical side effects occur, it becomes an urgent operation, which allows a delay of few hours, to admission to the operating rooms as an urgent low-risk procedure.

We report a case of a young woman in need of urgent operation for surgical site infection with negative screening symptoms at admission to the surgical ward. When she was admitted to the operating room, a fever was discovered and linked to the breast disease, and surgery was allowed with standard surgical attire and protective equipment for the operating room team. Afterwards, in the recovery room, there was a de novo worsening clinical respiratory condition, in addition to a thorough anamnestic investigation, at which time the patient revealed a contact situation and exposure to a COVID-19–positive patient in the family.

This case illustrates 2 problems. First, frequently in urgent surgery, a delay (sometimes of several hours) may occur between diagnosis and admission to the operating room. Second, many urgent surgical diagnoses can occur with fever or respiratory difficulty linked to infection, inflammation, or bowel distension.

In conclusion, in low-risk COVID-19 urgent surgical procedures with an initial negative symptom screen, we recommend carrying out a new symptom screening before each patient movement. Second, during phase 2 of the COVID-19 outbreak, we recommend considering COVID-19 as a differential diagnosis, especially within risky conditions like urgent surgical procedures in cancer patients.

REFERENCE

1. Forrester JD, Nassar AK, Maggio PM, Hawn MT. Precautions for operating room team members during the COVID-19 pandemic. J Am Coll Surg 2020 Apr 2 [Epub ahead of print].

Disclosure Information: Nothing to disclose.

Gun Violence and Lawful Self-Defense

Mark J Kulbaski, MD, FACS
Brockton, MA

The article by Manley and colleagues[1] has laudably analyzed FBI files concerning gun-related homicides during a 37-year period ending in 2016. They advocate that surgeons, as healers, should support ongoing research aimed to reduce firearm-related violence.

The authors imply that because only 1.8% of gun-related homicides (239 per year) were categorized officially as justifiable, that is, with a felon killed by a private citizen, presumably in self-defense, that more vigorous research is needed to validate the argument of the pro-gun lobby that "good guys" with guns are needed to protect against "bad guys" with guns. Although gun-related deaths in self-defense events are few compared with overall gun deaths, the Department of Justice reported that between 2007 and 2011, 235,700 victims of nonfatal violent crime (47,000 per year) used a firearm in self-defense.[2] Surgeons should support law enforcement and public health interventions aimed to reduce gun-related deaths, but firearm policy must not dismiss defensive gun use as insignificant.

REFERENCES

1. Manley NR, Fischer PE, Sharpe JP, et al. Separating truth from alternative facts: 37 years of guns, murder, and violence across the US. J Am Coll Surg 2020;230:475–483.