Sir,

Polytrauma in a kyphoscoliotic (KS) patient heightens the risks manifold as the physiology is already compromised. A 28-year-old male, a known case of severe KS, presented with multiple rib fractures on the right side and right tibia fracture. Blunt force trauma to the chest pointed to suspected hemothorax which was managed with intercostal drain placement (32 Fr). After initial resuscitation, tracheal intubation was attempted in view of persistent hypoxemia. Severe thoracolumbar KS was observed clinically which was later confirmed by radiography (Cobb’s angle $>$100°) [Figure 1]. Trachea was intubated in the second attempt (as per institutional protocol) due to distorted anatomy, and the patient was shifted to the intensive care unit for further management. Bedside, echocardiography was performed (ejection fraction of 49% with normal valvular function). Computed tomography of the chest was planned to assess the nature of the injury, but the patient developed cardiopulmonary arrest secondary to hypovolemic shock which was refractory to conservative management.

KS is due to disruption of balance between structural and dynamic components of the spine.[1] Such patients pose a challenge to anesthesiologist for surgery or intensive management.[2,3] KS with Cobb’s angle $>$100° is rarely encountered.[4] Rib fractures distort the already compromised anatomical and physiological derangements and make the patient prone to complications, e.g. pneumonia, pulmonary effusion, acute respiratory distress syndrome, and atelectasis or lobar collapse.[5] A 30% reduced compliance along with weakened chest wall and lung parenchyma predisposes the patients to ventilation–perfusion mismatch. As the disease progresses, the patient may land into pulmonary hypertension and right heart failure. Rib cage deformity may result in kinking and compressing great vessels and ultimately causing cardiac failure.[6]

In our patient, the chest wall compliance was already compromised, but the rib fractures aggravated the insult and led to cardiopulmonary overload. KS patients with deranged status further hinder the management and may deviate the course toward more aggressive one. Complete understanding of the anatomical and pathophysiological changes warrants the need for urgent evaluation of cardiopulmonary system. Although KS is rare, it might present to an anesthesiologist in any scenario and basic understanding of the pathophysiology may change the course of treatment.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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Dear Editor,

The world is reeling under the threat of the novel coronavirus with hundreds of people dying every day. Every epidemic in a country goes through four phases: Phase 1, introduction or emergence in the community; Phase 2, local transmission; Phase 3, amplification; Phase 4, reduced transmission and immunity.

For an emergency physician, who is at the frontline of the health delivery system, it is crucial to develop a mechanism during the Phase 2 and 3, where the patients with the disease are identified and properly isolated without getting themselves and other patients infected in the process. As the pandemic is progressing through different stages, we suggest a system of a two-step triage of the suspected cases.

**Pre-Triage**

During the Phase 2, when there are sporadic infections, the priority is early identification and isolation. There will be a spike of ambulatory patients, with flu-like symptoms flooding the emergency department (ED) with concerns of coronavirus-19 (COVID-19). There are two ways a patient can come to the ED: one is the pre-informed transfer of a confirmed/suspected case from a different facility and the second is when a patient with mild symptoms walks in the ED. In the former scenario, the designated triage nurse/doctor can route the patient directly to the isolation ward or intensive care unit based on the physiologic status of the patient.

The second set of patients with symptoms who walk in directly to the ED have to be "pre"-triaged before being triaged based on physiological parameters. A designated nurse or doctor at a separated ED triage desk will ask focused questions about symptoms, history of travel, and history of contacts. As per the case definition of COVID-19, a checklist [Table 1] will be made.

**Table 1: Pretriage checklist for coronavirus 19**

| Name:                               | Sex/Age:                   | Address:                             |
|-------------------------------------|---------------------------|--------------------------------------|
| Symptom:                            |                           |                                      |
| Fever                               |                           |                                      |
| Cough                               |                           |                                      |
| Breathlessness                      |                           |                                      |
| Sore throat                         |                           |                                      |
| Rhinorrhea                          |                           |                                      |
| Nausea/vomiting                     |                           |                                      |
| Diarrhea                            |                           |                                      |
| Vitals                              |                           |                                      |
| SPO2                                |                           |                                      |
| Temperature                         |                           |                                      |
| History of travel                   |                           |                                      |
| Recent travel to any country with COVID19 outbreak |   |                                      |
| Specify – Date of travel            |                           |                                      |
| History of contact                  |                           |                                      |
| Any contact with confirmed or suspected case of COVID19 | Yes/no |                                      |
| Any co-morbid illness               |                           | Yes/no if yes, specify               |
| COVID19 testing done                |                           | Yes/no if yes, results               |
| Decision                            |                           |                                      |
| Shift to isolation unit             |                           | Send for home quarantine             |
| Shift to routine ED                 |                           |                                      |

COVID19: Coronavirus, ED: Emergency department

Once the case is identified, they should be immediately shifted to an isolation ward where further triaging will be done of physiological parameters. A separate "pre"-triage system with restricted activity of health-care workers (HCWs) and patients will prevent cross-infection. This way, normal patient flow is segregated from the suspected cases of coronavirus [Figure 1].

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