








COUNTER-REFERRAL DIFFICULTIES IN AN EMERGENCY CARE UNIT: IMPACT OF COVID-19

Brenda Meinschein Freitas¹ 
Eliane Regina Pereira do Nascimento¹ 
Patricia Madalena Vieira² 
Luciana Bihain Hagemann de Malfussi¹ 
Fernanda Forster¹ 
Mirelly do Amaral¹ 
Ximena Alejandra Navarro Maldonado³ 

¹Universidade Federal de Santa Catarina, Programa de Pós-Graduação em Enfermagem. Florianópolis, Santa Catarina, Brasil.

²Secretaria Municipal de Saúde de Florianópolis. Florianópolis, Santa Catarina, Brasil.

³Universidad de Magallanes, Departamento de Enfermería. Magallanes, Punta Arenas, Chile.

ABSTRACT

Objective: to describe the influence of the COVID-19 pandemic on counter-referral in an Emergency Care Unit.

Method: a descriptive, qualitative study conducted with 13 health professionals. Data were collected through individual, semi-structured interviews and analyzed using the Collective Subject Discourse technique.

Results: five speeches were extracted from the interviews about the influence of the pandemic on counter-referral which reveal the difficulties in this process: before the pandemic, overcrowding of specific basic health units that were unable to absorb the population demand and a lack of professionals in teams stood out; the difficulty during the pandemic was in relation to prioritizing care for respiratory symptomatic patients in basic units and the use of communication technology in care and scheduling appointments; there is still difficulty in the transpandemic time in providing care in basic units and the consequent overload in the Emergency Care Unit.

Conclusion: COVID-19 had a negative impact on implementing counter-referral with difficulties in logistics, resources and structure, represented by access for the general population, which was even more limited in basic units due to the pandemic.

DESCRIPTORS: Nursing research. Qualitative research. Emergency medical services. Referral and consultation. Transitional care. Nursing. Pandemics. COVID-19.

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DIFICULDADES DA CONTRARREFERÊNCIA EM UNIDADE DE PRONTO ATENDIMENTO: IMPACTO DA COVID-19

RESUMO

Objetivo: descrever a influência da pandemia pela COVID-19 na contrarreferência em uma Unidade de Pronto Atendimento.

Método: pesquisa descritiva, qualitativa, realizada com 13 profissionais de saúde. Os dados foram coletados por meio de entrevista individual, semiestruturada e analisados a partir da técnica do Discurso do Sujeito Coletivo.

Resultados: das entrevistas foram extraídos cinco discursos sobre a influência da pandemia na contrarreferência, os quais revelam as dificuldades nesse processo: antes da pandemia destacou-se a superlotação de unidades básicas de saúde específicas que não conseguiam absorver a demanda populacional e a falta de profissionais nas equipes; durante a pandemia a dificuldade foi em relação à priorização dos atendimentos de pacientes sintomáticos respiratórios nas unidades básicas e ao uso de tecnologia de comunicação nos atendimentos e agendamento de consultas; no momento da transpandemia segue a dificuldade de atendimento nas unidades básicas e a consequente sobrecarga na Unidade de Pronto Atendimento.

Conclusão: a COVID-19 impactou negativamente na concretização da contrarreferência com dificuldades de logística, recursos e estrutura, representadas no acesso da população em geral, ainda mais limitado às unidades básicas com a pandemia.

DESCRITORES: Pesquisa em enfermagem. Pesquisa qualitativa. Serviços médicos de emergência. Encaminhamento e consulta. Cuidado transicional. Enfermagem. Pandemias. COVID-19.

DIFICULTADES DE CONTRAREFERENCIA EN UNA UNIDAD DE ATENCIÓN DE EMERGENCIA: IMPACTO DEL COVID 19

RESUMEN

Objetivo: describir la influencia de la pandemia de COVID-19 en la contrarreferencia en una Unidad de Atención de Emergencia.

Método: investigación descriptiva, cualitativa, realizada con 13 profesionales de la salud. Los datos fueron recolectados mediante entrevistas individuales semiestructuradas y analizados mediante la técnica del Discurso del Sujeto Colectivo.

Resultados: de las entrevistas se extrajeron cinco discursos sobre la influencia de la pandemia en la contrarreferencia, que revelan las dificultades de este proceso: antes de la pandemia, la sobrepoblación de unidades básicas de salud específicas que no lograron absorber la demanda de la población y la falta de profesionales destacaron en equipos; durante la pandemia, la dificultad estuvo en relación con la priorización de la atención a pacientes sintomáticos respiratorios en unidades básicas y el uso de tecnologías de comunicación en la atención y programación de citas; en el momento de la transpandemia aún existe dificultad para brindar atención en las unidades básicas y la consecuente sobrecarga en la Unidad de Atención de Emergencias.

Conclusión: El COVID-19 impactó negativamente en la implementación de la contrarreferencia con dificultades en logística, recursos y estructura, representadas en el acceso de la población en general, que quedó aún más limitado a las unidades básicas debido a la pandemia.

DESCRITORES: Investigación en enfermería. Investigación cualitativa. Servicios médicos de emergencia. Referencia y consulta. Atención de transición. Enfermería. Pandemias. COVID-19.

INTRODUCTION

The COVID-19 pandemic at the beginning of 2020 created a challenging global scenario in relation to public health with the international spread of the disease¹. Brazil also suffered consequences from the pandemic², being a country marked by diverse contexts, mainly in relation to inequalities, whether through the provision of health services or access, especially regarding medium and high complexity services.

In view of this, reorganization of the Healthcare Network (*Rede de Atenção à saúde – RAS*) through patient care flows, and the functions of each point of care and articulation between them through the referral and counter-referral system, were some of the strategies adopted to combat the pandemic, enhancing the cure and survival chances of patients and minimizing the disease transmission³.

Primary healthcare (PHC) played a fundamental role in implementing care flows for patients with mild symptoms, reducing the burden on intermediate care services and referral hospitals. This organization made it possible for highly complex services to focus attention on the most serious cases of the disease, being an essential factor in combating the pandemic⁴.

It is also important to highlight the role of Emergency Care Units (*Unidades de Pronto Atendimento – UPA*) in this context. These units aim to attend patients with health conditions of intermediate complexity. Therefore, they can resolve most urgencies and emergencies. Health services had to undergo major reorganizations during the pandemic, for which *UPA* acted vigorously in this process in caring for patients suspected of having this disease, from their reception at the unit, to screening, consultations, exam collections, retests, diagnosis, and until stabilization, discharge and transfer of patients⁵.

Thus, care transition stands out, being defined as a group of actions planned to ensure safe coordination and continuity of care when patients undergo a change in their health situation or need to be transferred from one location to another within the same location, service, or even between different healthcare levels⁶. In this movement, counter-referral or vertical communication is configured as a strategy that facilitates the care transition process between *RAS* care points, being considered fundamental for the continuity of healthcare⁷.

However, the literature highlights an incipience in care transition between services of different technological densities, with repercussions not only on the continuity of care, but also on patient safety⁸. Thus, considering that PHC is responsible for coordinating care and organizing the *RAS*, it is recommended to develop a regulatory system centered on PHC using clinical protocols which favor qualifying the referral and counter-referral process⁹.

In view of the above, the present study is justified by the relevance of counter-referral in care transition from the *UPA* to PHC with a view to continuing healthcare and patient safety, especially in the context of a pandemic. In turn, the guiding question of this study is: How did the COVID-19 pandemic influence counter-referral in an Emergency Care Unit in Brazil (*UPA*)? This study aimed to describe the influence of the COVID-19 pandemic on counter-referral in a *UPA*.

METHOD

This is an exploratory and descriptive study employing a qualitative approach, reported according to the international guide Consolidated Criteria for Reporting Qualitative Research (COREQ)¹⁰, conducted at the Norte de Florianópolis *UPA*, Santa Catarina, Brazil. The unit was opened in 2008, being characterized as size III, in which 29 doctors and 16 nurses work.



A total of 13 professionals participated in the study considering the following inclusion criteria: being a doctor or nurse focused on adult clinical care in the *UPA*, working in the period before, during and trans-pandemic with participation in counter-referral. No exclusion criteria were adopted in the investigation and sampling was done by convenience.

Face-to-face contact was initially made with the *UPA* Nursing Coordinator before starting the study, during which the project objectives and data collection technique were presented, the project was requested to be disseminated among the medical and nursing professionals, encouraging participation, and permission was requested to start data collection.

Professionals who met the eligibility criteria were personally invited during working hours to participate in the study, at which time they were informed about the objectives and procedures, in addition to scheduling data collection and signing the Informed Consent Form (ICF).

Data were collected from April 11 to July 30, 2022, through an individual semi-structured interview, with questions related to the personal characteristics of the participants (age, gender, professional category, time since professional training and additional training), and regarding patient transfer from the *UPA* to PHC before and during the COVID-19 transpandemic period.

The script used in the interview was adapted from another study¹¹. The interviews were performed by one of the authors, mostly in person in a private environment at the *UPA*, during the day and night, had an average duration of 25 minutes, and were recorded and later transcribed in full. Two interviews took place online through a free digital platform. The interviews ended when all professionals who agreed to participate in the study were interviewed. Transcripts were personally delivered to the participants for validation.

The Collective Subject Discourse (CSD)¹² technique was used in the analysis, which comprises a synthesis-discourse prepared with parts of statements with similar meaning. The technique involves the following methodological figures: Key Expressions (KEs), which constitute the most relevant excerpts from the statements and enables highlighting the Central Ideas (CIs), which express the meaning or significance of the statement; Anchoring (AC) is used when the author of the speech uses a theoretical or ideological basis to support their statement. However, the AC methodological figure was not identified in this study. Finally, Collective Subject Discourse (CSD) was then used, which is the result of grouping the KEs, whose CIs or AC have a similar meaning¹².

The statements were transcribed into the Microsoft Word program, grouped and organized according to the question asked and the response from each professional. Next, the KE and their respective CI were identified in the statements. The KEs of all participants whose CI were similar or complementary then gave rise to the CSD. No software was used in data analysis.

The study followed the recommendations of Resolution No.466, of December 12, 2012, of the National Health Council, and was approved by the Research Ethics Committee of the Federal University of Santa Catarina. Participants signed the ICF and were identified by the letter "I" (Interviewee), followed by the sequence number of the interviews (I1, E2...).

RESULTS

A total of 13 of the 24 eligible professionals participated in the study. The 11 non-participants had diverse reasons such as lack of interest or withdrawal, lack of response after contact via Whatsapp® for the interview, or sick leave.

Eight (62%) nurses and five (38%) doctors participated in the study, with the majority (n=8; 62%) being female. There was a predominance of the age group between 37 and 48 years old (n=11; 85%). The majority of professionals (n=11; 85%) declared themselves as white. Regarding professional training, the majority (n=10; 77%) completed their undergraduate degree more than 10 years ago. All 13 interviewees (100%) have additional training, highlighting specializations in different areas such as

oncology, dermatology, obstetrics, auditing, public health, geriatrics, occupational nursing, acupuncture and intensive care, with emphasis on specialization in urgency and emergency (n=5; 38.5%).

Only two of the 13 participants have residency training (oncology and family and community medicine) and one has a Master's degree (public health).

Next, five CSDs emerged from the statements. CSD1 portrays the difficulties of UPA professionals in counter-referral before the pandemic, which involves overcrowding of certain basic health units which are unable to absorb population demand, as well as the lack of professionals or even health teams in these units.

CI1: Specific basic units were overcrowded and with outdated teams

CSD1: *There were more specific difficulties before the pandemic. There were some specific basic units that had some type of problem. For example, overcrowded units, such as Ingleses and Rio Vermelho, are basic health units which cannot absorb the demand very well because they have fewer teams or, occasionally, when the unit was short of doctors or on leave. The patient ended up going to the basic unit, receiving first care from the nurse or health agent who informed them that there was no doctor available to assist them. So, these patients ended up returning to the UPA. This always happens, it never stopped happening, but pre-pandemic it was less than it is today (I2, I3, I5, I7, I8, I9, I10 and I11).*

CSD2 highlights the difficulty of prioritizing care for COVID-19 cases at the basic health units during the pandemic period, which had a negative impact on patients with chronic illnesses or pregnant women, as they were left without routine monitoring in PHC.

CI2: Prioritization of care for COVID-19 cases at basic health units

CSD2: *Counter-referral worsened with the pandemic because health units prioritized the care of respiratory patients. So, other non-symptomatic patients were left a little aside. I understand that it was necessary at the beginning of the pandemic, but I realized that it disorganized the network. We had pregnant patients with complications without having received prenatal care and they came straight here to the UPA, providing care for pregnant women without requests for exams, already in the second and third trimester. Patients with chronic illnesses were generally left without follow-up, the unit only renewed medication prescriptions. So, it was bad enough for people to have access. As care was greatly restricted during the pandemic, the referral of patients from the UPA to the basic health units was practically non-existent (I3, I4, I5, I7, I9, I10, I11, I12 and I13).*

Also in relation to the pandemic period, CSD3 portrays further difficulties faced by patients in accessing information, the health team in their territory and scheduling appointments at basic health units, with the use of technology implemented *a priori* to facilitate such access.

CI3: Use of technologies for service at basic health units during the pandemic: Whatsapp® in counter-referrals

CSD3: *Another factor that made the counter-referral process difficult was the service via Whatsapp® in basic units, because it was very difficult for patients to get information. As the demand is very high, I imagine that the units must have received many messages per day and thus it was difficult to prioritize those who needed a more urgent response. On the one hand, using Whatsapp® for customer service was good because they were able to serve more people and resolve some processes such as renewing prescriptions via Whatsapp®, but it was also bad, because not everyone was able to receive the necessary care. So, what I notice in relation to the reports I receive from patients is that access has become more difficult. The complaints were about the difficulty of scheduling, difficulty in*

accessing the team, that everything is via online scheduling, even with the referral role they need to do the entire process via Whatsapp® to get an appointment (I1, I4, I11 and I13).

CSD4 reveals the difficulty patients have in accessing the basic health units in the transpandemic period after medical referral. The long waiting time for consultation and the difficulty in accessing the family health team were highlighted among the components of this fragility.

CI4: The doctor refers them to the basic health unit, but the patient returns to the UPA

CSD4: I think the main weakness is the difficulty for patients to get care at the UBS, because they end up coming back. There are reports of difficulty in scheduling. Sometimes the waiting time is two, three, four days. The doctor often refers them to the health center and a few days later the patient returns to the UPA saying that they were unable to access the family health team to which they belong. There is a huge fragility in this situation, because it is a situation that should be observed by primary care, as the patient had their first care in a UPA and is being returned to the team, but, in fact, when they arrive at the UBS they are blocked. So, counter-referral in this sense is bad with UBS. I think this is a difficulty in the system, there should be better organization so they could be attended in a different way (I1, I2, I3, I4, I5, I6, I7, I8, I9, I10, I11 and I12)

CSD5 presents the perception of health professionals in relation to the increase in non-emergency demand in the UPA during the transpandemic period resulting from the difficulty in providing care in basic units and the immediacy of patients in obtaining care.

CI5: Increase in non-emergency demand at UPA during the pandemic

CSD5: The demand for patients with demands that were not urgent and emergency here at the UPA has greatly increased. As it is an emergency care unit and has to respond to the patient, they will be seen at some point no matter how long it takes to be seen. The UPA is 24 hours a day and does not have appointments. This makes it much easier and I believe it is one of the main reasons users attend the unit. So, a culture was created for the population to seek out UPA directly and the demand for the unit increased significantly. Some health centers have not yet resumed elective, spontaneous care. So, today we have a huge overload here at the UPA of non-serious cases. I imagine that there are a number of people who were not receiving treatment at the height of the pandemic and are seeking treatment now. I think COVID influenced the sense that during the pandemic patients didn't look for it. So, what patients did not see as extreme urgency, they postponed. And this has had a lot of impact, because patients are seeking care and they are not getting that care at basic health units (I1, I2, I3, I5, I6, I7, I9 and I13).

DISCUSSION

The transition of care between RAS points with a view to comprehensive, continuous, and coordinated healthcare which meets health needs involves counter-referral and can be favored by adequate organization for referrals between services of different complexities¹³. In this sense, the present study focused on understanding how the COVID-19 pandemic influenced counter-referral in a UPA, and revealed difficulties in referral in the pre-pandemic, during and transpandemic periods.

Difficulties in counter-referral related to access to primary care services that existed in the pre-COVID-19 period became even more prominent with the pandemic. In line with this, a scoping review study¹⁴ on the impact of COVID-19 on PHC showed that the pandemic placed additional pressure on pre-existing difficulties faced in integrating care pathways for patients with great social and health needs¹⁵.

The overcrowding of specific basic health units and the lack of professionals or even family health teams, understood in the present study (CSD1) as difficulties in counter-referral in the *UPA*, are corroborated by the literature as occurring prior to the pandemic. It is understood that the lack of professionals in PHC has been a difficulty for many years and that the family health strategy (*Estratégia Saúde da Família – ESF*) initiative, implemented in 1994, was an attempt to adapt this service to increase population coverage and encourage proximity between patients and their reference unit, which had results from the 2000s onwards. However, this expansion had a different pace when evaluating different regions of Brazil¹⁶.

Thus, the More Doctors Program (*Programa Mais Médicos – PMM*) was implemented in 2013, which advocated the emergency hiring of doctors, greater investment in primary care and expanding doctor training with a focus on valuing the basic health units¹⁷. This strategy contributed to strengthening population coverage and organizing the already-implemented *ESF*. However, this coverage is still unequal in the country, as even with strategies, difficulty in accessing health services is still one of the predominant challenges¹⁸.

Despite the difficulties in accessing basic health units, there is no denying the important role played by PHC in combating COVID-19, as family health teams in contact with the community favored the social distancing and isolation process, as well as surveillance of suspected or confirmed cases. This action helped to reduce the transmissibility of the disease^{19–20}. In addition to health surveillance, PHC services provided direct care to patients with COVID-19. Care was provided to those who presented mild or moderate conditions, being separated from non-symptomatic cases who required face-to-face care. Cases that required greater technological density were referred to other points of care, aiming for care continuity²¹.

Furthermore, it is noteworthy that actions in PHC to contain viral proliferation proved to be essential in protecting the health system, contributing to controlling the overload of high complexity. In this sense, an experience of building and implementing a flowchart for treating suspected or confirmed cases of COVID-19 impacted the direction and accessibility of patients treated at basic health units, reducing overcrowding in *UPA* and reference hospitals²².

If on the one hand, PHC acted favorably in confronting the pandemic, on the other hand prioritizing care for COVID-19 cases at the basic health units had a negative impact on monitoring patients with chronic diseases and pregnant women in primary care, as revealed in the speeches of participants (CSD2). This is particularly relevant considering the fact that hypertensive people, diabetics, pregnant women and children under five years of age constitute the groups most at risk for COVID-19²³.

International literature corroborates that the pandemic caused substantial interruptions in routine primary care provision, with emphasis on the loss of follow-up care for chronic patients²⁴, and justified by the increase in the number of patients with flu-like symptoms and the overload of health workers²⁵. Disruptions in chronic disease management caused by prioritizing acute and urgent care signal the need to strengthen primary care capacity to promote expanded access to regular health services during pandemics and to lessen the potential harmful effects of delay in patient care²⁴.

In line with this, the study highlights that it is essential to continue routine care in PHC, since health demands remain and the suspension of services at this care point can aggravate health-illness situations and increase the risk of suffering and death due to other causes²³.

A study conducted in Singapore implemented an indicator of the process and regularity of monitoring patients with chronic diseases in PHC, such as the number of follow-up consultations, the types of services provided and clinical parameters that remain within the ideal range through financial incentives for doctors, thus preventing a possible deterioration of these patients and subsequent need for specialized care²⁶.

Other difficulties related to counter-referral in *UPA* during the pandemic were attributed to the use of communication technology (CSD3) implemented during COVID-19 *a priori* to facilitate access to PHC services, but which hindered patients' access to information, to the health team in their territory and to scheduling appointments at the basic health units.

It is justified that primary care had to remodel care flows to continue its primary actions. Thus, measures were adopted, mainly in relation to the use of information and communication technologies, such as consultations via video calls (teleconsultations), prescription renewal and search for medication through a messaging application (WhatsApp®), essentially for patients with chronic conditions and belonging to priority groups such as pregnant women and infants²⁰⁻²¹.

An international study confirms that reorganizing primary care has often led to a reduction in access and quality of care, with adverse consequences for the health of many patients, and perhaps more seriously for the vulnerable, including those with existing health problems, older populations, victims of domestic violence and people with serious psychological and/or addiction problems²⁷.

In this context, the study recommends that developing a regulatory system centered on PHC, with an emphasis on information technologies, communication and clinical protocols, qualifies the referral and counter-referral process and strengthens PHC as a structuring element of the Unified Health System in Brazil (*Sistema Único de Saúde – SUS*)⁹.

Therefore, unlike what was evidenced in this study, the *UPA*'s counter-referral cannot have the strong appeal to the use of technology in basic health units limiting patient access as a barrier. It is often necessary to make rules more flexible and consider the possibility that not all patients are equipped with this resource or are proficient in its use, which places them in a situation of more or less social vulnerability. In agreement, a study suggests that primary care must exercise greater flexibility, resilience and responsiveness from now on in order to optimize patients' health outcomes and improve service delivery in future pandemic situations²⁷.

The difficulty in accessing basic health units continued to be highlighted during the transpandemic period, causing consequences in the *UPA* such as: the return of patients with non-urgent demand to this service after their counter-referral to PHC (CSD 4), or the search for it as the first gateway to the health system (CSD5), being motivated by: cultural issues of population preference for urgent and emergency services; due to the delay in the return of spontaneous and elective demand services at the basic health unit; and the search for treatment by those who chose to postpone their healthcare during the pandemic.

Thus, what occurred at *UPA* during the transpandemic period was an overload of the service, an aspect which requires an expanded analysis of the Emergency and Urgent Care Network (*Rede de Atenção às Urgências e Emergências – RUE*), so that it is more organized in future similar public health emergency situations, aiming to ensure the care required by the population at the care point which is most appropriate to their health needs.

In this sense, a PHC evaluation study contributes to this discussion when it highlights that reorganization of the work process in this care scenario in face of the pandemic should occur in order to preserve its attributes: First Contact Access, Comprehensiveness, Longitudinality, Care Coordination, Family Guidance and Community Guidance. However, in line with the findings of the present investigation, the First Contact Access attribute obtained the worst performance in the evaluation, suggesting a failure in the continuity of organizational situations which favor accessibility in PHC, such as scheduling an appointment, waiting time and availability of a telephone number to contact the service and professionals²⁸.

Another study also carried out in Brazil showed that “Access to first contact” during the pandemic was the attribute with the worst evaluation²⁹. Therefore, it is understood that planning and improving strategies to continuously strengthen PHC to meet the population’s health needs is opportune at any time and epidemiological situation, with a view to ensuring First Contact Access at basic health units and enabling the necessary conditions for counter-referral from the *UPA* and other *RUE* care points.

Despite this, the literature adds that frequent interaction between services of different technological densities is fundamental to guarantee effective and continuous care³⁰. A large part of the care provided at the *UPA* could be resolved and monitored at the basic health unit in order to avoid overload of the *UPA* and guarantee integration of these health units. Therefore, it is essential to formulate strategies to adjust the demand for these services, as well as provide guidance to the population on the service flows carried out at the different care points which compose the network¹⁸.

This study has a limitation of only investigating a single care scenario, which makes it impossible to generalize the results. Despite this, it is believed that the study contributes to advance knowledge in the Nursing area, and can support management and care actions at specific points in the Healthcare Network (*RAS*). It is also believed that carrying out new studies on this topic can reveal other counter-referral elements influenced by the pandemic, expanding the body of knowledge necessary for reflections, which can further prepare managers for the changes required in similar epidemiological situations that require a prompt response to health problems.

CONCLUSION

Counter-referral is fundamental in organizing health services and in care comprehensiveness. However, COVID-19 had a negative impact on its implementation with difficulties in logistics, resources and structure. It was evident that counter-referral presented fewer weaknesses before the pandemic and afterwards. The difficulties of counter-referral include overcrowding of basic health units, the lack of professionals and the difficulty for patients accessing their healthcare team, being reported both before and after the pandemic.

In relation to the pandemic, the counter-referral process and care continuity for the population were hampered, as basic health units focused on symptomatic respiratory patients. Furthermore, it was highlighted that the use of communication technologies implemented to maintain patient care caused access difficulties in the basic health units.

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NOTES

CONTRIBUTION OF AUTHORITY

Study design: Freitas BM, Nascimento ERP.

Data collection: Freitas BM, Nascimento ERP.

Data analysis and interpretation: Freitas BM, Nascimento ERP, Vieira PM, Malfussi LBH.

Discussion of results: Nascimento ERP, Vieira PM, Malfussi LBH, Forster F.

Writing and/or critical review of content: Nascimento ERP, Vieira PM, Malfussi LBH, Forster F, Amaral M, Maldonado XAN.

Review and final approval of the final version: Freitas BM, Nascimento ERP, Vieira PM, Malfussi LBH, Forster F, Amaral M, Maldonado XAN.

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CORRESPONDING AUTHOR

Brenda Meinschein Freitas.

brenda24freitas@gmail.com

