Coronavirus disease 2019 (COVID-19) and spatial control in times of pandemic

Marcelo Carneiro MD, MSc1,2,4, Camilo Darsie PhD2,5, Janine Koepp PhD2,3,4, Andreia Rosane de Moura Valim PhD2,4, Lia Gonçalves Possuelo PhD2,4, Marina Weiss Kist1,2, Eliane Carlosso Krummenauer RN, MSc1,4, Rochele Mosman de Menezes PharmD, MSc1,4, Lea Vargas RN6 and Pola A Brenner RN, MSc7

1Hospital Infection and Epidemiology Control Committee, Hospital Santa Cruz, Rio Grande do Sul, Brazil, 2School of Medicine, Universidade de Santa Cruz do Sul, Rio Grande do Sul, Brazil, 3School of Nursing, Universidade de Santa Cruz do Sul, Rio Grande do Sul, Brazil, 4Strictu Sensu Program in Health Promotion, Universidade de Santa Cruz do Sul, Rio Grande do Sul, Brazil, 5Strictu Sensu Program in Education, Universidade de Santa Cruz do Sul, Rio Grande do Sul, Brazil, 6Consortium for Clinical Research in Health (CISVALE), Santa Cruz do Sul, Rio Grande do Sul, Brazil and 7Strictu Sensu Program in Healthcare-Associated Infections, Universidade de Valparaíso, Valparaíso, Chile

To the Editor—Coronavirus-19 infection (COVID-19) occurs through the spread of the severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2) among individuals, mainly by direct contact or droplet transmission when infected individuals cough or sneeze. Pulmonary epithelial cells are the main target of the virus.1

The worldwide proliferation of this virus has caused a pandemic capable of changing paradigms related to healthcare delivery, and the resources needed to cope with the disease have directly influenced the safety of medical care offered to individuals on a global scale. The purpose of interventions, such as social distancing, is to guarantee broad and safe assistance to the global population and to minimize uncontrolled viral spread. Notably, pulmonary epithelial cells are the main target of the virus.1

Unlike the 2009 influenza pandemic, the emphasis on spatial control with the COVID-19 pandemic has interfered with social, political, and economic relationships. This disruption has resulted in the destabilization of global geopolitics and the economy. The important concepts of space management and educational actions related to disease control originally emerged from previous health crises. These interventions can be considered geobiopolitical strategies, that is, actions directed at the control of life through geopolitical demands.4

At first, science was able to control contagious diseases and increase the survival of the populations exposed to them through biology (eg, isolation of populations by natural geographical barriers). However, with the increase in a mobile and diverse global population with different lifestyles and the inequalities related to health care, the dissemination of new infectious agents has occurred, primarily through the transmission of disease-producing viruses that have escaped the usual biological control mechanisms.

As more people worldwide aspire to better lives, it is no longer sufficient to control infections at any cost. We must learn how our interventions to control diseases not only impact population but also the lives of individuals. Such strategies are characterized as biopolitical actions associated with biopower. Biopower can be understood as the inclusion of biology in the context of politics. Using biopower, governments start to calculate and act on health issues aiming to strengthen the lives of populations as a group of individuals. Over the years, strategies to save and maintain the quality of human life have been highlighted. Biopower comprises the relationships among 3 dimensions: (1) universally held truths regarding the value of the individual and their quality of life and authorities willing to defend those truths; (2) different strategies that allow interventions in favor of life or death to occur; and finally, (3) allowing individuals to subjectively choose and act on their own behalf incorporating these universal truths.

In the case of COVID-19, the subjectivity regarding the importance of social isolation stands out, being considered a “norm” of safety to prevent infection or disease. Although a rational approach, considering the lack of actually efficient and/or sufficient treatment structures, this strategy generates...
An outbreak of coronavirus disease 2019 (COVID-19) in hematology staff via airborne transmission

Lisa Saidel-Odes MD1,2, Lior Nesher MD2, Ronit Nativ RN, MPH3 and Abraham Borer1,2

1Infection Control and Hospital Epidemiology Unit, Soroka University Medical Center and the Faculty of Health Sciences, Ben-Gurion University of the Negev, Beer-Sheva, Israel; 2Infectious Diseases Unit, Soroka University Medical Center and the Faculty of Health Sciences, Ben-Gurion University of the Negev, Beer-Sheva, Israel; and 3Infection Control and Hospital Epidemiology Unit, Soroka University Medical Center, Beer-Sheva, Israel

To the Editor—Severe acute respiratory syndrome coronavirus-2 (SARS-CoV-2) has caused the coronavirus disease 2019 (COVID-19) pandemic. The most common type of transmission is through large respiratory droplet particles. The 2 other accepted modes of SARS-CoV-2 transmission are direct contact and through inhaling aerosols.1,2 At the beginning of the pandemic, airborne transmission was recognized only for aerosol-generating procedures (AGPs) in healthcare settings. Since then, the World Health Organization and the scientific community are evaluating whether SARS-CoV-2 also spreads through aerosols in the absence of AGPs, particularly in indoor settings with poor ventilation.3

Hematopoietic cell transplantation (HCT) and cellular therapy recipients are unique populations at increased risk for complications from SARS-CoV-2.4 Currently, limited data exist on the epidemiology, clinical manifestations, and optimal management of COVID-19 in this patient population. Patients who have tested positive for COVID-19 should be isolated in negative-pressure room if available or in a neutral-pressure room.5

Our index case, a 48-year-old immunocompromised man with multiple myeloma IgA κ underwent an autologous stem-cell transplant on September 21, 2020. He tested positive for SARS-CoV-2 on a screening test 3 days later, and the cycle threshold (Ct) value was 15. He developed a high temperature and a dry cough, and a computed tomography scan demonstrated bilateral ground-glass opacities consistent with COVID-19. Treatment included convalescent plasma, remdesivir, and antibiotics. AGPs were not performed. He was discharged on October 8, and a nasal swab for SARS-CoV-2 PCR was still positive with a Ct value of 19.

The transplant unit includes 6 positive-pressure isolation rooms with high-efficiency particulate air (HEPA) filters; each has an anteroom with self-closing doors that cannot be opened simultaneously. Patient rooms are built to primarily assure patients

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