**Clinical Librarian Service Search Results**

**Request:** What literature is there on the impact of covid-19 lockdown, or other similar lockdown or quarantine situations, on referrals to secondary care?

**Summary**

A search of bibliographic databases and the internet retrieved no relevant information on the impact of lockdown or quarantine on referrals to secondary care. Articles and resources on related topics were found, and may be of interest.

[Statistics](#_Statistics): Four nationally collected statistics collections may be of interest. The most useful will be the referral to treatment data. This includes information on the number of new patients who start the referral to treatment clock each month, by organisation and specialty (1). Information on outpatient (2), emergency (3), and GP (4) attendances may also be of interest. Unfortunately data for March and April is not yet available for any of these datasets. NHS Digital may be able to provide access to this data and can be contacted on [enquiries@nhsdigital.nhs.uk](mailto:enquiries@nhsdigital.nhs.uk) or 0300 303 5678. The Transformation Team at UHDB may be able to help with manipulating the data.

[Guidance on referrals](#_Guidance_on_referrals): There is a wide range of UK guidelines on management of different patient groups who do not have covid-19 during the pandemic (6-8, 12, 13), and also on measuring referral to treatment times (5). Guidelines from other countries may also be of interest (14-16).

There are conflicting reports on referrals to secondary care in practice. An NHS England bulletin states that referrals to secondary care should continue as normal (9). However, a couple of news articles and comments on those articles suggest some referrals have been rejected by hospitals simply because of the covid-19 pandemic (10, 11).

[Journal articles](#_Journal_articles): The articles most closely addressing the impact of an epidemic on referrals are from African countries, and unlikely to be directly applicable to the UK due to the differences in health systems and economic circumstances. These discuss paediatric referrals during the ebola crisis (24, 25) and the impact of AIDS (or not) on paediatric cancer (26).

A number of journal articles were retrieved which report experience of managing patients without covid-19 during the pandemic (17-23)

Unfortunately there is no research or easily accessible data on the impact of lockdown or quarantine on referrals to secondary care. Some of the national statistical collections may be able to provide current data.

**Disclaimer:** Please note that the information supplied by the Library and Knowledge Service in response to a literature search is for information purposes only. Every reasonable effort will be made to ensure that this information is accurate, up-to-date and complete. However, it is possible that it may not be representative of the whole body of evidence. No responsibility can be accepted by the Library for any action taken on the basis of this information.

Guidance or information relating to specific drug queries or procedures should be referred to Medicines Information on [UHDB.MedicinesInformation@nhs.net](mailto:UHDB.MedicinesInformation@nhs.net)​ or RDH ext. 85379 or Burton ext. 5168 or 5101. For local UHDB guidelines and policies please refer to the red / pink Policies button on the Trust intranet, or <https://derby.koha-ptfs.co.uk/cgi-bin/koha/opac-main.pl>

**Current at:** 24th April 2020

**Time taken for search:** 5 hours.

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I hope that I have interpreted your request correctly. Please let me know if you would like me to search further.

**Accessing Articles**

Links are provided where online access to the full-text is available. An OpenAthens username and password may be required for online access to articles. You can register for one here: <https://openathens.nice.org.uk/>

Unfortunately there may occasionally be some problems accessing the links provided. In this case the items can be accessed via the Library Journals link: <http://journals.nice.org.uk/>. [Log in to OpenAthens via the link in the top tight-hand corner].

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**Please acknowledge this work in any resulting paper or presentation as:**

Evidence Search: Non-covid-19 referrals (LS17). Lindsay Snell (2020). Derby, UK: University Hospitals of Derby & Burton NHS Foundation Trust Library and Knowledge Service.

**Feedback**

Once you have read this report, I would appreciate it if you would complete our online literature search feedback form at:

<https://www.smartsurvey.co.uk/s/LiteratureSearchFeedback20202021/>

This relates to this specific search and will help us to monitor and improve our service. Many Thanks.

Kind regards,

Lindsay Snell

Clinical Librarian

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**Results**

# Statistics

## 1. Consultant-led Referral to Treatment Waiting Times Data 2019-20

NHS Digital (2020)

<https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-data-2019-20/>

Data is available from 2011-12 onwards and is broken down by Trust and specialty. For each month, the files “New periods provider” and “New periods commissioner” should give some idea of how referral numbers change over time.

NHS Improvement gives an example of how Referral to treatment data can be used in a dashboard format at <https://improvement.nhs.uk/resources/displaying-referral-to-treatment-data/>

## 2. Hospital Outpatient Activity

NHS Digital (2020)

<https://digital.nhs.uk/data-and-information/publications/statistical/hospital-outpatient-activity>

This data set gives details of outpatient activity in each English Trust (with 3 and 4 digit diagnosis codes). However it does not include referral numbers.

## 3. Hospital Accident & Emergency Activity

<https://digital.nhs.uk/data-and-information/publications/statistical/hospital-accident--emergency-activity>

This data set gives details of attendances in Accident & Emergency, including how long people stayed, how they arrived, and information about whether they were admitted or discharged.

## 4. Appointments in General Practice

<https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice>

This data set gives details of appointments in general practice. An interactive data view is also available.

# Guidance on referrals

## 5. Referral to treatment measurement and COVID19

NHS England (2020).

<https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2020/03/C0009-RTT-measurement-and-COVID-19.pdf>

Outpatient services should be provided virtually whenever possible to progress treatment where face-to-face contact is not required. Where this is not possible, this guidance provides advice on referral to treatment (RTT) waiting time measurement where patients are not able, or do not wish, to come into a hospital setting, and where appointments are cancelled.

## 6. GI Endoscopy Activity and COVID-19: Next steps

British Society of Gastroenterology (2020).

<https://www.bsg.org.uk/covid-19-advice/gi-endoscopy-activity-and-covid-19-next-steps/>

## 7. Management of acute dental problems during covid-19 pandemic

NHS Education for Scotland (2020)

<http://www.sdcep.org.uk/wp-content/uploads/2020/03/SDCEP-MADP-COVID-19-guide-300320.pdf>

## 8. Specialty guides for patient management

NHS England (2020)

<https://www.england.nhs.uk/coronavirus/publication/specialty-guides/>

This web page links to guidance on a wide range of conditions during the pandemic. Examples include anticoagulation services, major trauma, fragility fractures, and diabetes.

## 9. COVID-19: today's round-up for primary care

NHS England (2020)

<http://createsend.com/t/d-1BB9717A27E368FD2540EF23F30FEDED>

## 10. GPs should continue to refer patients to secondary care, says NHS England

Lind, S in Pulse, 17/04/20

<http://www.pulsetoday.co.uk/clinical/clinical-specialties/respiratory-/gps-should-continue-to-refer-patients-to-secondary-care-says-nhs-england/20040632.article>

## 11. GPs should refer patients as normal during COVID-19 outbreak, says NHS England

Bower, E in GP Online, 17/04/20

<https://www.gponline.com/gps-refer-patients-normal-during-covid-19-outbreak-says-nhs-england/article/1680599>

## 12. Advice on maintaining cancer treatment during the COVID-19 response

NHS England (30/03/2020)

<https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0119-_Maintaining-cancer-services-_-letter-to-trusts.pdf>

## 13. To cancer alliance

NHS England (19/03/2020)

<https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/cancer-alliance-information-on-managing-cancer-referrals-19-march-2020.pdf>

## 14. Triage Considerations for Patients Referred for Structural Heart Disease Intervention During the Coronavirus Disease 2019 (COVID-19) Pandemic: An ACC /SCAI Consensus Statement

**Author(s):** Shah P.B.; Welt F.G.P.; Kleiman N.S.; Young M.N.; Sherwood M.; Batchelor W.; Davidson L.; Wyman J.; Kadavath S.; Anwaruddin S.; Mahmud E.; Szerlip M.; Hermiller J.; Phillips A.; Fullerton D.; Wang D.D.

**Source:** Catheterization and cardiovascular interventions : official journal of the Society for Cardiac Angiography & Interventions; Apr 2020

Available at [Catheterization and cardiovascular interventions : official journal of the Society for Cardiac Angiography & Interventions](https://go.openathens.net/redirector/nhs?url=https%3A%2F%2Fonlinelibrary.wiley.com%2Fdoi%2Ffull%2F10.1002%2Fccd.28910) - from Wiley Online Library Medicine and Nursing Collection 2019 - NHS

Available at [Catheterization and cardiovascular interventions : official journal of the Society for Cardiac Angiography & Interventions](https://doi.org/10.1002/ccd.28910) - from Unpaywall

The COVID-19 pandemic has strained health care resources around the world causing many institutions to curtail or stop elective procedures. This has resulted in the inability to care for patients valvular and structural heart disease (SHD) in a timely fashion potentially placing these patients at increased risk for adverse cardiovascular complications including congestive heart failure and death. The effective triage of these patients has become challenging in the current environment as clinicians have had to weigh the risk of bringing susceptible patients into the hospital environment during the COVID-19 pandemic versus the risk of delaying a needed procedure. In this document, we suggest guidelines as to how to triage patients in need of SHD interventions and provide a framework of how to decide when it may be appropriate to proceed with intervention despite the ongoing pandemic. In particular, we address the triage of patients in need of trans-catheter aortic valve replacement and percutaneous mitral valve repair. We also address procedural issues and considerations for the function of structural heart disease teams during the COVID-19 pandemic. This article is protected by copyright. All rights reserved.

**Database:** EMBASE

## 15. Practical Guidance for Managing EMG Requests and Testing during the COVID-19 Pandemic.

**Author(s):** Kassardjian CD1, Desai U2, Narayanaswami P3; AANEM Quality and Patient Safety Committee of the AANEM.

**Source:** Muscle Nerve. 2020 Apr 11. doi: 10.1002/mus.26891. [Epub ahead of print]

The COVID-19 pandemic has necessitated cancelation of elective or non-urgent contact with the healthcare system, including non-urgent nerve conduction studies and electromyography (electrodiagnostic [EDX] studies). The definitions of elective and non-urgent are physician judgments, and often are not straightforward. Clinical care must be provided to help our patients in a timely manner, while keeping them, health care personnel and the community safe. Benefit/risk stratification is an important part of this process. We have stratified EDX studies into 3 categories: Urgent, Non-urgent and Possibly Urgent, in an effort to help clinicians triage these referrals. For each category, we provide a rationale and some examples. However, each referral must be reviewed on a case-by-case basis, and the clinical situation will evolve over time, necessitating flexibility in managing EDX triaging. Engaging the referring clinician and, at times, the patient, may be useful in the triage process. This article is protected by copyright. All rights reserved.

## 16. [Recommendations on the identification and transfer of children with critical diabetes during the COVID-19 outbreak].

[Article in Chinese] NB a contact who is a trainee translator has offered to translate Chinese articles for free during covid-19. Please ask if you would like us to contact them to request a translation.

**Author(s):** Subspecialty Group of Endocrinology and Metabolism, Society of Pediatrics, Chinese Medical Association; Subspecialty Group of Endocrinology and Metabolism, Society of Pediatrics, Chinese Medical Doctor Association.

**Source:** Zhongguo Dang Dai Er Ke Za Zhi. 2020 Apr;22(4):285-289.

Coronavirus disease 2019 (COVID-19) is the most serious public health problem in China. Children with diabetes are also among the population susceptible to severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). Traffic problems caused by epidemic prevention and control increase the difficulty in the management of children with severe diabetes. In order to control the spread of epidemic, children with mild diabetes are advised to be managed at home and in the community. However, how to treat children with severe diabetes effectively and safely during the outbreak of COVID-19 brings great challenges to primary doctors. The Subspecialty Group of Endocrinology and Metabolism, Society of Pediatrics, Chinese Medical Association and the Subspecialty Group of Endocrinology and Metabolism, Society of Pediatrics, Chinese Medical Doctor Association have developed the recommendations on the identification and transfer of children with critical diabetes during the COVID-19 outbreak, which provide a reference for primary doctors to quickly assess the severity of patient's condition and treat the illness accordingly, thus reducing the risk of referral infection and improving clinical prognosis.

# Journal articles

## 17. Assessing the Burden of Nondeferrable Major Uro-oncologic Surgery to Guide Prioritisation Strategies During the COVID-19 Pandemic: Insights from Three Italian High-volume Referral Centres

**Author(s):** Campi R.; Serni S.; Minervini A.; Carini M.; Amparore D.; Checcucci E.; Fiori C.; Porpiglia F.; Capitanio U.; Salonia A.; Briganti A.; Montorsi F.

**Source:** European Urology; 2020

Available at [European urology](https://auth.elsevier.com/ShibAuth/institutionLogin?entityID=https://idp.eng.nhs.uk/openathens&appReturnURL=https%3A%2F%2Fwww.clinicalkey.com%2Fcontent%2FplayBy%2Fdoi%2F%3Fv%3D10.1016%2Fj.eururo.2020.03.054) - from ClinicalKey

The coronavirus 2019 (COVID-19) pandemic has led to an unprecedented emergency scenario for all aspects of health care, including urology. At the time of writing, Italy was the country with the highest rates of both infection and mortality. A panel of experts recently released recommendations for prioritising urologic surgeries in a low-resource setting. Of note, major cancer surgery represents a compelling challenge. However, the burden of these procedures and the impact of such recommendations on urologic practice are currently unknown. To fill this gap, we assessed the yearly proportion of high-priority major uro-oncologic surgeries at three Italian high-volume academic centres. Of 2387 major cancer surgeries, 32.3% were classified as high priority (12.6% of radical nephroureterectomy, 17.3% of nephrectomy, 33.9% of radical prostatectomy, and 36.2% of radical cystectomy cases). Moreover, 26.4% of high-priority major cancer surgeries were performed in patients at higher perioperative risk (American Society of Anesthesiologists score >=3), with radical cystectomy contributing the most to this cohort (50%). Our real-life data contextualise ongoing recommendations on prioritisation strategies during the current COVID-19 pandemic, highlighting the need for better patient selection for surgery. We found that approximately two-thirds of elective major uro-oncologic surgeries can be safely postponed or changed to another treatment modality when the availability of health care resources is reduced. Patient Summary: We used data from three high-volume Italian academic urology centres to evaluate how many surgeries performed for prostate, bladder, kidney, and upper tract urothelial cancer can be postponed in times of emergency. We found that approximately two-thirds of patients with these cancers do not require high-priority surgery. Conversely, of patients requiring high-priority surgery, approximately one in four is considered at high perioperative risk. These patients may pose challenges in allocation of resources in critical scenarios such as the current COVID-19 pandemic. Our study involving three Italian high-volume centres provides real-life data to contextualise ongoing recommendations on the selection of priority surgeries in the emergency scenario caused by the COVID pandemic. Overall, 67.8% of elective major uro-oncologic surgeries can be postponed. Copyright © 2020

**Database:** EMBASE

## 18. Cancer care under the outbreak of COVID-19: A perspective from Italian tertiary referral center for surgical oncology.

**Author(s):** Marano, Luigi; Marrelli, Daniele; Roviello, Franco

**Source:** European journal of surgical oncology : the journal of the European Society of Surgical Oncology and the British Association of Surgical Oncology; Apr 2020

**Publication Type(s):** Letter

Available at [European Journal of Surgical Oncology](https://auth.elsevier.com/ShibAuth/institutionLogin?entityID=https://idp.eng.nhs.uk/openathens&appReturnURL=https%3A%2F%2Fwww.clinicalkey.com%2Fcontent%2FplayBy%2Fdoi%2F%3Fv%3D10.1016%2Fj.ejso.2020.04.004) - from ClinicalKey

Available at [European Journal of Surgical Oncology](https://doi.org/10.1016/j.ejso.2020.04.004) - from Unpaywall

**Database:** Medline

## 19. COVID-19: Initial experience of an international group of hand surgeons.

**Author(s):** Ducournau F et al.

**Source:** Hand Surg Rehabil. 2020 Apr 9. pii: S2468-1229(20)30074-8. doi: 10.1016/j.hansur.2020.04.001. [Epub ahead of print]

The emergence of the COVID-19 pandemic has severely affected medical treatment protocols throughout the world. While the pandemic does not affect hand surgeons at first glance, they have a role to play. The purpose of this study was to describe the different measures that have been put in place in response to the COVID-19 pandemic by hand surgeons throughout the world. The survey comprised 47 surgeons working in 34 countries who responded to an online questionnaire. We found that the protocols varied in terms of visitors, health professionals in the operating room, patient waiting areas, wards and emergency rooms. Based on these preliminary findings, an international consensus on hand surgery practices for the current viral pandemic, and future ones, needs to be built rapidly. Copyright © 2020 SFCM. Published by Elsevier Masson SAS. All rights reserved.

## 20. Essere cardiologo ai tempi del SARS-COVID-19: è tempo di riconsiderare il nostro modo di lavorare? [Being a cardiologist at the time of SARS-COVID-19: is it time to reconsider our way of working?]

[Article in Italian]

**Author(s):** Tarantini L et al.

**Source:** G Ital Cardiol (Rome). 2020 May;21(5):354-357. doi: 10.1714/3343.33133.

The SARS-COVID-19 pandemic is bringing to light significant issues that require deliberations on how to manage patients at high cardiovascular risk or with proven heart disease. The evidence that the hospital can be a place where one might contract the infection and spread the disease has drastically reduced non-COVID-19 accesses to emergency rooms (ER) and to elective non-COVID-19 hospital activities. If this, on one hand, results in reducing improper access to the ER and hospital, on the other hand it substantiates the risk of underestimating problems not connected to COVID-19, such as an increased delay in the diagnosis and treatment of acute myocardial infarction and other cardiovascular emergencies. In addition, the need to reorganize hospital activities to treat patients suffering from serious COVID-19 disease forms forces us to reflect on how to safely manage patients who stay at home with milder COVID-19 disease forms and the need to keep the most vulnerable subjects, such as patients with chronic heart failure, away from the hospital. The problem is furtherly amplified by the uncertain trend of the epidemic, by the duration of forced isolation and limited mobility measures and by the inadequate integration between hospital and territory, especially in high-risk areas such as residences for the elderly or in socially and economically fragile environments. Our opinion is that a syndemic approach, which considers the complex interplay between social, economic, environmental and clinical problems, can be the most appropriate and achieved by means the contribution of telemedicine and telecardiology, intended as integration and not as an alternative to traditional management. A flexible use of telematic tools, now available for teleconsultation, and/or remote monitoring adapted to the needs of clinical, family and social-health contexts could allow the creation of integrated and personalized management programs that are effective and efficient for the care of patients.

## 21. Management of Acute Myocardial Infarction During the COVID-19 Pandemic.

**Author(s):** Mahmud E et al.

**Source:** Catheter Cardiovasc Interv. 2020 Apr 20. doi: 10.1002/ccd.28946. [Epub ahead of print]

The worldwide pandemic caused by the novel acute respiratory syndrome coronavirus 2 (SARS-CoV2) has resulted in a new and lethal disease termed coronavirus disease 2019 (COVID-19). Although there is an association between cardiovascular disease and COVID-19, the majority of patients who need cardiovascular care for the management of ischemic heart disease may not be infected with COVID-19. The objective of this document is to provide recommendations for a systematic approach for the care of patients with an acute myocardial infarction (AMI) during the COVID-19 pandemic. There is a recognition of two major challenges in providing recommendations for AMI care in the COVID-19 era. Cardiovascular manifestations of COVID-19 are complex with patients presenting with AMI, myocarditis simulating a ST-elevation MI presentation, stress cardiomyopathy, non-ischemic cardiomyopathy, coronary spasm, or nonspecific myocardial injury and the prevalence of COVID-19 disease in the US population remains unknown with risk of asymptomatic spread. This document addresses the care of these patients focusing on 1) the varied clinical presentations; 2) appropriate personal protection equipment (PPE) for health care workers; 3) role of the Emergency Department, Emergency Medical System and the Cardiac Catheterization Laboratory; and 4) Regional STEMI systems of care. During the COVID-19 pandemic, primary PCI remains the standard of care for STEMI patients at PCI capable hospitals when it can be provided in a timely fashion, with an expert team outfitted with PPE in a dedicated CCL room. A fibrinolysis-based strategy may be entertained at non-PCI capable referral hospitals or in specific situations where primary PCI cannot be executed or is not deemed the best option. This article is protected by copyright. All rights reserved.

## 22. Management of inflammatory bowel disease patients in the COVID-19 pandemic era: a Brazilian tertiary referral center guidance.

**Author(s):** Queiroz NSF et al.

**Source:** Clinics (Sao Paulo). 2020 Apr 17;75:e1909. doi: 10.6061/clinics/2020/e1909. eCollection 2020.

The world is fighting the COVID-19 outbreak and health workers, including inflammatory bowel diseases specialists, have been challenged to address the specific clinical issues of their patients. We hereby summarize the current literature in the management of inflammatory bowel disease (IBD) patients during the COVID-19 pandemic era that support the rearrangement of our IBD unit and the clinical advice provided to our patients.

## 23. COVID-19 Pandemic - Is Virtual Urology Clinic the answer to keeping the cancer pathway moving?

**Author(s):** Connor MJ1,2, Winkler M1,2, Miah S3.

**Source:** BJU Int. 2020 Mar 30. doi: 10.1111/bju.15061. [Epub ahead of print]

The COVID-19 pandemic presents an unprecedented challenge to our National Health Service (NHS) (1). As the need to appropriately direct all efforts towards providing emergency supportive care to those suffering, there will be a knee-jerk tendency to cancel all outpatient activity by NHS trusts. Whilst this appears to be a pragmatic approach to reducing risk of transmission, there will be an unmet cost to those patients who are high-risk and are already on the cancer referral pathway. This article is protected by copyright. All rights reserved.

## 24. Offering general pediatric care during the hard times of the 2014 Ebola outbreak: looking back at how many came and how well they fared at a Médecins Sans Frontières referral hospital in rural Sierra Leone.

**Author(s):** Hermans, Veerle; Zachariah, Rony; Woldeyohannes, Desalegn; Saffa, Gbessay; Kamara, Dauda; Ortuno-Gutierrez, Nimer; Kizito, Walter; Manzi, Marcel; Alders, Petra; Maikere, Jacob

**Source:** BMC Pediatrics; Jan 2017; vol. 17 ; p. 1-8

Available at [BMC pediatrics](http://bmcpediatr.biomedcentral.com/articles/10.1186/s12887-017-0786-z) - from BioMed Central

Available at [BMC pediatrics](http://europepmc.org/search?query=(DOI:10.1186/s12887-017-0786-z)) - from Europe PubMed Central - Open Access

Available at [BMC pediatrics](http://search.ebscohost.com/login.aspx?direct=true&scope=site&site=ehost-live&db=mdc&AN=28122533) - from EBSCO (MEDLINE Complete)

Available at [BMC pediatrics](http://gateway.proquest.com/openurl?ctx_ver=Z39.88-2004&res_id=xri:pqm&req_dat=xri:pqil:pq_clntid=145298&rft_val_fmt=ori/fmt:kev:mtx:journal&genre=article&issn=1471-2431&volume=17&issue=1&spage=34) - from ProQuest (Health Research Premium) - NHS Version

Available at [BMC pediatrics](https://bmcpediatr.biomedcentral.com/track/pdf/10.1186/s12887-017-0786-z) - from Unpaywall

Background: In Bo district, rural Sierra Leone, we assessed the burden of the 2014 Ebola outbreak on under-five consultations at a primary health center and the quality of care for under-15 children at a Médecins Sans Frontières (MSF) referral hospital. Methods: Retrospective cohort study, comparing a period before (May-October 2013) and during the same period of the Ebola outbreak (2014). Health worker infections occurred at the outbreak peak (October 2014), resulting in hospital closure due to fear of occupational-risk of contracting Ebola. Standardized hospital exit outcomes and case fatality were used to assess quality of care until closure. Results: A total of 13,658 children under-five, were seen at the primary health center during 2013 compared to 8761 in 2014; a consultation decline of 36%. Of 6497 children seen in the hospital emergency room, during the outbreak, patients coming from within hospital catchment area declined with 38% and there were significantly more self-referrals (80% vs. 61%, P < 0.001). During Ebola, 23 children were dead on arrival and the proportion of children in severe clinical status (requiring urgent attention) was higher (74% during Ebola vs. 65% before, P < 0.001). Of 5,223 children with available hospital outcomes, unfavorable outcomes (combination of deaths and abandoned) were less than 15% during both periods, which is within the maximum acceptable in-house threshold set by MSF. Case fatality for severe malaria and lower respiratory tract infections (n = 3752) were similar (≤15%). Conclusions: Valuable and good quality pediatric care was being provided in the pediatric hospital during the 2014 Ebola outbreak, but could not be sustained because of hospital closure. Health facility and health worker safety should be tackled as a universal requirement to try to avoid a déjà-vu.

**Database:** CINAHL

## 25. The impact of the 2014-15 Ebola virus disease epidemic on emergency care attendance and capacity at a tertiary referral hospital in Freetown, Sierra Leone: A retrospective observational study

**Author(s):** Youkee D.; Howlett P.; Lado M.; Brady L.; Harrison H.-L.; Williams N.; Laggah M.; Seisay S.B.

**Source:** The Lancet; Feb 2016; vol. 387 ; p. 109

**Publication Type(s):** Conference Abstract

Background The Ebola virus disease epidemic in West Africa has infected 28 457 people and claimed more than 11 000 lives. Many more people may have died from the indirect effects of the epidemic and closure of normal healthcare facilities. Unlike other facilities in West Africa, the emergency department in Connaught Hospital, Freetown, Sierre Leone, protected by an onsite Ebola holding unit, continued to provide emergency care throughout the outbreak. We aimed to assess the effect of the outbreak on emergency department attendance and presentation. We also analysed emergency care capacity across Freetown. Methods Attendance data from the emergency department and Ebola holding unit at Connaught Hospital were collected from June 1, 2014, to June 1, 2015. Severity of presentation was derived from South African Triage Score (SATS) assigned at first presentation to the emergency department. A mean severity score was calculated by dividing the number of presentations with a SATS of 1-2 by the total number of presentations. Local prevalence of the disease was counted as RT-PCR positive cases at the Ebola holding unit. Emergency care capacity was assessed at the seven principal hospitals in Freetown in May, 2013, and in April, 2015, with a standardised tool, the Emergency Care Capacity Score (ECCS), specifically designed for the low-income setting. All data were collected in Excel (2013). Stata (version 13) was used for statistical analysis. Findings 8935 patients presented to the emergency department; mean attendance was 172 patients per week (95% CI 153-191), with attendance varying from 41 patients in the week beginning July 28, 2014, to 284 patients in the week beginning May 11, 2015. Emergency department attendance had a negative correlation with local prevalence of Ebola virus disease (r=-0.640, p<0.0001) (appendix). The proportion of severe cases also varied from a peak of 26.5% in week 40 of 2014 (a period of high local prevalence, 74.6%) to 3.2% in week 28 of 2014 before any case had occurred in Freetown. The mean severity of presentation was 11.9% (95% CI 10.3-13.4). The ECCS was reduced across all domains except the systems domain (appendix). Total ECCS for all seven hospitals decreased by 10% from 2013 to 2015, and all facilities showed a decrease in their individual ECCS score. Interpretation The reduction in attendance probably demonstrates both a change in health-seeking behaviour-ie, great public fear of hospitals because of the perceived risk of nosocomial transmission of the virus-and a reduction in access to care. The decrease in emergency care capacity was expected and reflects the closure of many health services other than those for Ebola virus disease. Overall, this is an important case study of the impact of an infectious disease outbreak on a tertiary referral hospital in a low-income setting.

**Database:** EMBASE

## 26. Childhood cancers in a referral hospital in Kenya: a review

**Author(s):** Macharia W.M.

**Source:** East African medical journal; Oct 1996; vol. 73 (no. 10); p. 647-650

Following the outbreak of human immune deficiency virus (HIV) infection in the early 1980's, there has been an increase in reported cases of Kaposi's sarcoma, among other childhood malignancies, from the East and Central African region. To assess the status of childhood cancers at Kenyatta National Hospital during the AIDS epidemic period and to compare the findings with those obtained before the outbreak, relevant data were extracted from ward admission registers for all children admitted in the paediatric wards and in whom a diagnosis of a malignant disease was confirmed. The data were summarised in tables and bar charts. The hospital based prevalence for malignant diseases was 1.27% (CI = 1.23,1.31). Lymphoma (51.3%), leukaemia (21.3%), nephroblastoma (8.5%) and rhabdomyosarcoma (5.2%) are the most common childhood cancers. Compared with earlier studies, the frequency of acute lymphoblastic leukaemia, Hodgkin's disease and rhabdomyosarcoma appear to have increased. Despite the AIDS epidemic, there has been no obvious increase in number of cases of Kaposi's sarcoma.

**Database:** EMBASE

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**Databases searched:** MEDLINE, EMBASE, Emcare, Cinahl, PubMed, NHS Digital, Google.

**Search History:**

|  |  |  |  |
| --- | --- | --- | --- |
| **#** | **Database** | **Search term** | **Results** |
| 1 | Medline | (covid-19).ti,ab | 1551 |
| 2 | Medline | (wuhan ADJ2 coronavir\*).ti,ab | 40 |
| 3 | Medline | (ncov).ti,ab | 340 |
| 4 | Medline | (sars-cov\*).ti,ab | 2777 |
| 5 | Medline | exp CORONAVIRIDAE/ | 12696 |
| 6 | Medline | exp "CORONAVIRIDAE INFECTIONS"/ | 10756 |
| 7 | Medline | (sars OR "severe acute respiratory").ti,ab | 10989 |
| 8 | Medline | (mers OR "middle east respiratory" OR "middle eastern respiratory").ti,ab | 4369 |
| 9 | Medline | PANDEMICS/ | 4923 |
| 10 | Medline | EPIDEMICS/ | 9918 |
| 11 | Medline | (pandemic\* OR epidemic\* OR outbreak\*).ti | 73274 |
| 12 | Medline | (lockdown).ti,ab | 113 |
| 13 | Medline | (lock-down).ti,ab | 25 |
| 14 | Medline | (quarantin\*).ti,ab | 4550 |
| 15 | Medline | (curfew).ti,ab | 65 |
| 16 | Medline | (confine\*).ti,ab | 95471 |
| 17 | Medline | (self-isolat\*).ti,ab | 126 |
| 18 | Medline | QUARANTINE/ | 2136 |
| 19 | Medline | "PATIENT ISOLATION"/ OR "SOCIAL ISOLATION"/ | 16841 |
| 20 | Medline | (1 OR 2 OR 3 OR 4 OR 5 OR 6 OR 7 OR 8 OR 9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18 OR 19) | 220030 |
| 21 | Medline | (refer OR referred OR referral OR refers OR referring).ti | 19614 |
| 22 | Medline | \*"REFERRAL AND CONSULTATION"/ | 25622 |
| 23 | Medline | (21 OR 22) | 38127 |
| 24 | Medline | (20 AND 23) | 171 |
| 25 | EMBASE | (covid-19).ti,ab | 1452 |
| 26 | EMBASE | (wuhan ADJ2 coronavir\*).ti,ab | 21 |
| 27 | EMBASE | (ncov).ti,ab | 342 |
| 28 | EMBASE | (sars-cov\*).ti,ab | 2950 |
| 29 | EMBASE | exp CORONAVIRIDAE/ | 12703 |
| 30 | EMBASE | exp "CORONAVIRIDAE INFECTION"/ | 11511 |
| 31 | EMBASE | (sars OR "severe acute respiratory").ti,ab | 12761 |
| 32 | EMBASE | (mers OR "middle east respiratory" OR "middle eastern respiratory").ti,ab | 4915 |
| 33 | EMBASE | \*PANDEMIC/ | 2608 |
| 34 | EMBASE | \*EPIDEMIC/ | 32261 |
| 35 | EMBASE | (pandemic\* OR epidemic\*).ti | 37490 |
| 36 | EMBASE | (outbreak\*).ti | 31230 |
| 37 | EMBASE | (lockdown).ti,ab | 130 |
| 38 | EMBASE | (lock-down).ti,ab | 32 |
| 39 | EMBASE | (quarantin\*).ti,ab | 4629 |
| 40 | EMBASE | (curfew).ti,ab | 83 |
| 41 | EMBASE | (confine\*).ti,ab | 99837 |
| 42 | EMBASE | (self-isolat\*).ti,ab | 147 |
| 43 | EMBASE | QUARANTINE/ | 895 |
| 44 | EMBASE | exp "PATIENT ISOLATION"/ | 720 |
| 45 | EMBASE | exp "CONTACT ISOLATION"/ OR "SOCIAL ISOLATION"/ | 22118 |
| 46 | EMBASE | ISOLATION/ | 1948 |
| 47 | EMBASE | (25 OR 26 OR 27 OR 28 OR 29 OR 30 OR 31 OR 32 OR 33 OR 34 OR 35 OR 36 OR 37 OR 38 OR 39 OR 40 OR 41 OR 42 OR 43 OR 44 OR 45 OR 46) | 234020 |
| 48 | EMBASE | (refer OR referred OR referral OR refers OR referring).ti | 29650 |
| 49 | EMBASE | \*"PATIENT REFERRAL"/ | 17652 |
| 50 | EMBASE | (48 OR 49) | 38985 |
| 51 | EMBASE | (47 AND 50) | 185 |
| 52 | EMCARE | (covid-19).ti,ab | 333 |
| 53 | EMCARE | (wuhan ADJ2 coronavir\*).ti,ab | 11 |
| 54 | EMCARE | (ncov).ti,ab | 89 |
| 55 | EMCARE | (sars-cov\*).ti,ab | 262 |
| 56 | EMCARE | exp CORONAVIRIDAE/ | 1979 |
| 57 | EMCARE | exp "CORONAVIRIDAE INFECTION"/ | 3674 |
| 58 | EMCARE | (sars OR "severe acute respiratory").ti,ab | 2958 |
| 59 | EMCARE | (mers OR "middle east respiratory" OR "middle eastern respiratory").ti,ab | 943 |
| 60 | EMCARE | \*PANDEMIC/ | 1252 |
| 61 | EMCARE | \*EPIDEMIC/ | 6896 |
| 62 | EMCARE | (pandemic\* OR epidemic\*).ti | 9715 |
| 63 | EMCARE | (outbreak\*).ti | 7404 |
| 64 | EMCARE | (lockdown).ti,ab | 27 |
| 65 | EMCARE | (lock-down).ti,ab | 13 |
| 66 | EMCARE | (quarantin\*).ti,ab | 739 |
| 67 | EMCARE | (curfew).ti,ab | 43 |
| 68 | EMCARE | (confine\*).ti,ab | 13454 |
| 69 | EMCARE | (self-isolat\*).ti,ab | 53 |
| 70 | EMCARE | QUARANTINE/ | 239 |
| 71 | EMCARE | exp "PATIENT ISOLATION"/ | 262 |
| 72 | EMCARE | exp "CONTACT ISOLATION"/ | 86 |
| 73 | EMCARE | ISOLATION/ OR "SOCIAL ISOLATION"/ | 8625 |
| 74 | EMCARE | (52 OR 53 OR 54 OR 55 OR 56 OR 57 OR 58 OR 59 OR 60 OR 61 OR 62 OR 63 OR 64 OR 65 OR 66 OR 67 OR 68 OR 69 OR 70 OR 71 OR 72 OR 73) | 45693 |
| 75 | EMCARE | (refer OR referred OR referral OR refers OR referring).ti | 8618 |
| 76 | EMCARE | \*"PATIENT REFERRAL"/ | 3681 |
| 77 | EMCARE | (75 OR 76) | 10070 |
| 78 | EMCARE | (74 AND 77) | 55 |
| 79 | CINAHL | (covid-19).ti,ab | 237 |
| 80 | CINAHL | (wuhan ADJ2 coronavir\*).ti,ab | 24 |
| 81 | CINAHL | (ncov).ti,ab | 9 |
| 82 | CINAHL | (sars-cov\*).ti,ab | 101 |
| 83 | CINAHL | exp CORONAVIRIDAE/ | 764 |
| 84 | CINAHL | exp "CORONAVIRIDAE INFECTIONS"/ | 2956 |
| 85 | CINAHL | (sars OR "severe acute respiratory").ti,ab | 3186 |
| 86 | CINAHL | (mers OR "middle east respiratory" OR "middle eastern respiratory").ti,ab | 1130 |
| 87 | CINAHL | (pandemic\* OR epidemic\*).ti | 11630 |
| 88 | CINAHL | (outbreak\*).ti | 8938 |
| 89 | CINAHL | (lockdown).ti,ab | 70 |
| 90 | CINAHL | (lock-down).ti,ab | 12 |
| 91 | CINAHL | (quarantine).ti,ab | 461 |
| 92 | CINAHL | (curfew).ti,ab | 51 |
| 93 | CINAHL | (confine\*).ti,ab | 7200 |
| 94 | CINAHL | (self-isolat\*).ti,ab | 49 |
| 95 | CINAHL | exp "PATIENT ISOLATION"/ | 2641 |
| 96 | CINAHL | "SOCIAL ISOLATION"/ | 8595 |
| 97 | CINAHL | QUARANTINE/ | 526 |
| 98 | CINAHL | (79 OR 80 OR 81 OR 82 OR 83 OR 84 OR 85 OR 86 OR 87 OR 88 OR 89 OR 90 OR 91 OR 92 OR 93 OR 94 OR 95 OR 96 OR 97) | 44340 |
| 99 | CINAHL | (refer OR referred OR referral OR refers OR referring).ti | 10913 |
| 100 | CINAHL | \*"REFERRAL AND CONSULTATION"/ | 13488 |
| 101 | CINAHL | (99 OR 100) | 20225 |
| 102 | CINAHL | (98 AND 101) | 69 |

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