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MEDIA RELEASE

REHABILITATION FROM COVID-19 NEEDS INNOVATIVE PLANNING

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AUSTRALIA must prepare for the “aftershocks” from COVID-19 or risk leaving survivors of the virus struggling to rehabilitate, according to the authors of a Perspective published online today by the Medical Journal of Australia.

Associate Professor Steven Faux, Director of Rehabilitation and Pain Medicine at St Vincent’s Hospital, Sydney, and colleagues wrote that rehabilitation needs following COVID-19 were “broad, complex and include cognitive, motor and respiratory sequelae to the infection, acute respiratory distress syndrome, and the thromboembolic response”.

“In Wuhan, China, 36% of those with severe COVID-19 had neurological complications such as stroke, critical care neuropathy, and the complications of prolonged bed rest (eg, venous thromboembolism, disseminated intravascular coagulation, acute kidney injury, delirium anxiety, post-traumatic stress disorder),” they wrote.

“In Italy, rehabilitation physicians have been treating post-extubation dysphagia, impaired mobility, critical care myopathy and neurocognitive losses.

“In the US, hospitals have had to rapidly transition acute patients to rehabilitation hospitals. In New Orleans, a 1000-bed post-acute hospital was dedicated to post-COVID-19 disability, with rehabilitation teams treating patients battling persistent hypoxia, stroke and mental illness.

“The majority of patients who are ventilated for more than 7 days suffer complications that require rehabilitation, 60% are unable to walk, and 17% die within a year,” Faux and colleagues wrote.

“One-third suffer neurological complications, many require inpatient rehabilitation for over 3 weeks, and some take over 150 days to regain their capacity to walk independently. Others with stroke or cardiac complications of COVID-19 will require rehabilitation for up to 6 weeks, with some requiring lifelong support.”

Australia needed to plan now, not just for survivors in the initial post-acute stage of COVID-19, but also to manage individuals affected in subsequent waves.

“Such patients may require rehabilitation, along with those, fearful of infection, who present to hospital late with non-COVID-19 conditions like stroke, and those with deteriorating chronic diseases who have not had access to hospital based services.”

Faux and colleagues wrote that “many rehabilitation units are not prepared”.

“Inpatient rehabilitation units (public and private) are almost always working to capacity. COVID-19 patients will be expected to be accommodated in addition to usual patients (eg, strokes, spinal injuries, amputations),” they said.

Subsequent waves of COVID-19 would strain the rehabilitation sector.

“If Australia and New Zealand’s success at flattening the curve continues, our existing subacute sector will manage,” they wrote.

“If not, mobile rehabilitation teams will need to be expanded, systems for patient flow to the private sector will need to be operational, and enhanced tele-rehabilitation services will need to be working.

“This will require the same vision and leadership that made our acute COVID-19 response world leading, collaborative and publicly supported.

“In the UK and the US, we see the brutality of this pandemic, with mass burials and the tragic toll on health care workers.

“Australia and New Zealand have avoided this so far, but it is because we have planned well. We now need to prepare for the recovery phase because surviving may not be the same as living.”

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