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realization that much of what has become dogmatic in cardiothoracic surgical training has been uprooted and redefined during this unprecedented time. The pandemic has required that we as surgeons and educators step back and take a thoughtful look and approach to how we are training our trainees, both from a fund of knowledge and technical standpoint.

Previous reliance on spending hours on the wards and in the operating room has become challenging in many training programs as a result of COVID-19. This has pushed our trainees into realizing the utility of the multiple online platforms that are available to them as described by Luc and Antonoff.¹ As the authors imply, taking this to the next level allows for the bridging of geography and institutional boundaries through the use of multimedia platforms. Multiple examples of this have been implemented on a small scale; for example the training program at MD Anderson is broadcasting their “debate style” journal club electronically for increased participation outside of the home institution. This concept of educational open access across cardiothoracic training programs can only strengthen the depth and breadth of experiences to which our trainees are exposed. Additionally an added bonus of these experiences is the ability of our trainees to “virtually meet” each other across the country, providing important networking opportunities that will only enhance their careers moving forward.

The vision of the Thoracic Educational Cooperative Group is that with multiinstitutional collaborative efforts we can accomplish more, and the critical importance of this type of educational strategy has never been more important. We agree with the Thoracic Educational Cooperative Group, Luc, and Anfonoff: Through every storm there is a silver lining. COVID-19 has shown us that as a specialty we can be stronger and more impactful with our educational efforts through collaborative efforts built out of necessity in the setting of a global pandemic. The ability to bridge geography, institutional boundaries, and previously held surgical educational dogma is now.

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Thoracic Surgery for Malignancy and Emergency Irrespective of COVID-19



To the Editor:

Two months have passed since the spread of the coronavirus disease 2019 (COVID-19) pandemic. In our editorial,¹ we reported that until March 24, 2020, a COVID-19 test by nasopharyngeal swab was offered to the patients presenting with symptoms of COVID-19. However, from April 2, 2020, we changed that policy, offering 2 COVID-19 tests by

nasopharyngeal swab to everyone undergoing thoracic surgery for malignancies before admission to our general university hospital, even if asymptomatic. Just in case both tests were negative for severe acute respiratory syndrome coronavirus-2, we admitted the patient. This measure may have improved the safety for patients and health givers. Moreover, during the period between the end of February and May 3, 2020, among the 203 patients admitted to our division for surgery, none developed COVID-19, except 1 patient who presented with COVID-19, 45 days after surgery and 39 days after the discharge.

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Thoracic Surgical Oncology in Lombardy: How to Do It During COVID-19 Time?



To the Editor:

The health emergency from coronavirus disease 2019 (COVID-19) requires special attention to lung cancer (LC) patients, vulnerable by tumor disease or by the effects of oncologic treatment and radiotherapy. Delayed LC operations could cause LC progressions with tumors that are no longer resectable. In stage I LC, a time-to-treat of more than 8 weeks was associated with a reduction in 5-year survival; in stage III LC, a lag between neoadjuvant therapy and surgery of more than 3 months was associated with shorter median survival.^{1,2}

In March 2020, to avoid the complete stop of oncologic surgical procedures, Lombardy designed a hub system that diverted all cancer patients to our Comprehensive Cancer Centre. Until April 10, 2020, all in our institution patients received an extensive COVID-19–related history interview, but the swab test was done only in symptomatic patients. Nonetheless, this approach resulted in a biased selection.

Despite the current lack of robust data,³ our Thoracic Surgery Division (first as volume and delivered quality in Italy) decided on testing for a baseline COVID-19 swab all LC surgical patients. The aim was to maintain, during COVID-19 epidemic, high-volume LC operations with well-established protected protocols and pathways.

From April 10, 2020, to date, even after a negative triage with temperature and medical history, in the days before hospital admission, COVID-19 swabs were tested for 58 entirely asymptomatic patients scheduled for endobronchial ultrasound or LC surgery. Of these, 7 patients (12.1%) had a swab positive for COVID-19 and were rescheduled for surgery.

In conclusion, our initial clinical evidence supports the mandatory use of the COVID-19 swabs as a screening tool in all asymptomatic patients who should undergo LC operations. The COVID-19 grid search in LC patients could decrease the in-hospital transmission (eg, indirect transmission between patients using the same bathroom with standard disinfection). Besides, the early identification of asymptomatic COVID-19