Review of: "What Impact Have SARS-CoV-2/Covid-19 Pandemic induced lockdown on the number of OPD patients of Diabetes, Hypertension, Stroke (CVA), Acute Heart Disease, Mental Illness, Epilepsy, Ophthalmic, Dental and oncology in India during the lockdown months (April/May/2020) Observational Research Analysis?"

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It is a good attempt to capture the study of outpatients and inpatients scenarios during Covid times. The hypothesis has no novelty as the lockdown, and its subsequent effect on outpatient's hospitalisation have already been published[1]. Lockdown on public transport is known even to the lay public. This perhaps could have been analysed from a different perspective altogether. The impact of lockdown was very different in the larger cities compared to the smaller towns. The major tertiary care centres in metros were more affected than the smaller towns.

The methodology of the collection of data is a bit controversial. It could have been more focussed on different geographical areas and should have had a representative sample of government and private hospitals in that area. Wherever electronic medical records were available, the data would have been authentic. Having weekly trends using graphs would be visually appealing for the readers.

What has been observed and worrying during Covid times was that the acute admissions came down drastically. The published data on acute coronary syndrome and acute heart failure admissions in the country is ample proof. This data on many acute coronary syndrome admissions is remarkable because of the diversity in different states[2]. In Kerala, the health care system is hugely diverse, unlike Delhi. In Kerala the dip in acute coronary admissions was only an 8% decrease whereas in Delhi it was 50%. A similar situation in acute decompensated heart failure across south India was also observed[3]. Similar trends were observed in hospitals in Rajasthan[4].

Perhaps even more interesting fact is the sudden surge in outpatient and inpatient volumes in the hospitals worldwide. However, a few weeks later the pattern changed[5].

The discussion part needs to address many issues. Being routine visits, these were all postponed. The fear of catching covid from hospitals was probably an essential determining factor. Teleconsultation came in a big way, and most consultants and hospitals embraced this. Doctors had sufficient time to do this, and the novel option came in handy. All these have to be factored in. Moreover, the local village outpatient clinics catered to these patients, which was positive during covid times. The significant risk was sicker patients not reaching hospitals, and many died at home. The essential services and the nonavailability of specialised care in certain hospitals as it was only treating covid patients need to be emphasised. The shift from specialist care to the local primary contact needs to be analysed.

The limitation of the collection and reliability is a significant factor. This was not analysed state-wide / zone-wise, which could have given more value. The conclusion part needs to be short, though no novelty came out. However, developing a network among general practitioners, physicians, and hospitals needs to be considered for better delivery of health care services during such a crisis

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