Dear Editor,

Pulmonary alterations are the most frequent manifestations of COVID-19 infection and an accurate assessment of pulmonary parenchyma is essential to prevent the “relapse” of some patients after discharge from the hospital.

The World Health Organization recommendations for the management of clinically recovered COVID-19 patients who are able to be discharged from isolation, published on 12 January 2020 (available on: https://apps.who.int/iris/bitstream/handle/10665/330374/WHO-2019-nCoV-laboratory-2020.1-eng.pdf), require two negative reverse-transcription polymerase chain and reaction (RT-PCR) results on sequential samples taken at least 24 hours apart. In recovered-discharged patients, the possibility of a reactivation of COVID-19 infection may be considered.

In a study by Zhou et al.,[1] among the factors determining the reactivation of COVID-19 infection such as re-fever and positive RT-PCR in discharged patients, the re-infection or secondary bacterial virus infection are considered. Zhou et al.,[1] suggested that in view of this phenomenon, further stratified management of discharge from hospital should be carried out on the basis of guidelines, especially for elderly patients >60-year-old and patients with underlying diseases or severe or critical pulmonary lesions. Finally, different discharge evaluation criteria should be adopted to ensure the complete cure of patients and prevent recurrence after discharge from hospital.[1]

The role of chest computed tomography (CT) in detecting typical parenchymal patterns, their evolution over the time of COVID-19 infection,[2,3] other additional findings such as enlarged subsegmental pulmonary vessels in 59%-89% of the cases[4,5] related to pro-inflammatory factors or hyperemia[6,7] and pulmonary thromboembolism[8-10] has been reported.

According to Zhou et al.,[1] we suggest that in recovered COVID-19 patients before discharge from hospital, chest CT in addition to normal blood oxygen saturation, absence of symptoms, normal body temperature for more than 1 week and at least two negative RT-PCR results, with sampling time at least 24 h apart, may be considered.

The discharge should be considered on the basis of chest CT results that can show a residual or complete resolution of the pulmonary lesions. A potential secondary infection should be prevented especially after discharge of COVID-19 patients with severe or underlying diseases, partly due to the presence of hypoxia in pulmonary interstitial fibrosis.[1]

In COVID-19 patients considered recovered, an individualized protocol, including chest CT is suggested to ensure complete recovery and to prevent “relapse” after discharge.

Conflicts of interest
There are no conflicts of interest.

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Sir,

A lung nodule is a rounded opacity, well or poorly defined, measuring up to 3 cm in diameter. [1] The majority of such lesions are benign, but malignancy needs to be excluded in most. Nodules may be detected incidentally or by screening. Indeed, lung cancer screening has demonstrated mortality benefits in the national lung screening trial in the United States. [2] Applying these recommendations to the Indian population is controversial since there are no evidence-based guidelines on lung nodule detection and management that take into consideration indigenous factors such as prevalence of lung cancer and available local resources. It may be speculated that implementing consensus guidelines for lung nodule management in Asia [3] may more closely mimic the Indian population. We conducted a survey in three metropolitan cities across India to identify perspectives of physicians managing lung nodules.

We surveyed 210 participants, of whom 165 (78.5%) answered every question. Of those answering, 144 (72.3%), 18 (9%), and 12 (6%) respondents were practicing pulmonologists, internists, and general practitioners, respectively. Furthermore, 121 (73.3%), 108 (58%), and 140 (67.3%) respondents were aware of the size ranges of micronodules, nodules, and masses, respectively. Further, 165 (78.5%) respondents answered that they saw up to five patients a month with incidental nodules. In addition, 140 (70%) physicians felt on clinical grounds that up to 10% of their patients had multiple nodules attributable to the prior granulomatous disease.

Table 1 indicates the distribution of responses by physicians of percentage of patients with an eventual histologic diagnosis of the nodules. Majority of respondents reported using either chest or Fleischner Society guidelines for nodule management. Majority of nodules were visualized using physical films (n = 131; 74%) for radiographic imaging. A total of 70 (35.9%) respondents utilized a multidisciplinary approach (1 pulmonologist and any two specialists from radiology, medical oncology and/or surgery).

Through this survey, we aim to highlight the heterogeneity in practice patterns of physicians managing lung nodules in India. Intuitively, formulating guidelines for lung cancer screening and incidental nodules should reduce this variability. However, the situation is complex with a great deal of variability in patient education, perspectives, preferences, and available resources. Furthermore, the prevalence of nodules may vary greatly due to endemic granulomatous diseases, which may make it more difficult to make recommendations for tissue diagnosis.

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