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Editorial

COVID-19 Pandemic and the Response of Surgical Team - 3

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KEYWORDS

Covid 19; Non urgent surgery; Emergency surgery; Trauma; Ethics; Priority

INTRODUCTION

The current COVID-19 pandemic is most challenging for healthcare systems all over the world. The most difficult part for the surgeons is to change their usual focus from trying to benefit their individual patients to focusing on the benefit of the community. This shift from patient-centred ethics to public health ethics has occurred in many ways throughout the world. Many patients had their surgeries postponed due to the pandemic. Surgeons had to cancel their patients' non urgent operations, even though the patients needed surgery and patients accepted the risks of having surgery with unknown COVID-19 status. The risk of perioperative morbidity and mortality increased when operating on patients with either asymptomatic or symptomatic COVID-19. During the postoperative period, if patient develops fever or pulmonary complications will lead to diagnostic challenge which will complicate the recovery of patients from elective surgery. There is a possibility of performing elective operative interventions on patients with asymptomatic or mild form of COVID-19 which will lead to contamination of operative room and surgical equipment's, with increased risk of transmission of the COVID-19 infection to surgical team and other healthcare providers in hospitals. Most of the surgeons explain operations to patients and a shared decision is made giving high priority to patient choices. As scarcities of materials increase, surgeons frequently unable to respect patient's choice as much as they have traditionally done. During COVID-19 pandemic surgeons and health care organizations responded appropriately and cancelled many elective surgical procedures. Many cancer screening procedures were stopped, and priority was given to urgent cancer treatment. Endoscopy and proctological procedures were performed highly selectively. Preservation of emergency surgical response takes top priority. Critical services such as trauma, thoracic surgery, vascular surgery, and neurosurgery were continued to be operated when rosters for the COVID-19 duty was prepared. Surgeons prioritized operations that are both surgically necessary and time sensitive to perform. Patient needing an emergency operation was not cancelled. Most tricky one is to decide which operations to proceed with and which can wait is this unusual circumstance. All invasive Cardiovascular and cancer surgeries were cancelled if not urgent when there are high risk factors (age > 60 y, HTN, DM, smoking history, CAD, CHF, COPD). Efforts were made to temporarily postpone urgent cases using nonoperative means and discharge patients home at increasing rates.

HIGH PRIORITY

Patients requiring an emergency operation within 24 h to preserve life.

- Patients with acute conditions which may cause irreversible harm if not operated on urgently i.e. within 72 h. [ex.

gastrointestinal bleeding, bowel obstructions, or spine fracture with spinal cord compression etc.]

- Lifesaving or limb-saving procedures, such as oncology and limb revascularization operations, were prioritized.
- Trauma patient were not delayed for evaluation COVID-19 status but took appropriate precautions.

INTERMEDIATE PRIORITY

Patients scheduled to be operated on within 4 weeks with the intention of cure and prevention of progression of the disease to an inoperable stage or secondary complications. Interventional radiological or gastroenterological procedures (e.g. stents) were utilised in cases where operative intervention has been postponed.

LOW PRIORITY

Cancers amenable to pharmacological, endoscopic, radiotherapy AND early cancers (i.e. T1N0) or with low aggressiveness; surgery were deferred over 2 months without negative consequences.

Due to anticipated shortages of medical providers, many surgeons were called on to provide medical care that is outside of their usual comfort zone. Post Anaesthesia Care Unit (PACU), operating rooms, and even hallways were converted into ICU beds. A large theatre room could house 4 to 6 patients. By reducing the number of surgeries many saves resources were saved like blood, ventilators hospital beds, personal protective equipment, as well as preserving the health of surgical staff. Appointments were given only to urgent and emergency surgical cases only. Restriction of visitors to immediate families was done. All procedures done at patient bedside if not possible do it in OR. In many cases, the possibility of conservative treatments that have been proven to be safe options were followed (eg antibiotic treatment in young patients with incipient acute appendicitis, conservative treatment of certain acute cholecystitis, etc. Steps were taken to reduce the chance of undiagnosed COVID-19 patients entering the "clean" OT, risking disease transmission, and compromising provider safety. Surgery was done depending on the urgency of the condition needing surgery, overall health of the patient and any other medical condition, local COVID-19 activity, local stores of PPE supplies, length of inpatient recovery, whether or not recovery requires care in the ICU. Patients were priority. Considerations for the health care people were undertaken. They are facility policy should require face coverings for all patients, staff, and visitors, hand sanitizer must be readily available to all patients, staff, and visitors, temperature checks are required for patients, staff and visitors; optimal social distancing policy should followed. Restoration of elective activity was guided by avoiding harm and mitigating risk of deferral of procedure or services in line with clinical guidelines, and appropriate use and supply of PPE. Certain clinical decisions were made like procedures representing low risk, high value care, selection of patients who are at low risk of post-operative deterioration, children who require essential procedures have exceeded clinical wait times, assisted reproduction, Endoscopy, cancer screening programs.