Since December 2019, the global COVID-19 outbreak has been raging. Emerging infectious disease threats such as this require a prompt and decisive response. When implementing non-pharmaceutical interventions to slow the spread of disease, such as forms of partial or total lockdown, special attention must be paid to frail people. Emerging epidemiological and clinical data indicate that older people are more likely to develop severe forms of COVID-19, and the presence of comorbid conditions worsens prognosis and leads to increased mortality. Therefore, it follows that nursing home residents represent a particularly vulnerable group. In this regard, information and communication technologies should be an indispensable part of the public health armamentarium. Remote consultations have the potential to protect healthcare workers from unnecessary exposure to disease, while ensuring continuity in the delivery of care to the most vulnerable.

Because it is highly contagious, any resident with suspected COVID-19 in a nursing home must be quarantined. An initial medical teleconsultation can be performed for screening purposes, and further examinations can be prescribed as required. If the resident is in good general health, they may stay in the nursing home, and further examinations can be prescribed as required. If the resident is in good general health, they may stay in the nursing home, and further examinations can be prescribed as required. If the resident is in good general health, they may stay in the nursing home, and further examinations can be prescribed as required. If the resident is in good general health, they may stay in the nursing home, and further examinations can be prescribed as required. If the resident is in good general health, they may stay in the nursing home, and further examinations can be prescribed as required. If the resident is in good general health, they may stay in the nursing home, and further examinations can be prescribed as required. If the resident is in good general health, they may stay in the nursing home, and further examinations can be prescribed as required. If the resident is in good general health, they may stay in the nursing home, and further examinations can be prescribed as required. If the resident is in good general health, they may stay in the nursing home, and further examinations can be prescribed as required. If the resident is in good general health, they may stay in the nursing home, and further examinations can be prescribed as required. If the resident is in good general health, they may stay in the nursing home, and further examinations can be prescribed as required. If the resident is in good general health, they may stay in the nursing home, and further examinations can be prescribed as required. If the resident is in good general health, they may stay in the nursing home, and further examinations can be prescribed as required. If the resident is in good general health, they may stay in the nursing home, and further examinations can be prescribed as required.

An important point for the nursing home staff is to focus on sanitation of telemedicine equipment. In an epidemic context, the use of telemedicine equipment requires rigorous asepsis and disinfection methods, the absence of which may give rise to clusters of infection in the nursing home.

Our hospital has been rolling out a telemedicine program since 2018 with 36 participating nursing homes to date. In early March 2020, based on our experience over the last 18 months, we drew up protocols to be ready to implement telemedicine solutions during a COVID-19 outbreak. About 1 month later, the epidemic is in full swing, but we have observed no significant increase in the hospital teleconsultation rate.

To anticipate the massive influx of patients, French health authorities positioned general practitioners (GPs) at the center of outbreak management for COVID-19. At the same time, two legal decrees have relaxed the rules, and now allow GPs to perform teleconsultations, while prescriptions for chronic diseases have had their duration of validity automatically extended to April 15, 2020. While the national health insurance announced in the press that more than 600 000 teleconsultations were performed between March 1 and 28, 2020 which is 15 times more than in February, we believe that it is the GPs who are carrying out these teleconsultations to prevent hospitals from reaching saturation.

Telemedicine has great potential to deliver efficient, appropriate and safe care in the context of highly transmissible disease epidemics, both for screening and management, and for regular
Dear Editor,

We read with great interest the article by Boran et al. about the comparison of the applicability of surgical tracheostomy and percutaneous tracheostomy with ultrasound in nursing homes during the COVID-19 outbreak: A star is born (again). Geriatr. Gerontol. Int. 2020; 20:646–647. https://doi.org/10.1111/ggi.13934

We read with great interest the article by Boran et al. about the comparison of the applicability of surgical tracheostomy and percutaneous tracheostomy (PDT) in geriatric patients admitted to intensive care units. We read that the PDT was carried out with the use of ultrasound to: (i) identify the space between the second and the third cartilage rings; (ii) detect the presence of vascular formation under the chosen site; and (iii) evaluate the distance between the skin and anterior tracheal wall did not affect the ventilation resistance. Fiberoptic bronchoscope (FBS) during PDT was used by 70% of intensive care unit physicians participating in a worldwide survey. The most used FBS during PDT had a diameter of 5 mm. Inserting a FBS of 5 mm inside the ETT increases the resistance to gas flow during simulated mechanical ventilation. We previously calculated that the cross-sectional area of different ETT was reduced by at least 50% by the presence of vascular formation under the chosen site; and (iii) evaluate the distance between the skin and anterior tracheal wall did not affect the ventilation resistance. Fiberoptic bronchoscope (FBS) during PDT was used by 70% of intensive care unit physicians participating in a worldwide survey. The most used FBS during PDT had a diameter of 5 mm. Inserting a FBS of 5 mm inside the ETT increases the resistance to gas flow during simulated mechanical ventilation. We previously calculated that the cross-sectional area of different ETT was reduced by at least 50% by inserting a FBS of 5 mm.3 The author should declare the external diameter of the lightwand used inside the ETT to assess its potential effect on the ventilation resistance.

Second, neck ultrasound was used more frequently in situations where other neck structures were considered to be at increased risk of injury. The use of ultrasound to assess the distance between the skin and the anterior tracheal wall did not avoid the accidental puncture of the posterior tracheal wall. To our knowledge, only the double lumen endotracheal tube, equipped with an upper channel that allows passage of a flexible lightwand, can be used with ultrasound to safely carry out percutaneous tracheostomy.

CASE REPORT

Double lumen endotracheal tube, flexible lightwand and ultrasound to safely carry out percutaneous tracheostomy

Dear Editor,

We read with great interest the article by Boran et al. about the comparison of the applicability of surgical tracheostomy and percutaneous tracheostomy (PDT) in geriatric patients admitted to intensive care units. We read that the PDT was carried out with the use of ultrasound to: (i) identify the space between the second and the third cartilage rings; (ii) detect the presence of vascular formation under the chosen site; and (iii) evaluate the distance between the skin and anterior tracheal wall. Furthermore the authors inserted a flexible lightwand, previously marked to reach the root of the cuff, inside the endotracheal tube (ETT) with the aim to withdraw the ETT until the light was located at the level of the thyroid cartilage.

We appreciate this promising method to carry out a PDT in critically ill geriatric patients; however, we have some concerns. First, the authors declared that the use of the flexible lightwand inside an ETT with a minimum internal diameter of 7 mm did not affect the ventilation resistance. Fiberoptic bronchoscope (FBS) during PDT was used by 70% of intensive care unit physicians participating in a worldwide survey. The most used FBS during PDT had a diameter of 5 mm. Inserting a FBS of 5 mm inside the ETT increases the resistance to gas flow during simulated mechanical ventilation. We previously calculated that the cross-sectional area of different ETT was reduced by at least 50% by inserting a FBS of 5 mm. The author should declare the external diameter of the lightwand used inside the ETT to assess its potential effect on the ventilation resistance.

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