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VEIN SPECIALIST NEWSLETTER

Pandemic Perspectives: Personal Stories from your AVF Colleagues

May 2020 | veinforum.org

LETTER FROM THE EDITOR: COVID-19 STORIES

Steve Elias, MD

Steve Elias, MD

This special issue of VEIN SPECIALIST is a little more about feelings and a little less about facts. AVF members write about their experiences during this time. We put out a call and you responded. Read what our colleagues wrote. Understand the commonality and the differences. The authors are from around the world. We embrace all of our members everywhere. I thank you for contributing. Below are my thoughts:

Uphill Against The Wind In Both Directions

People are dying. Usually I don't read the New York Times Obituary Section. But I did one Sunday. This is the "hot ticket" for obituary listings. These people were dead. A lot from COVID-19. They are old and they are young. The really sad thing is that all of the obituaries end with a very similar sentence: "A celebration of his (her) life will be held later this year." So hopeful, the phrase, "later this year," maybe. Those who died at home were lucky. They had people they knew and loved around them. You die in the hospital, you die alone. A fate worse than death.

We all die. It is the loneliness of a COVID hospital death that is so sobering. As a vascular surgeon there really is not that much I can add to the care of a hospitalized COVID patient. But there was something that could impact their loved ones. Our hospital developed a Physician Liaison Team. I volunteered. Our role was to review the charts of COVID patients on our assigned floors and then contact a representative from the team caring for these patients and get an update. Then we called the families. The COVID team doesn't have time. 95% of our hospitalized patients were COVID positive.

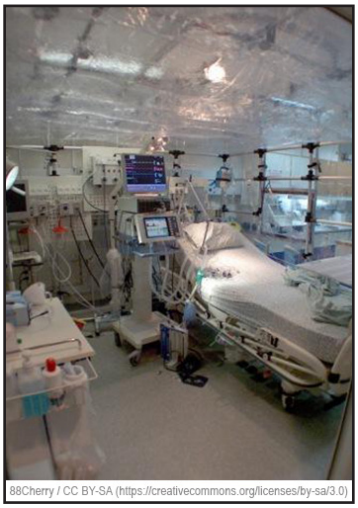
We all try to give good news when possible. Sometimes there is no good news. Sometimes it is really bad. The families felt isolated, powerless and alone. We tried to make contact every day. When speaking with the wife of a young patient not doing well, I hear her young children in the background and hear her say, "We need him, I can't exist without him, he is our provider…." How do you tell her he is not doing well, he is dying, and that he is being started on an experimental Interleukin 6 Inhibitor? Because we have nothing else. Or how surprised I was when I called an obviously very religious Orthodox Jew on a Saturday afternoon. He answered the phone. The rules are relaxed with COVID. He tells me God will forgive him. I have good news, his wife is getting better. And he says, "Thank God." He never doubted.

So as we struggle through this, it may seem as if we are walking uphill against the wind in both directions. We are not. At some point we reach the top and the wind becomes calm. At some point we survive. Thank all of you for your contributions. Be safe.

Windsor Ting, MD

WALKING INTO AN ABYSS

Windsor Ting, MD



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Fear and death were never concerns during my years as a vein surgeon.

I was the weekend covering physician on the hospital access team. The patient is a 41 year old woman, transferred from an outside hospital, intubated with severe respiratory failure, oxygen saturating only in the 80's on 100% FiO2, first hospitalized two weeks ago with COVID-19 associated pneumonia. **The woman needed a triple lumen catheter for her medications**.

The ICU was surprisingly quiet when I arrived. The smaller than usual ICU team was making morning rounds. Some nurses were inside the patients' rooms, some outside.

Everyone was friendly, acknowledging my presence with a smile, something that I don't recall before COVID-19. Everyone seemed busy, there was little conversation. **The door to each ICU room was closed tight, scribbled on the glass door with magic marker were the most crucial information**: COVID-19 diagnosed 4/2, transferred 4/14. Medications Aztreonam, Levophed, Propofol. Azithromycin/Plaquenil/Remdesivir completed. Plans today: new TLC, possible prone, check blood cultures, check CXR. Outside each ICU room was an IV pole attached with multiple pumps tethered to the patient with long IV tubings snaking underneath the door along the floor to inside the room.

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I put on my hair bouffant, isolation gown, shoe covers, two masks, face shield and two pairs of gloves. I was ready, protected. I double checked all the supplies that I might need. My assistant opened the door, I gave her a knowing look, walked into the room, the door closed behind me. **I was terrified. I felt like walking into an abyss**.

The room was noisy, a constant blowing noise from the negative room pressure pump. I wondered if there were millions of COVID-19 jelly particles in the air, on the bed, everywhere. OMG, I wondered why was I even doing this? I was given a

WALKING INTO AN ABYSS *continued*

Windsor Ting, MD

pass of not having to do this. But I volunteered. Hero? Kind? No, it was downright stupidity. I said to myself, stop dithering around, put the central line in, do it quickly, do it without complication, get out of the room as quickly as possible.

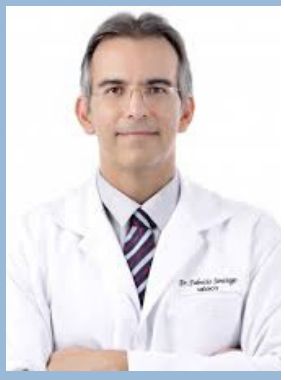
I looked at the woman, she was young, she could really be anyone of us, too young to be going through this, probably vibrant just three weeks earlier, living her life oblivious to this approaching calamity. She is too young to be dying. I wondered if she has children, a husband. I wondered if she had any awareness. Did she know I was in the room? Is it like general anesthesia, you are awake one minute, then you are in this complete blackness and total void until you come out from the anesthesia at the other end, that is if you come out of the anesthesia.

I set up my procedure tray and put on a surgical gown and a sterile glove.

The procedure went smoothly enough as it should as I have done many of these pre-COVID but I was relieved. I knew removing the gowns and gloves were just as important as this is where one can get contaminated. I carefully followed the sequence of ungowning. Every small step is potentially consequential. **When I left the room, I felt inexplicably light, like I escaped death**. But in just a few minutes, the worry will start. I will not know if I am home free for at least four days.

These experiences have given me a deep understanding of trauma. Mine was nothing. I have a better appreciation of those who have to face these experiences for long periods and without choice. You are right there, face to face with death. You are physically right next to someone who is like you but dying. You feel fear, tremendous sadness.

BRAZIL EMBRACES TELEMEDICINE



Fabricio Santiago, MD

Dr. Fabricio Santiago is a Brazilian Vascular Surgeon dedicated to Venous and Lymphatic disease and member of the American Venous Forum

There were several impacts caused by the arrival of COVID-19 in Brazil, possibly all of them common to colleagues from different parts of the globe: suspension of appointments and elective procedures, social isolation, medical isolation for those not in the frontline, as well as a huge negative psychological impact generated by an unknown disease whose consequences are not yet known.

However, I would like to draw attention to a specific situation. Motivated by the need for isolation for healthy and some categories of sick patients (low to moderate clinical manifestations,) and at the same time having to remotely assist this population and the community in general, the **Brazilian Ministry of Health encouraged, with specific rules, the broader use of Telemedicine** as a tool to combat COVID-19. Initially targeted specifically to the COVID situation, several vascular surgeons saw an opportunity to use the tool to continue to care and guide chronic patients, even in cases where care should be immediate. However, a series of thoughtful and challenging questions arose around telemedicine, in a medical specialty where the therapeutic decision often involves a physical examination. As a member of a local committee created to debate this topic, **I believe that it is time to start a serious discussion involving the role of this new tool in the reality of the vascular surgeon** and in its different areas of expertise, especially because its use will certainly be extended beyond the time of the pandemic moment.

UK VASCULAR SOCIETY PROVIDES GUIDANCE

Miss Sarah Onida

Miss Sarah Onida, NIHR Academic Clinical Lecturer in Vascular Surgery at Imperial College London

The COVID-19 pandemic has affected all aspects of society, including healthcare. Hospitals have responded to the crisis by reducing elective admissions, increasing ICU bed capacity, and reducing face to face interactions with patients. This has included cancellation of routine outpatient investigations, establishment of virtual clinics via telephone and expansion of critical care capacity by employing theatre and recovery spaces. Surgical specialties have been particularly affected with all elective operating, except emergency cases, being cancelled and the number of inpatient admissions vastly reduced.

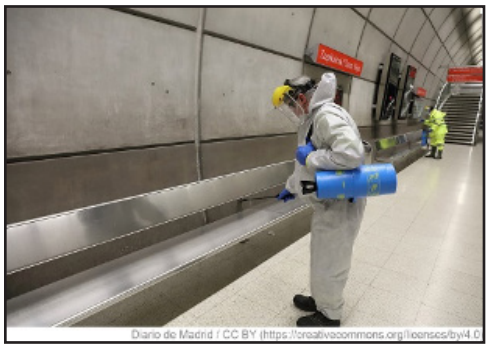
In vascular surgery, **guidance is provided by the UK Vascular Society**[1]. According to their recommendations, cases including ruptured aneurysms, immediately threatened critical limb ischemia, and crescendo TIA's should be treated as a matter of urgency. All elective arterial and venous surgery should be deferred. This includes asymptomatic carotids, claudicants, asymptomatic abdominal aortic aneurysms <7 cm in size, and all superficial venous patients. Patients presenting with extensive deep vein thrombosis are still able to undergo assessment and management as emergency cases.

Reference:
1. https://www.vascularsociety.org.uk/professionals/news/113/covid19_virus_and_vascular_surgery

Enric Roche, MD, PhD

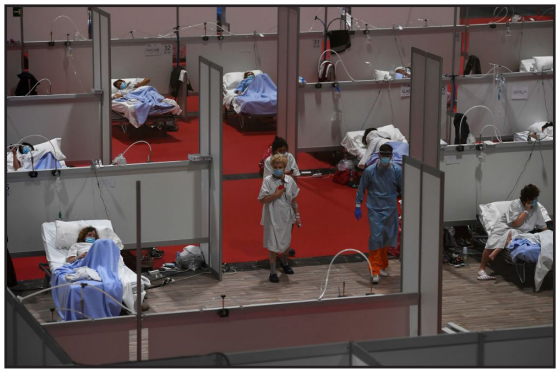
FROM DISSONANCE TO SOLIDARITY: CONTRASTS IN BARCELONA

Enric Roche MD, PhD, Vascular Surgeon



I write this from Barcelona, the second city in Spain most affected by the COVID-19 pandemic, which has been even harder hit than Madrid. The data as of May 10 are 224,350 cases diagnosed in Spain, over 137,000 recovered and 26,621 deaths. **Spain's treasured national health system meets the needs of the population and is complemented by a network of centers and professionals working in the private healthcare field**. In Catalonia, the region where Barcelona is the capital, 31% of the population has private coverage.

Since the declaration of the pandemic and observing the magnitude of the problem in Italy, Spain started a shy prevention strategy. **A dissonance between the scientific and political vision of the problem was revealed**. We have also suffered from irritating clashes between local and central governments. The reality is that the most effective measures such as total confinement and control of positives through the mass detection of rapid tests, have not been implemented effectively.



Health professionals experience this pandemic with a double feeling. On the one hand, we feel the need to help the affected population even though our specialty is not prepared for it, and on the other hand, we are concerned about the lack of protective measures that exist in some hospitals.

In Barcelona, there is an important tradition of private medicine. Many professionals like myself work in the public hospital setting as well as private centers. During this crisis, most private centers, where non-severe pathologies are mainly treated, are closed or have limited their activity.

I personally chose to close my clinic and dedicate myself exclusively to working at the Hospital Universitari General de Catalunya as an assistant in the Internal Medicine service. My activity consists of evaluating and exploring COVID-19 respiratory insufficiency symptoms, reviewing analytics, requesting radiological examinations, and prescribing treatments. Our 350-bed hospital has become a

FROM DISSONANCE TO SOLIDARITY: CONTRASTS IN BARCELONA *continued*

Enric Roche MD, PhD

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COVID center, so we do not accept patients with other non-COVID conditions. Just yesterday we had to refer an acute ischemia to another hospital because they were a negative COVID patient.

It is surprising to observe how patients with critical ischemia, heart disease and other cardiovascular events have reduced their presence in the Emergency Department, **which makes us predict a future uncontrolled influx**. It is interesting to discover that this viral infection is affecting and causing symptoms of non-embolic pulmonary vein thrombosis, as well as a phenomenon of acute distal thrombosis. These clinical manifestations and findings suggest the prescription of full anticoagulation doses versus prophylactic anticoagulation guidelines. We are experiencing dramatic situations in the hospital, **married couples who are widowed during their admission, broken families who cannot say goodbye to their loved ones, feelings of extreme loneliness**. These experiences are very moving and generate anguish and sadness.

I am moved daily by numerous examples of solidarity from large or small companies, anonymous people, and all different of groups. All of them acknowledge the effort and commitment of the healthcare workers. As a gesture of solidarity and encouragement, citizens go out on their balconies at 8pm every evening to applaud.

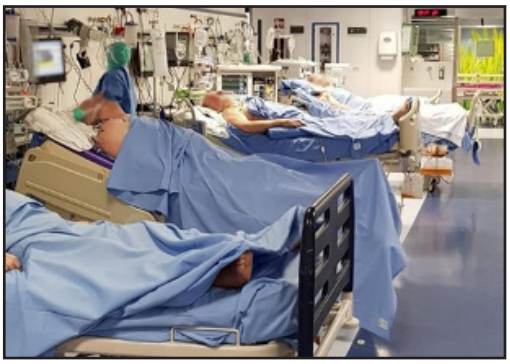
I watch with concern and sadness as the population of New York State is being affected and is currently becoming the fastest growing place for infected and dead. I am also concerned about the progression of the pandemic across countries with less prepared health systems.

From my privileged position, I only hope that as soon as possible a treatment will be found that mitigates symptoms and prevents progression to serious forms pending a vaccine that will protect us in the future.

A.Kürşat Bozkurt, MD

GOVERNMENT HEALTH SYSTEM AND PRIVATE PRACTICE CONTRASTS IN TURKEY

A.Kürşat Bozkurt, MD



The COVID-19 pandemic was officially confirmed to have spread to Turkey on 11 March 2020, later than several countries. Turkey has taken prompt measures to prevent the outbreak from entering and spreading in our country. Despite these facts, the total number of confirmed coronavirus cases surged to 138,657 as of May 10, and the death toll reached 3,786. The population of Turkey is approximately 83 million and 60% of the patients were recorded from Istanbul, a major city with a population of about 17 million. Our country has a strong health system, and relatively good social assistance. As of April 12, we do not have a shortage of ICU or standard hospital beds. All citizens have free access to health service.

We have two parts of phlebology practice in Turkey: government health system and private practice. We stopped all elective phlebology procedures following the obligations of the Ministry of Health in order to reserve our resources for COVID cases. I have not done a single elective procedure in my University hospital for four weeks now. We had a few cases with deep vein thrombosis with a possibility of catheter directed thrombolysis, but we ended up with conservative measures. The patients do not want to spend any time in a hospital and ICU environment, as almost all public hospitals accept COVID case**s. Early on, we tried to separate some hospitals, or some units of hospitals for non-COVID cases, but this strategy failed** due to the false negative results in approximately 40% of cases.

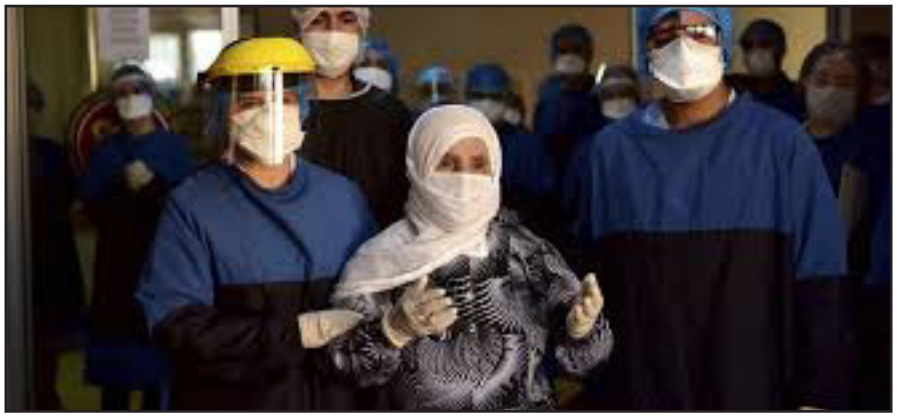
The scenario is different for private practice. Interestingly, there are still patients who want to continue their ongoing treatment for C1 diseases. We have two months to the summer season, and many want the treatment to be completed. We perform their treatment with serious personal protective measures as an outpatient procedure. We are attempting to postpone all elective truncal ablation procedures as much as we can. However, as the situation is not as grave as in the other countries, some patients want to undergo their endovenous

GOVERNMENT HEALTH SYSTEM AND PRIVATE PRACTICE CONTRASTS IN TURKEY *continued*

A.Kürşat Bozkurt, MD

ablation procedures during these quiet days while their jobs are not as busy. **This is a tricky situation and hard decisions are made**. However, one of the private hospitals has been reserved as COVID free, and elective surgery can be carried out relatively safely. The patient and the operating team receive the COVID PCR test before the procedure and this test is valid for five days. On the day of surgery, the patient is evaluated clinically by a dedicated physician including full blood count, CRP, and routine chest X-ray, although the procedure will be under local anesthesia. If everything is ok, the procedure can be performed.

Finally, practically speaking, we stopped almost 95% phlebology practice in Turkey, but it does not mean some patients will not have the procedure with strict personal protection for the patient and health care provider.

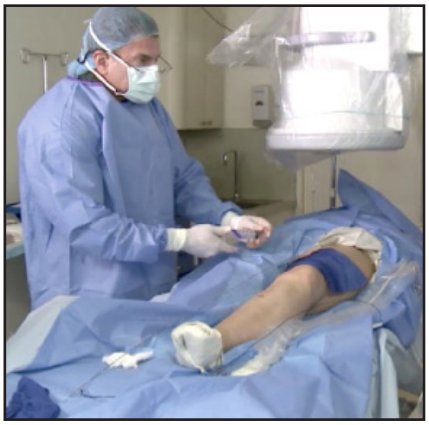


93 year old Turkish woman recovers from COVID-19

Jose I. Almeida MD, FACS

CALLED TO THE FRONT LINE

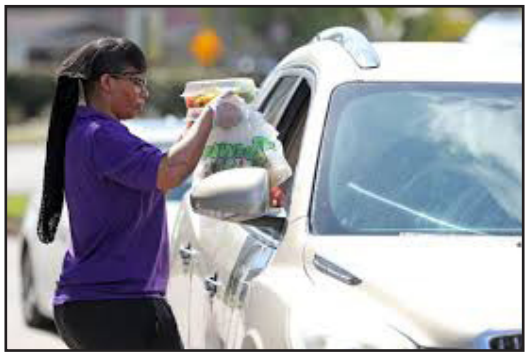
Jose I. Almeida MD, FACS



It has been 17 years since I have restored pulsatile flow. For many reasons, mostly burnout as a solo vascular surgeon covering eight hospitals, I forged a career in 100% venous disease and never looked back. I've maintained my vascular & general surgery boards, recently completing my third recertification in both specialties.

Then came COVID-19.

We have all watched with suspension of disbelief as the virus takes the world by storm. We see the horror of New York City and other countries such as Italy. We see the courageous healthcare personnel on the front lines with their PPE caring for these patients.



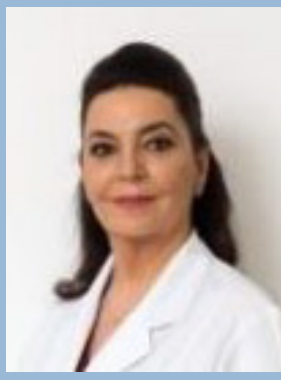
Recently, one our vascular surgeons retired after many years of tireless service at a local hospital here in Miami. I was approached by other vascular surgery colleagues to see if I could cover during the crisis while other arrangements were made.

Who am I to say no?

So, the last few days as I sit here on call 24/7 every other week until the early summer, I am reviewing arterial procedures in my vascular library. Thankfully, I have some simulation models with vascular tubing so I can suture end-to-end anastomoses with vascular grafts using 6.0 prolene. Thank God for my 2.5 x loupes because presbyopia has caught up with my 56 years and I cannot see like I used to. Trying to get my stiff hands moving again to tie delicate knots. After a career in percutaneous ablation, phlebectomy and iliocaval stenting (and 41 years of bodybuilding) - I'm rusty to say the least.

Onward. Here I sit waiting for a ruptured AAA.

POST COVID CONCERNS ABOUT SCIENTIFIC EVENTS



Solange Evangelista, MD

Solange Evangelista, Brazil, Past President, Brazilian Society for Vascular Surgery

After the social isolation caused by COVID-19, several aspects of the professional life of vascular surgeons have changed.

A great number of scientific events already scheduled for 2020 in Brazil may have to be rescheduled or even canceled due to the uncertainty provoked by the current lockdown. This accumulation of scientific events, now pushed to the end of this year, will possibly have to be postponed until 2021, which will in turn affect next year's schedule, etc. This impact will roll forward into 2021 too! There is currently a dispute among various organizing committees over event dates, as the intervals will be very close. **These raise concerns regarding the number of vascular participants for each event and a possible overload from the pharmaceutical industry**, as there is already a great restriction on their sponsorships. There have already been difficulties with flights and accommodations with respect to previously confirmed International events.

In addition, with the prohibition from the healthcare regulators to perform surgeries and other elective procedures during this period of social isolation, we need to consider the impact of the loss of profit that this will lead to - not only from procedure but also from having to stay closed and all the expenses associated with having to maintain their businesses. All these impacts raise concerns and anxiety, and financial losses are inevitable.

With our extra available time (gained through this isolation), **there has been a greater proximity among the vascular WhatsApp group members**, as well as an increase of online courses. We have also exchanged information and scientific articles concerning COVID-19, especially those that address vascular complications.

Lastly, with all the ongoing uncertainties, we have been keeping ourselves updated with the determinations of the health regulatory agencies (AMB and Ministry of Health) for the appropriate conducts of prophylaxis and the safety of employees, nurses, doctors and patients in regards to the return of activities and services in clinics and offices with PPE.

We hope that this phase will pass soon and that we will be able to return to our personal and professional routines as quickly as possible.

SOLIDARITY, CLEAN AIR, AND SCENES FROM "ET"

Jorge H. Ulloa, MD, FACS

Jorge H. Ulloa, MD, FACS, President of the Colombian Society for Vascular Surgery, Chair of the International Committee of AVF

Colombia is one of the Latin-American countries that closed its borders and airports earlier than other countries of the region, and quarantine, as of this writing, is in its fourth week now.

Social distress has evolved into a condition where most industries are in the process of reinventing themselves, schools and universities are in virtual mode now, and **we have never seen such a solidarity among employers, neighbors, and families**.

The morning air smells like…nothing; I did not realize that the air could get to that level. Images of clear rivers with animals on the shores, clear bays with dolphins playing and bears in the streets of my eight million people, cities by night is something weird that makes you feel that perhaps the virus of nature could be us.

Most of my hospital has become a gigantic ICU. The ER is splinted into an external set of containers specializing in COVID triage and the traditional indoor one. Surgery is redefining itself into a new mode of emergency type, where the concept is getting stiffer each week. Even oncological surgery is stalling now, not to mention outpatient clinics. **Getting in and out of the hospital resembles that scene from ET** where tunnels of sprinklers decontaminate our astronaut suits.

The lives of academia struggle to continue as usual, using Zoom as the new classroom and conference center, learning each day on the way, not only on a day by day basis but also, **getting a glimpse of what seems to be an evolutionary jump where things will change forever**, and we pray every day to get to that point quick, without any major fee to be paid. I know that this virus will go away and the day we learn how to live in a different way and we understand, that this time up in our rushed lives, was meant for some purpose that we are still deciphering.

John G. Carson, MD, FACS

STILL DOING WHAT WE LOVE

John G. Carson, MD, FACS, Medical Director, MaineGeneral Medical Center
Associate Professor of Surgery, New England School of Medicine

Once thought of as the place to go to get away from the hustle and bustle, eat lobster, play golf, and relax, **we quickly learned we are not immune from the pandemic**. Over the last three years, our vascular group grew from two surgeons, to a group of seven providers, two nurses, and three MAs. Our practice could not keep up with the demand, then - things changed. We were the first in the hospital to create a plan to limit clinic visits, limit non-urgent procedures and cases, and then to re-create our daily work schedules. We now have two teams, working three days at a time, signing out through a virtual platform, and still doing what we love.

Several staff members have commented to me how proud they are to be a vascular surgeon; how proud they are to cover the hospital in a time of uncertainty and fear. **This is the reason many of us pursued our calling**, our desire, our passion. While we may not be doing the cases we were so busy doing two months ago, we are still happy, still operating (only on emergent/urgent cases), and still enjoy coming to work.

It is important we remember this as many of our patients cannot see family members in the hospital and we are the only hope they have to the outside world. The smiles, thanks, and welcome we receive twice a day on rounds keeps us doing what we love. While our practices have changed, remember, this is a chapter that we will never forget, nor will our patients.

Maine is also beautiful in the winter! Come visit and say hello!

Edgar Guzman, MD, FACS

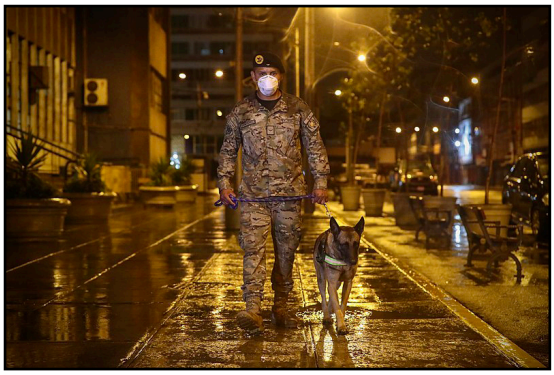
QUICK RESPONSE IN PERU OFFSET BY ECONOMIC REALITY

Edgar Guzman, MD, FACS

During the first week of April, I decided to write about the COVID-19 experience in Peru, my country of origin. I had a sense of pride by the strategy implemented and the results achieved. **There were less than 2,000 cases, and growth was flat at under 100 new patients per day**.

On March 15th, quarantine was put in effect nine days after the first reported case. There was a ban on national and international travel, activities were limited to life sustaining tasks with prior written authorization, and a nightly curfew was established. The police and armed forces were deployed to enforce these rules, and for a time, there were more arrests for quarantine violations than newly diagnosed cases.

Peru is a multiracial republic with a population of 31 million, with 80% of the population living in urban areas. Healthcare is primarily a state-run enterprise, and resources are limited when compared to what is available in the United States. Therefore, **prevention rather than treatment of an epidemic was seen as the only viable strategy** for the country.



After two weeks, further measures were implemented. Use of masks was made compulsory and a gender rotation for leaving home was established. Easter festivities, which span a week of daily mass gatherings, were cancelled.

Although Peru has been one of the worlds fastest growing economies since the 2000's, equitable wealth distribution has remained elusive. While the income level is classified as "upper middle" by the world bank, 19% of the Peruvians live in poverty, with just under half of that group living in extreme poverty. **A significant portion of the people rely on frequent small-scale transactions to procure food and basic necessities**. 70% of the population lacks access to reliable refrigeration and means of food storage. Even if these were readily available, bulk purchasing and stockpiling are outside the economic means of many.

QUICK RESPONSE IN PERU OFFSET BY ECONOMIC REALITY *continued*

Edgar Guzman, MD, FACS

Today, Peru has nearly 68,000 cases; the second largest number in South America. It is ranked 14th in the world in COVID-19 cases. In contrast, it is ranked 43rd by population size. Epidemic growth is accelerating daily, with a curve very similar to that seen in Italy and the US.

I was saddened to learn that the mode of failure was an economic one. From the start, a segment of the population could simply not afford to stay home as it relied on daily earnings for daily sustenance. In spite of government aid, this group has grown. As more people violate quarantine orders, arrests have become just a token measure and an epidemiologic concern of their own. Authority has eroded, discontent is on the rise. For many the decision is between securing nourishment or risking contagion.

Sometimes one has to look far to see near. In the past, learning about US history helped me understand the disparities I was immersed in while growing up in Peru. Today, understanding the plight of many Peruvians gives me greater empathy towards some voices we may have been too quick to judge.

Malay Patel, MD

INDIA AT A STAND STILL

Malay Patel, MD

We started to hear about the SARS-Co-2 virus in late January 2020, and by mid-February knew that it was spreading out of China. By mid-March it had come to India and on March 22 our government announced a lockdown. It has essentially meant no routine work, no going out of our homes unless to buy groceries or medicine. Shops, malls, cinemas, highways, railways, and airways all were closed. **Practically nothing to do but to stay home and do nothing**.

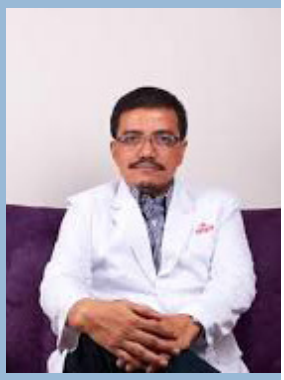
Work came to a standstill and we have not done any elective cases since then. The lockdown is now extended until May 3, 2020 and we hope by then the appearance of COVID-19 cases will start reducing.

Incomes have taken a hit. We hope that professional work will pick up gradually and symptomatic patients will return first. There has been no travel to any professional meeting since mid-January and I believe that most meetings planned till mid-2020 will be postponed for at least a year. The way the virus is moving geographically, I would be surprised if there will be any meetings in 2020. Even if some take place in the fourth quarter of 2020, I predict they will be poorly attended.

Online virtual consults are an option but cannot replace real consults. Overall, there will be a change towards more virtual conferencing and this trend will continue at least over the next two years.

Thank you and see you all on the other side of this.

IN INDONESIA, SCREENING IS THE FIRST ORDER OF BUSINESS



Dedy Pratama, MD

Dedy Pratama, MD

The number of COVID-19 patients are still steadily increasing in our country. The government has issued a partial lockdown in our capital city, Jakarta, and the surrounding city. The medical practice time for non-emergency patients and unrelated to COVID-19 was also being reduced. In cases of vascular surgery in Jakarta and other cities where a partial lockdown has been implemented, we rescheduled and delayed all our elective surgery. The only surgery we are doing right now is emergency. **Even when we were doing an emergency surgery, the patient needs to pass the screening for SARS-COV2**, and when the patient has slight symptoms which can be associated with SARS-COV2, such as fever, cough, shortness of breath, or the patient had previous contact with a COVID-19 patient or a patient suspected of COVID-19, the surgeon will need to do the surgery using complete personal protective equipment.

The emergency surgery we are still doing as of now includes Deep Vein Thrombosis, temporary hemodialysis access, aortic aneurysm, acute limb ischemia, vascular trauma, and a few other vascular emergencies. We postponed nearly all our elective vascular surgeries. In an outpatient setting, we limit our daily patients and educate our patients so that only the patients that need immediate treatment should leave their house to our outpatient clinic. **Every patient that comes to our outpatient clinic is also screened for COVID-19**, and all the healthcare personnel are wearing the necessary personal protective equipment in our hospital.

I hope all of us can safely pass this global pandemic.

SHORTAGES PLAGUE PORTUGAL

Armando Mansilha, MD, PhD, FEBVS, Past President of EVF

Armando Mansilha, MD, PhD, FEBVS

The first patient with SARS-Cov2 virus was diagnosed in Portugal on March 2. Since then, progressive restrictions to social activities and mobility were put in place. Schools were closed on March 16. A State of Emergency was declared on March 19, starting a full country lockdown for the next four weeks. As of this printing, 1,144 deaths were recorded.

We are facing problems related with the numbers of reagents for tests, adequate PPE and availability of ventilators. The surgical elective activity at NHS Hospitals has been postponed with only emergent cases being done. The number of strokes and myocardial infarctions significantly decreased. Private hospitals and clinics are with residual activities. Remote consultation is progressively increasing.

We are concerned about the duration of this pandemic and how our economy will endure, similarly to all other countries.

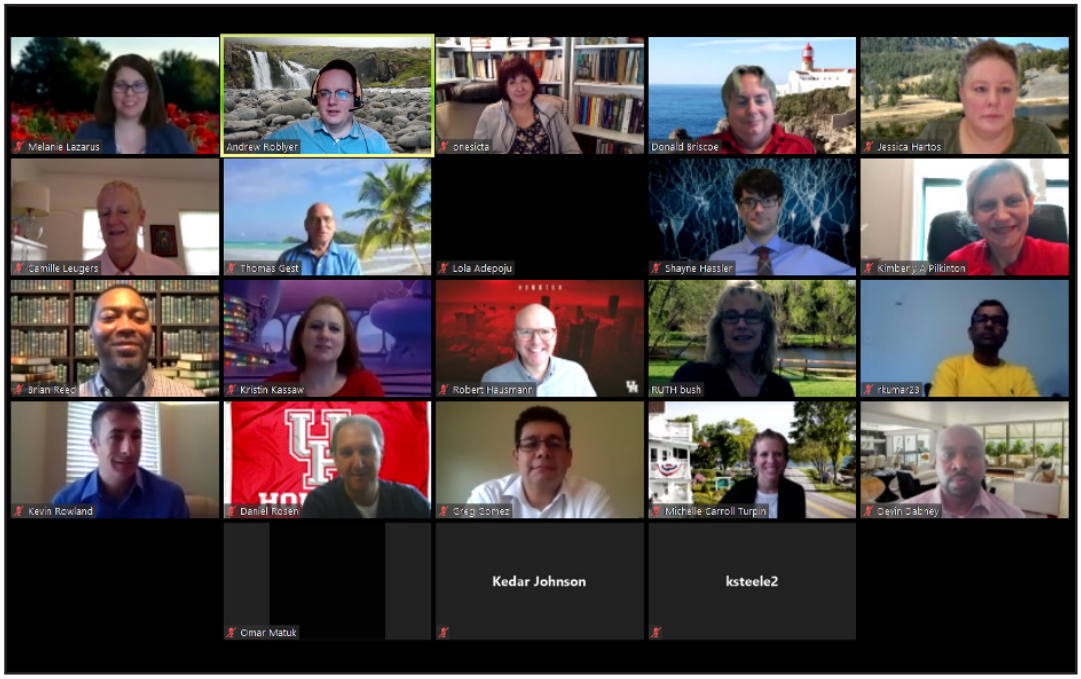
Ruth Bush, MD

LAUNCHING A COLLEGE OF MEDICINE IN A PANDEMIC

Ruth Bush, MD

I don't have a frontline healthcare story to tell and I am truly thankful for each and every one of our brave surgeons, members, and other healthcare professionals. Just my everyday job change. Mid-March, the University of Houston had already transitioned undergrad and graduate classes to an online environment and the normally bustling campus of 45K+ students was empty. My Dean gathered associate deans and chairs together and asked for immediate contingency planning, advising us to prepare faculty and staff for remote working. As Associate Dean for Medical Education, I oversee the development and delivery of the education program for this newly accredited college. **My job was just ratcheted up a few levels and I had to learn tech like a teenager**! My fabulous team of curriculum support and educational tech worked furiously to set up Microsoft Teams sites for faculty and committees and we transferred our weekly faculty development sessions to online in less than a week's time.

UH College of Medicine is on track to welcome our inaugural class late July 2020. The university has been incredibly supportive, and leadership is in constant touch with our clinical partners and public health officials. We have several levels of contingency planning for a rigorous medical education program, including gross anatomy and clinical skills, both for live, hybrid, and virtual delivery. **The world needs smart, enthusiastic doctors and we need to continue to train them**.



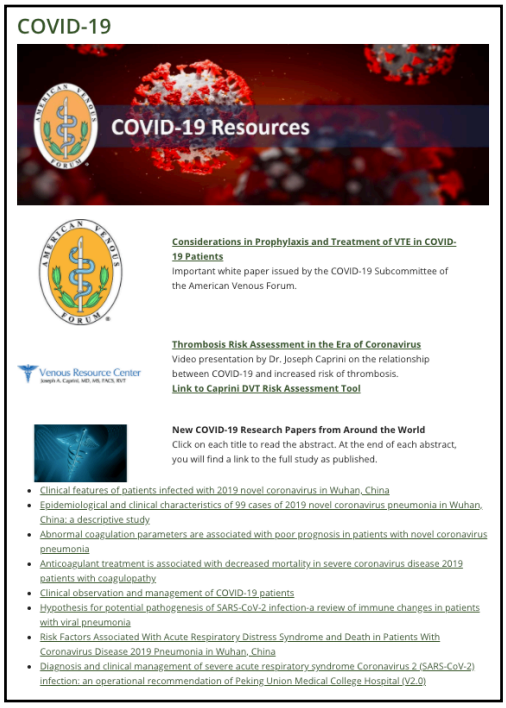
Anil Hingorani, MD

AVF COVID-19 RESOURCES AND WHITEPAPER

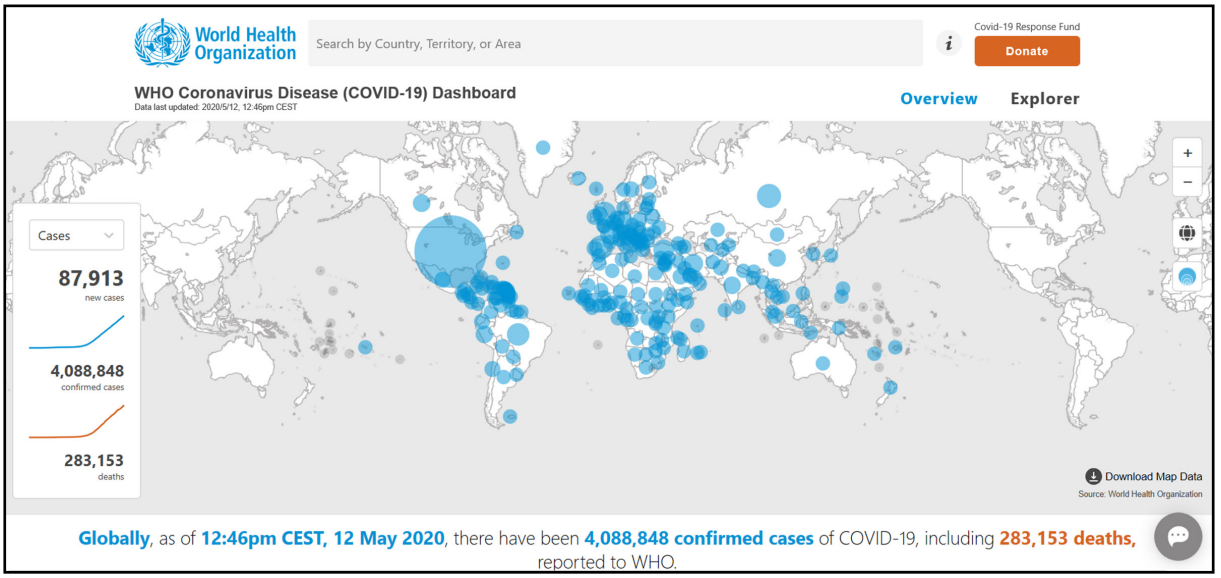
Anil Hingorani, MD

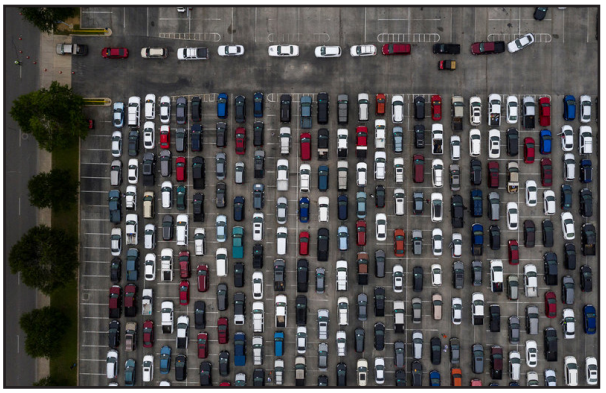
Our AVF COVID-19 Subcommittee recently wrote a whitepaper, "**Considerations in Prophylaxis and Treatment of VTE in COVID-19 Patients**," should not be considered to be informed practice guidelines and can be found on the AVF COVID-19 Resource page.

In the rapidly evolving management of seriously ill patients affected with coronavirus disease 2019 (COVID-19) there is usually insufficient evidence available to make true practice guidelines. The question responses represent the opinion of a group of venous specialists who have reviewed the currently available evidence and have communicated with specialists in high volume sites in the US and internationally. These responses are, in their opinion, the best available responses based on current knowledge. Some areas are controversial and best patient management depends on individual patient situations. The COVID-19 Subcommittee has attempted to highlight these areas and provide the evidence available in the literature summary/references. They will attempt to update this document frequently as new information becomes available. Please send any questions or comments to COVID-19@veinforum.com.



COVID-19 AROUND THE WORLD





COVID-19 AROUND THE WORLD

American Venous Forum
Promoting venous and lymphatic health

VEIN SPECIALIST PUBLICATION

Want to receive monthly updates?
Contact us 847-752-5355 or info@avfmail.org

VEIN SPECIALIST welcomes your thoughts and comments. Please send all comments to info@avfmail.org.

**Disclaimer: The information featured in this newsletter selected by AVF, which offers educational materials, are not intended to be representative of patients with venous disease generally and should not be considered medical advice. Patients should consult their doctor to determine the best treatment decision for their individual disease.*