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The catch-22 of the COVID-19 “lockdown”

To the Editor

The turn of the year marked the ominous birth of what later developed into a pandemic. The Chinese city of Wuhan reported a cluster of 44 cases of pneumonia which had an unknown etiology [1]. The offending agent was later found to be a novel coronavirus, the third of its type to cause a major outbreak in humans over the past two decades following SARS and MERS. The resulting disease was later named COVID-19 [2]. The virus’ high rate of infectivity in a city of almost 10 million people led to a rapid and exponential growth of cases. The healthcare system quickly became overwhelmed and the Chinese government responded by imposing a lockdown. The aim was straight-forward: to stagger the exponential growth of new cases and thus “flatten the curve” [3]. This allowed the healthcare system to have some more flexibility in order to respond to the huge number of patients.

India identified its first case on 30th January 2020 [4]. The patient was a student returning from the city of Wuhan. With an ever-increasing number of cases being diagnosed over the coming weeks, countries further imposed travel restrictions and closed international borders to prevent the spread of the disease. This initial measure only delayed the unavoidable and many countries began to see a rapid increase in cases. Local transmission played a significant role in this increase. Consequently, on March 11th, 2020, the World Health Organization declared that COVID-19 was a “pandemic” [2]. Over the next 10 days, India noticed the beginning of an exponential upstroke in cases. The goal of the Government of India

was to “stagger the cases” and “flatten the curve”. Therefore, they responded by initiating an unprecedented nationwide lockdown which brought all non-essential services to a halt.

The flip side of the coin

In absence of a definitive treatment or an effective vaccine, lockdown and social distancing are the two weapons to combat this pandemic. The aim behind the lockdown was to contain the spread and to upscale healthcare facilities in order to better manage the potential “flood” of cases. Another merit of this plan was that it would theoretically allow for healthcare research teams to come up with an effective curative and/or prophylactic treatment plan. The strategy has arguably worked, with the number of new cases outside of “hotspot areas” not showing a disastrous increment. There are, however, unsolicited effects that bear considerable relevance in a country with limited resources.

A double-edged sword

State governments throughout India have designated major tertiary care hospitals to specifically manage COVID-19. Medical subspecialty services in the Indian public health setup are extremely scarce outside of tertiary care centers. A vast majority of super specialty and subspecialty services in India are limited to tertiary care centers. In most of these hospitals, routine out-patient services have been halted with only emergency services being delivered. In addition, resident doctors of these specialties have been

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diverted to perform COVID-19 duties in order to form a large pool of health care professionals (HCP) that are focused on this specific medical issue. This was largely done to maximize the treatment of the huge number of COVID-19 patients as well as to have adequate backup in the unfortunate event that frontline HCPs were to get infected. Further, planned medical procedures and surgeries have been postponed for the foreseeable future. Hospitals have been advised to discharge all patients who are not very ill in order to create space for COVID-19 patients. These steps also contribute towards decreasing potential cross-infection.

A majority of India's 1.3 billion population belong to low/middle-income groups which mainly utilize public health services for their health needs. These people also depend on government provisions for disease-related follow-up and pharmacological re-fills. This fact is further compounded by the country's high prevalence of diseases such as hypertension, coronary artery disease, diabetes mellitus, cataract, chronic obstructive pulmonary disease, tuberculosis, and various malignancies [5]. Considering the above-mentioned information, it is important to note that long duration lockdowns carry a risk of aggravating and losing control of the treatment of chronic illnesses. Financial constraints also inhibit the use of home-based monitoring devices which further heightens the risk.

Logic and logistics

The interconnected digital world has spread awareness about preventative measures against an infective pandemic disease more effectively and quickly than at any time in the past. To HCP's, avoiding hospital contact during this trying time has become fundamentally and logically pertinent. The 'nation' may be under lockdown, but the "disease" isn't. Even when people fall ill from diseases other than COVID-19, they will tend to avoid hospital contact. This has mostly been seen in patients experiencing acute coronary syndromes and cerebrovascular incidents. They may either ignore symptoms, consult local health services for symptomatic treatment, or even self-medicate. In doing so, an essential evaluation of symptoms that may require special tests is not completed. In addition, the majority of low/middle-income households primarily use affordable public transport systems. For people seeking care in public hospitals, the curbs on transport create a hurdle in their ability to physically be able to get to well-equipped centers culminating in treatment delay.

A receding ocean before the tsunami

During the periods of lockdown, stable patients with chronic diseases have been advised to stay at home and avoid going to hospitals for routine follow up. Patients requiring non-urgent care have been asked to wait and routine procedures/surgeries have also been put on hold. In addition to this, patients are avoiding hospital visits with a fear of contracting COVID-19. As a result, the number of these patients is accumulating. Once the lockdown restrictions are taken down, the flood of patients will undoubtedly put the health care system, which may already be depleted, in further distress. In addition, the lockdown hampers the economy of the country as a whole which can lead to an economic crisis. This will further impair our spending on strengthening healthcare services, purchasing testing kits, and funding the purchase of equipment and drugs.

The benefit of a nationwide "lockdown" has its positives and negatives. It has dampened the potential explosion of COVID-19 cases in countries such as India and Singapore. However, its doubtless effect on patients with non-COVID-19 illnesses is worrisome. A prolonged lockdown which will seemingly benefit COVID-19 containment will also impair patients with other diseases. As such, this period cannot be indefinite. India has slowly but progressively managed to reduce the morbidity and mortality resulting from "disease" in general. It is prudent to address this catch-22 situation extensively and promptly or else the good work that has been accomplished up to this point may be tarnished.

Conflict of interest

Authors have no conflict of interest to declare.

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