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Perspective

# Limitations of COVID-19 Fever Clinic as the First Point of Contact: Are We Relying Too Much? An Experience from a Tertiary Center

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In Nepal, after the first case was diagnosed with Corona Virus Disease -19 (COVID -19) in a 32-year-old returnee from Wuhan, China on 13 January 2020,[1] it took more than four months to reach a figure of 500 infected cases.[2] Seventy of them have already recovered and returned home.[2] However, the curve has been taking a steeper slope after the first 50 cases were documented. With the first mortality from COVID-19 confirmed on 16th May, 2020, the fact that this pandemic is tightening its grip in the country is more evident now. And with each passing day, more cases are being diagnosed. In such a situation, strategies of screening the infected/ suspects are of paramount importance and those already in place should be strengthened.

On March 19, the Nepal Medical Council asked all hospitals, both private and public, with over 100 beds to operate a separate fever clinics and postpone elective surgeries to conserve resources for an outbreak.[3] Such fever clinics aim at separating and filtering out the suspected/ diagnosed COVID-19 patients. Arguably started first in Kathmandu Medical College, fever clinics now have been established and run in almost every large health care centers. United Nations International Children's Emergency Fund (UNICEF) has been pivotal in supporting some of these centers.[4] Rising up to the task, Lumbini Medical College and Teaching Hospital started its fever clinic from 22 March 2020 in a separate make shift place which later moved to a more organized structure. The fever clinic is set up at a separate area in order to keep off suspected patients from the main hospital.

Each day, an average of 200 patients are being screened in the fever clinic. A consultant-supervised resident doctor teamed up by an intern and a nurse run the fever clinic. They assess the symptoms of the patients e.g. fever paired with cough, sore throat, shortness of breath, diarrhea, assess their travel history and takes a temperature reading to determine further actions.

Despite such elaborate investment in terms of human and materialistic resources, fever clinics have clearly been not able to detect all the suspicious cases. Reports of cases being transferred to isolation ward after being attended in emergency department and some after being treated in the ward for days are few evidences.

The key problem is the asymptomatic status of many positive cases. People with no symptoms and history of travelling, who might have acquired infection from contact to other unconfirmed cases easily escape detection at fever clinics. Formulation and implementation of stringent protocols, dedicated contact tracing and testing might minimize this to some extent.

Owing to the fear of being denied admission or treatments in the hospitals, many patients resort to concealing their true history at fever clinics. Many fever-patients are found to have self-medicated with over the counter anti-pyretic prior visiting to the hospital. Amidst disturbing news of patients being turned away from hospitals floating on the media, such way-outs on part of the patients are only but expected.[5] This actually is leading to assimilation of suspicious cases with the non-exposed ones.

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As it is an entirely new disease, no country was adequately prepared for the pandemic. As such, many fever clinics which are newly constructed or converted from old unused set-ups are not ideally separated from the main hospital buildings or isolation wards. Suspected/confirmed cases, while being transported from fever clinics, thus not only face challenge during the transit but equally confer the high probability of exposing the hospital premises themselves.

With inadequate and substandard personal protective equipment, health care workers who dedicated themselves round the clock in fever clinics are at high risk of being infected themselves. Furthermore, the immense mental pressure they are withstanding just adds on to their plight. The flip side of this whole re-direction of the resources, attention and focus to fever patients is; unfortunate incidents of serious cases being missed or delayed of their care. Patients dying on the way while being bounced from one hospital to another are not unheard of.

Having said so, currently there is no other ideal alternative to fever clinics as screening mechanism at first point of contact in the current scenario. The solution lies in continuing to strengthen the effectiveness of fever clinics complemented with strategies of accurate tracing and testing, quarantine management, expanding isolation capacity and raising awareness.

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