Mortality data of Covid-19 remain illusive and inconsistent

Nair et al. provide us “A Comprehensive Review of Novel Coronavirus” in this issue of the Journal. Authors intelligently, briefly, and assiduously draw a sketch of the unfolding pandemic after studiously going through several studies about the SARS-CoV-2. They capture several important and landmark events in their write up, which occurred in first one-third of the current year and provide us a snapshot of the period.[5]

Under a title “Epidemiology of Covid-19,” the authors write that China, where the disease actually started, suffered only 2%–3% of mortality. We believe that by this statement they want to underscore the virulence of the microbe to emphasis its significance for the mankind. However, we need to remember that quality of any data coming from China is suspect.[2] At present, the world is seriously considering if it can afford continual run of authoritarian regimen having a byproduct of hiding of the pandemic data at the initial stages. Had China disclosed its scale and scope of the spread of the novel Coronavirus then, perhaps the world would have been looking differently now. Baud et al. revised estimates of mortality figures in Chinese data to 5.6% in March-when authors prepared the initial draft of the Review.[3] Next month China itself revised its death toll on 17 Apr.[4] Hence, the world was apparently paying a high price by remaining oblivious to real time data then.

Second, in this fluid environment when governments are raising their testing and diagnosing capacity up against the SARS-CoV-2, denominator in mortality data is to be equated for the purpose of comparison. In the initial stages when only symptomatic cases and those returning from abroad were tested, mortality figures were high. Later on with wider availability of testing, as base of the population gets tested expanded, mortality dips to lower figure.[5] Therefore, in this dynamic situation, denominator reflects the pool of the people who are tested and this populace keeps on changing due to our policy-making criteria. Several authors use different terms to highlight the point. When we test only (symptomatic) cases, it is called case fatality rate; and when not specified, it is called infection fatality rate. What we also observe simultaneously is that sometimes eligible patients do not get tested and, on the other hand, several patients get wrongly labeled after testing due to inaccuracies.[6] Hence, rapid clinical assessment of the symptomatic cases is as much important as having good microbiological facilities. As all of these figures affect denominator of mortality figures, hence should be considered while making a calculation for epidemiology.

When a person is inaccurately labeled as positive, one may land up in a quarantine facility and subsequently may catch infection from one’s fellow cases. Conversely when someone is inaccurately labeled as negative, one may keep on spreading virus in community. Therefore, at every level of screening, the value of clinical assessment cannot be overemphasized. And to do so at the point of care, we need more primary care physicians than sophisticated, multispecialty, and corporate hospitals or nursing homes.

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We accessed all the webpages at the time of submission of this Letter to the Editor.