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EDITORIAL

Covid-19 and Physical and Rehabilitation Medicine

Since our last editorial the world has changed a lot. Coronavirus disease (COVID-19) has spread globally and very rapidly. It has changed medical priorities; the focus is now on saving the lives of persons who still have long life expectancies, scaling up intensive care unit (ICU) resources and, not least, providing sufficient and adequate personal protective equipment to keep people working near the infected patients safe.

Most of the departments of clinical Physical and Rehabilitation Medicine (PRM) in Europe have now closed part of their activities, at least for out-patients, and keep in contact with patients via telephone or telemedicine. Some PRM doctors and nurses have been transferred to other clinics and, in some cases, are directly involved in COVID-19 care. Other PRM professions, such as physiotherapists and occupational therapists, as well as social workers, have been trained as assistant nurses and are also working in COVID-19 care. Psychologists from the PRM departments are providing personal support to ICU staff. Thus, the work of the different professionals at the PRM departments has changed drastically, and this new way of working will continue for months.

Journal of Rehabilitation Medicine (JRM) has recently published 3 articles presenting overviews of the role of PRM in the COVID-19 pandemic (1-3). These articles, together with an informative video (4) concerning COVID-19 and rehabilitation issued by the European Academy of Rehabilitation Medicine (EARM), are also collected together on the homepage under the heading Covid-19 Corner. Upcoming articles concerning Covid-19 will also be shown here.

It is, of course, of utmost importance to continue the usual work within rehabilitation medicine in our core areas, including traumatic brain injury (TBI), stroke, spinal cord injury (SCI) and pain, and to keep these patients safe from infection with COVID-19. The virus affects not only the pulmonary function, due to acute respiratory distress syndrome (ARDS), but also other organs, including the cardiovascular system and the central nervous system (CNS). CNS involvement leads to hyposmia and dysgeusia, as well as alterations of consciousness and neuropsychological manifestations (3).

Mobilization of post-COVID-19 patients will often be a slow process, due to respiratory distress, with breathing problems and lung fibrosis, cardiovascular deconditioning and the long period of immobilization. Furthermore, psychological support and cognitive training are required (3). Due to the length of treatment on a ventilator in ICU one may also anticipate a large number of patients with acquired muscle weakness, including those with post-intensive care syndrome (PICS), who will need in-patient rehabilitation for longer periods of time (1–3).

Concerning the role of PRM in COVID-19, we conclude that now is the time to provide life-saving care for patients. However, the role of PRM in rehabilitation of patients in the immediate post-acute phase of COVID-19 is obvious. Following the acute phase of the pandemic there will be a surge in need for rehabilitation, including mobilization. The increased need for PRM efforts will last for months, if not years, including rehabilitation of secondary disorders, including PICS. This fact is well recognized by the different PRM bodies: the International Society of PRM (ISPRM), UEMS-PRM Section and Board, European Society of Physical and Rehabilitation Medicine, European Society of PRM (ESPRM) and the European Academy of Rehabilitation Medicine (EARM). We hope that this increase in requirement for PRM will also be recognized by healthcare authorities in order that PRM departments can be provided with adequate resources.

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