Our data may be misleading and underestimating COVID-19 mortality figures

Dear Editor,

Patel et al review in September issue of the Journal if quarantine is an effective mode for control of the spread of Covid-19. Although quarantine controls the spread of communicable diseases in the population, there are several associated drawbacks as well: including stress; economic standstill; travel restrictions – leading to inability to access hospitals sometimes even in case of emergency; job losses – especially in tourism, hotel, travel, and hospitality industries; and boredom. In the fourth paragraph, the authors have written a possible and logical sequence of events that may have occurred at the beginning of the pandemic in Wuhan, China wherein the virus was transferred from animal to human, and then human to human transmission occurred. What we need to realize here is that howsoever plausible and appealing this theory seems to be; there are still gaps in our knowledge—more so due to information suppression in that country.[2] When the academic community does not get the freedom to rigorously explore an event, certain relevant aspects may remain hidden behind the curtains.

Secondly, under the heading, “Prevention and Modes of control of spread,” the authors advise that maintaining a social distance of 1 m from a person who is coughing or sneezing is necessary. While few countries recommend this distance of 1 m, the Government of India recommends it to be 2 m. Moreover, a combination of measures need to be practiced with physical distancing, namely, gathering only outdoors, if it is necessary to meet in person at all; open windows and doors of your house and office as much as you can, to have more ventilation, and observe basic cough etiquettes.

Thirdly, under the heading, “Quarantine and Isolation,” the authors estimate the current case fatality rate to be 3.4%. Herein, we need to remember that the gold standard test to diagnose the illness—the RT-PCR—has several limitations. While in the 1st week its sensitivity is low; cumbersome sampling method and potential coughing by subject- to generate aerosol -exposing the healthcare workers to risk while collecting samples, are other potential drawbacks. Moreover, during various phases of lockdown—under travel restrictions, closure of routine OPDs in various hospitals, reported denial of care by various private physicians, and nursing homes—as reported in this review, it is reasonable to assume that we are not genuinely counting all the deaths. Patralekha Chatterjee raises this suspicion in the Current Issue of Lancet.[3] As per official records even when the pandemic was not around, we were medically certifying just more than one-fifth (22%) of the deaths. Therefore, now under disruptions of our routing services, the percentage is likely to be lower. Hence, our current system may not be capturing the true picture. To override this challenge, some countries are measuring excess deaths in this duration. They calculate how many deaths were there last year in this duration and then subtract that figure from this year’s figure. In this way, the impact of the pandemic on this vital event may be measured in quantitative terms.

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Conflicts of interest
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