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# Outpatient treatment of COVID-19: a pending learning

## Tratamiento ambulatorio de COVID-19: un aprendizaje pendiente

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The SARS-CoV-2 pandemic of 2020 made visible the great pending issues that are still pending in the Mexican Health System; without forgetting that Mexican specialized medicine has not stopped growing due to individual efforts or those of small groups housed in isolated institutions in the country such as medical centers, national health institutes and universities, achieving important contributions in some areas in an intermittent manner.

Today, we find a disjointed Health System, without clear guidelines in health policies. Preventive strategies are not a central governmental issue despite the costly and long pandemic suffered, we continue with lagging preventive programs without a clear definition of priorities. The first level health care centers have human resources with insufficient training, clinical laboratories with limited equipment, shortage of medicines and in most cases with high demand for care. During the COVID-19 health emergency, hospital units, both public and private, suffered the physical reconversion of areas; with health support personnel with little training for diagnosis, treatment and management of complications, the latter sometimes more serious than the infection itself due to the type of comorbidities of affected patients (elderly, obesity, diabetes, lung disease or chronic heart disease, etc.) that required intensive care units, which sometimes were not available or, in the best of cases, without the necessary equipment for their operation.

About 85 to 90% of those infected developed a mild to moderate disease; the vast majority were treated by physicians in private clinics or pharmacies, since most of them did not have social security and there was a great saturation of the public and private health system, otherwise, they could not have been treated. However, between 10 and 15% of those infected would develop a severe form of the disease, many of them not detected in time, with inadequate treatment, with a severe course of the disease and with complications (no less severe). Primary care physicians (private or pharmacy offices) did not have experience in the care of severe acute respiratory illnesses or treatment with very specialized drugs that required close monitoring during their use (such as anticoagulants, steroids, broad-spectrum antibiotics and handling of medical gases).

This issue publishes the article by Soriano-Hernández DC et al., *Tratamiento prehospitalario en COVID-19 atendidos en un hospital de referencia de la Ciudad de México*,[1] which describes that the most frequent comorbidities found in patients on admission were obesity (50.5%), followed by systemic arterial hypertension (36.6%) and diabetes mellitus (26.7%). Most cases received between four and five drugs as prehospital treatment; the most frequently prescribed drugs were corticosteroids and antibiotics. A mortality rate of 39% was reported due to some complication, while 55% of the patients were discharged due to improvement. In this context, patients arriving seriously ill to the emergency units had a history of being multitreated with long prescriptions (antibiotics, antivirals, steroids, NSAIDs, multivitamins) for several days. This sometimes affected the prognosis of patients due to the delay in hospital care, modifying the evolution of the disease and favoring co-infections by opportunistic germs (fungi, mycobacteria, etc.) and nosocomial infections once hospitalized (Pseudomonas, Acinetobacter and Stenotrophomonas), with an increase in days of hospitalization, mechanical ventilation and an impact on morbimortality and the cost of care.[2]

The therapeutic guidelines issued by the Ministry of Health in 2021 for the management of the pandemic in Mexico attempted to show clearer treatment guidelines based on the weight of scientific evidence levels up to

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that time. In the world scientific literature there was too much information for and against several groups of drugs, leaving open the possibility of their use according to interpretation until better evidence was available.[3] The pandemic continues and others may emerge, so it is of utmost importance not to stop observing, analyzing and reflecting on how we can improve all the crucial points in the face of a health emergency of this size. It is important to continue strengthening our first level of care (community health centers, family medicine units and private clinics), in terms of their basic operating structure and with continuing medical education (dissemination of updated scientific knowledge). Likewise, it is necessary to improve the referral and counter-referral systems (rapprochement and coordination between levels of care) in order to avoid delaying the priority care of patients who require more specialized assessment and management. Finally, it is necessary to review the regulation and supervision of the operation of private clinics with records of patients treated in their communities.

The challenge continues and the reality is beyond us, so it is necessary to work together and organized at all levels of care and with all those who care for these patients.

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