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.

Letters to the Editor

Physical Health and Psychosocial Considerations During the Coronavirus Disease 2019 Outbreak

TO THE EDITOR: In December 2019, a cluster of pneumonia cases, caused by a newly identified β-coronavirus, occurred in Wuhan, China. This coronavirus, was initially named as the 2019-novel coronavirus on 12 January 2020 by the World Health Organization. The World Health Organization officially named the disease as coronavirus disease 2019 (COVID-19), and the Coronavirus Study Group of the International Committee proposed to name the new coronavirus as SARS-CoV-2, both issued on 11 February 2020. The Chinese scientists rapidly isolated SARS-CoV-2 from a patient within a short time on 7 January 2020 and came out to genome sequencing of the SARS-CoV-2.[1] As of 7 July 2020, there have been 11,425,209 confirmed cases of COVID-19, including 534,062 deaths.[2] Most of the studies have focused on how the coronavirus attacks the respiratory system owing to the typical symptoms manifested by most patients. A recent study by sampling 1099 laboratory-confirmed cases found that the common clinical manifestations included fever (88.7%), cough (67.8%), fatigue (38.1%), sputum production (33.4%), shortness of breath (18.6%), sore throat (13.9%), and headache (13.6%).[3] Almost all COVID-19–related serious consequences feature pneumonia.[3] Available data indicate that about 40% of patients with COVID-19 develop acute respiratory distress syndrome, and 20% of cases with acute respiratory distress syndrome are severe.[4] Progressive, fibrotic irreversible interstitial lung disease is characterzsed by declining lung function, increasing extent of fibrosis on computed tomography (CT), worsening symptoms and quality of life, and early mortality.[5] COVID-19 pneumonia tends to manifest on lung CT scans as bilateral, subpleural, ground-glass opacities with air bronchograms, ill-defined margins, and a slight predominance in the right lower lobe. Abnormal lung CT findings can be present even in asymptomatic patients, and lesions can rapidly evolve into a diffuse ground-glass opacity predominance or consolidation pattern within 1–3 weeks after onset of symptoms, peaking at around 2 weeks after onset. Old age, male sex, underlying comorbidities, and progressive radiographic deterioration on follow-up CT might be risk factors for poor prognosis in patients with COVID-19 pneumonia.[6] Although the virus is eradicated in patients who have recovered from COVID-19, the removal of the cause of lung damage does not, in itself, preclude the development of progressive, fibrotic irreversible interstitial lung disease. Furthermore, even a relatively small degree of residual but nonprogressive fibrosis could result in considerable morbidity and mortality in an older population of patients who had COVID-19, many of whom will have pre-existing pulmonary conditions.[7] Preliminary data suggest patients with COVID-19 might experience delirium, confusion, agitation, and altered consciousness, as well as symptoms of depression, anxiety, and insomnia.[8] In addition, health care workers involved in the COVID-19 pandemic are exposed to high levels of stressful or traumatic events and express substantial negative mental health outcomes.[9] In addition to the respiratory damage caused by pulmonary fibrosis, patients will face psychiatric and neuropsychiatric symptoms. Having said this, respiratory rehabilitation for patients after COVID-19 will also and, above all, have to take into account psychological well-being issues. To date, there are no standard rehabilitation protocols, but given the large number of patients, it will be necessary to integrate and modulate the new respiratory rehabilitation protocols together with a psychological treatment program that should not be underestimated for the success of the therapy. In addition, health care professionals are put to the test during these situations of great health emergencies, thus developing the probability of being subject to psychosocial disorders because of accumulated stress in the workplace. One of the most significant and little investigated aspects is the psychological stress related to the emergency. Often, health care workers have to face intensive shifts with the

adoption of personal protective equipment that put the subject's physical and psychological endurance to the test. To face this problem and guarantee the psychophysical well-being of employees, health care facilities must guarantee the adoption of preventive and protective measures, including psychological support through dedicated pathways.

Conflicts of Interest: The authors declare that they have no conflict of interest.

Contributors: Andrea Giacalone conducted the research and wrote the first draft of the manuscript; Gennaro Rocco supported manuscript revisions; Enzo Ruberti conducted the research and drafting of the manuscript.

Andrea Giacalone, Ph.D.
Industrial Engineering Technologies for Sports Medicine and Rehabilitation, University Tor Vergata, Rome, Italy
Gennaro Rocco, Ph.D.
Department of Biomedicine and Prevention, Faculty of Medicine, University Tor Vergata, Rome, Italy
Enzo Ruberti, Ph.D.*
Department of Human Neuroscience, Sapienza University, Rome, Italy
*Send correspondence and reprint requests to Enzo Ruberti, PhD, Department of Human Neuroscience, Sapienza University of Rome, Roma 00185, Italy; e-mail: Enzo.ruberti@uniroma1.it

References

1. Lu R, Zhao X, Li J, et al: Genomic characterisation and epidemiology of 2019 novel coronavirus: implications for virus origins and receptor binding. Lancet 2020; 395:565–574
2. WHO coronavirus disease (COVID-19) dashboard. Available from: https://covid19.who.int/
3. Guan WJ, Ni ZY, Hu Y, et al: Clinical characteristics of coronavirus disease 2019 in China. N Engl J Med 2020; 1056:2002032
4. Wu C, Chen X, Cai Y: Risk factors associated with acute respiratory distress syndrome and death in patients with coronavirus disease 2019 pneumonia in Wuhan, China. JAMA Intern Med 2020; 180:1–11
5. Brown KK, Martinez FJ, Walsh SLF: The natural history of progressive fibrosing interstitial lung diseases. Eur Respir J 2020; 55:2000085
6. Shi H, Han X, Jiang N, et al: Radiological findings from 81 patients with COVID-19 pneumonia in Wuhan, China: a descriptive study. Lancet Infect Dis 2020; 20:425–434
7. Spagnolo P, Balestro E, Aliberti S, et al: Pulmonary fibrosis secondary to COVID-19: a call to arms? Lancet Respir Med 2020; 8:750–752
8. Rogers JP, Chesney E, Oliver D, et al: Psychiatric and neuropsychiatric presentations associated with severe coronavirus infections: a systematic review and meta-analysis with comparison to the COVID-19 pandemic. Lancet Psychiatry 2020; 7:611–627
9. Lai J, Ma S, Wang Y, et al: Factors associated with mental health outcomes among health care workers exposed to coronavirus disease 2019. JAMA Netw Open 2020; 3:e203976

Capacity and the COVID-19 Surge

TO THE EDITOR: Requests to evaluate patients' capacity to make medical decisions are a routine aspect of consultation-liaison (C-L) practice. The medical culture of different health systems and their surrounding communities define variable thresholds for primary teams to request assistance from psychiatrists in making such determinations. One study suggested that the percentage of inpatient consultation requests may comprise anywhere from 3 to 25% of cases on an inpatient C-L service.[1]

At our urban safety net hospital, the high-volume C-L practice that routinely cares for more than 10% of the acute hospital census has heretofore infrequently been called on for capacity assessments. Medical and surgical teams are accustomed to treating patients with educational and neuropsychiatric limitations who are unlikely to meet formal criteria for having capacity to consent for many of the advanced interventions proposed. Beneficence has always stood more equally alongside autonomy in our hospital to guide the work.

We write to report that, superimposed on this background of our established norms, there was a sudden increase in requests for assessment of decision-making capacity in the wake of the SARS-CoV-2 outbreak. During the 12-month period from February 1, 2019 through January 31, 2020, only 1.8% of nearly 4000 psychiatry consultation orders were placed for evaluation of capacity. Between February 1, 2020 and May 31, 2020, the fraction of requests for capacity assessment nearly tripled to 5.3%. Not unlike other C-L services, we routinely identify issues around decision-making in many evaluations wherein the initial "question" was not about capacity,[1] but we were surprised to have primary teams more frequently calling about this particular issue right after hospital routines and census were altered by coronavirus disease.

We hypothesize that restriction of hospital visitation in the interest of curtailing spread of the pandemic is a major factor. Despite the