The coronavirus disease 2019 (COVID-19) expanded worldwide, and as of now, it has not disappeared. People have concern about not only any issues related to the infection of coronavirus but also deterioration in the quantity and quality of medical care systems for other diseases, especially serious diseases, due to busyness in medical facilities. Cardiovascular disease, including stroke and coronary heart disease, is a serious disease requiring urgent medical care. Therefore, there is concern regarding change in medical care systems for cardiovascular disease during the COVID-19 pandemic.

As far as I know about Japan, to date, a few surveys have clarified the influence of the first wave of the COVID-19 pandemic on stroke care in limited areas of Japan. Ota et al.\(^1\) reported a decrease in the number of admissions due to stroke (−22%) and its subtype of large vessel occlusion (−22%) during the state of emergency (April and May 2020) compared to the preceding 2 months (February and March, 2020) before the declaration of the state of emergency at 19 stroke centers in the Tokyo metropolitan area. The number of total stroke admissions slightly recovered in the subsequent 2 months (June and July, 2020) after the declaration was lifted. However, the ratio of thrombectomy to total large vessel occlusion cases was not so different among these three periods. Koge et al.\(^2\) also reported that the number of stroke admissions decreased during the state of emergency (April and May 2020) compared to the preceding 2 months (February and March, 2020) before the declaration of the state of emergency at 19 stroke centers in the Tokyo metropolitan area. The number of total stroke admissions slightly recovered in the subsequent 2 months (June and July, 2020) after the declaration was lifted. However, the ratio of thrombectomy to total large vessel occlusion cases was not so different among these three periods. Koge et al.\(^3\) also reported that the number of stroke admissions decreased during the state of emergency and then increased after the lifting of the state of emergency. The COVID-19 pandemic prolonged the time metrics of patients with acute stroke who underwent reperfusion therapy, including the time from stroke onset to hospital arrival and the times from hospital arrival to imaging and to thrombolysis, compared with the preCOVID-19 period. However, the prevalence of modified Rankin Scale score 0–2 at discharge did not differ between the two periods before and after the state of emergency. Meanwhile, Ohara et al.\(^4\) reported that 13 stroke centers in Kobe city maintained medical care systems for stroke, with a temporal decrease in the number of stroke admissions between March and May in 2020, compared with the same months in 2019.

In this issue, Morishita et al.\(^5\) reported relevant issues regarding acute coronary syndrome (ACS) including acute myocardial infarction and unstable angina between July 2018 and June 2020. The authors analyzed data based on the Diagnosis Procedure Combination/Per-Diem Payment System\(^5\), which was collected from 265 advanced acute hospitals throughout Japan. The authors clarified an immediate reduction in the ACS cases per week (−18.3%) after the state of emergency in overall as well as in both seven prefectures, where a state of emergency was first declared, and other 40 prefectures’ subpopulations. The authors further clarified that the treatment approaches for the ACS and in-hospital mortality rate were broadly similar before and after the first wave of the COVID-19 pandemic in Japan. Despite several study limitations, this is a notable report having an indication that Japanese medical facilities maintained the quality of medical care (i.e., in-hospital mortality) for ACS during the first wave of the COVID-19 pandemic in Japan.

At end of this commentary, I would like to sincerely express my respect for all staff members at medical settings for COVID-19, cardiovascular disease, and any other diseases.
Conflict of Interest

None.

References