SASA
SOUTH AFRICAN SOCIETY OF ANAESTHESIOLOGISTS

SASA COVID-19 UPDATE

Issued 23 April 2020, 15h00

A PRAGMATIC APPROACH TO SURGERY DURING COVID-19 PERIOD IN SOUTH AFRICA

COVID 19 represents a particularly dynamic working environment for us all. Part of this reality is the relaxing and then tightening of lockdowns, regionally and nationally for the foreseeable future. This document provides a framework to apply through these periods and should be tailored to suit the lockdown in force in your specific area at any time. As the duration of the pandemic is unclear, but forecast to extend well past 3 months, this guideline is now essential. We do not propose an explicit list of what constitutes protocols in each category of procedure or surgery, but rather a definition that we encourage surgical/ procedural teams to classify patients into.

In this document we present:

- Principles to be applied throughout procedural care during the Covid19 Pandemic
- Procedural / Surgical care during an ease or no lockdown period during the Covid19 pandemic

Principles to be applied throughout procedural care during the Covid19 Pandemic

STIR

- **S**creening: All persons entering healthcare facilities (patients, visitors, deliveries, HCWs) should be screened at least daily. Repeat screening should take place with patient movement within facilities (to other departments/ wards).
- **T**esting: Should be guided by screening, facility resources and NICD guidance for patients and HCWs.
- **I**nfection Control: Education (donning, doffing, hand hygiene), implementation and monitoring should be continually improved, adapted, applied and reinforced.
- **R**esource assessment should occur at least *daily* at any facility that facilitates procedures and surgical interventions. Resource assessment should provide for increased numbers of admissions and care per day, and not be running at full capacity. At a minimum this should include:
    - Critical care bed, ward bed and equipment availability
    - Human resources incl. nursing staff, ancillary staff, surgical, anaesthesia & critical care staff
    - PPE (Personal Protective Equipment) availability
    - Medication and consumables
    - Reserve for anticipated admissions – consider dynamic admission statistics, local regional and national COVID19 prevalence and burden of disease.

We encourage each local facility to establish a Covid19 Team inclusive of representatives from hospital management and the disciplines of anaesthesia, surgery, internal medicine, infectious disease and critical care to assess and discuss resources collaboratively

There will be marked and dynamic **regional differences** in COVID admissions and resource. Every Anaesthesiologist and team must react to the challenges of their own institution and locality in accordance with resource assessment and NICD published guidance.

All advice published subscribes to adherence of legal framework and strategy provided by Government and the NICD. "STIR" Principles apply to both circumstances.

During the period of a "lockdown" we recommend avoidance of anaesthesia / procedures for Discretionary elective and Essential surgery.

Procedural / Surgical care during an ease or no lockdown period for the Covid19 pandemic

PICUP

- **P**rocedural selection: Triage and stratify cases by indication and urgency. Avoid discretionary elective surgery (see definitions below).
- **I**ntervention adjustment: To least invasive, least procedure duration and least time spent in hospital in order to limit morbidity, COVID spread and mortality. Where possible there should be prioritisation of day case surgery and those that should not require ICU care.
- **C**onsent for COVID 19: COVID19 positive patients, even if asymptomatic or if the disease is contracted post operatively during surgical recovery, may have ***significantly*** increased morbidity and mortality.[3] Adequate consent detailing these risks and assisting with risk-benefit considerations is mandatory to communicate. Each independent practitioner should obtain this understanding and consent.
- **U**nburden usual hospital systems to enable in-hospital and patient social distancing measures, thereby limiting likelihood of patient and staff COVID 19 spread. This includes staggering of admission times, planned increased turnover time between cases *(allowing for donning and doffing of appropriate PPE, extubation, application of a surgical mask and aim for recovery of patients in theatre – limit number of patients in recovery room if required)* and intermittent ward rounds to discharge patients undergoing day case procedures.
- **P**ost-operative screening, follow up and the provision of self-monitoring forms (as per NICD symptom monitoring forms or adapted) should be routine to ensure patient awareness and responsiveness to symptoms is heightened and acted upon.

Although COVID – 19 is a clear risk to all, it is but one of many competing risks for patients requiring surgical care.

Local resumption of surgery should follow the SASA Recommendations on Personal Protective Equipment (PPE) for anaesthesia providers during COVID-19 (4th April 2020), and SASA Recommendations for Workflow and Anaesthesia for COVID-19 Patients Presenting to the Operating Theatre (24th March 2020) which includes suggestions to minimize environmental contamination.

Definitions of Indication and urgency of Surgery/ Procedure

Discretionary Elective surgery *or* ***Discretionary elective procedure*** *is surgery that is scheduled in advance and where postponement of the surgery/ procedure will not result in the patient's outcome or quality of life being significantly altered by more than a 3 month delay.*

Essential surgery *or* ***Essential procedure*** *is surgery that is scheduled in advance and where postponement of the surgery/ procedure will result in the patient's outcome or quality of life being significantly altered if extended past 2 weeks to 3 months.*

Urgent essential surgery *is a surgery that must be performed in order to preserve the patient's life or limb or prevent longer term systemic morbidity, but does not need to be performed immediately and should be generally performed within 2 weeks.*

Emergent and Urgent surgery *is one that must be performed without delay or until the patient is medically stable; the patient has no choice other than to undergo immediate surgery if permanent disability or death is to be avoided.*

References:

1. Health Systems Respond to COVID-19 Technical Guidance #2 Creating surge capacity for acute and intensive care Recommendations for the WHO European Region (6 April 2020) http://www.euro.who.int/ data/assets/pdf_file/0006/437469/TG2- CreatingSurgeAcuteICUcapacity-eng.pdf
2. American College of Surgeons: Local resumption of Elective Surgery Guidance (17 April 2020): https://www.facs.org/-/media/files/covid19/local_resumption_of_elective_surgery_guidance.ashx
3. Lei S et al. Clinical characteristics and outcomes of patients undergoing surgeries during the incubation period of COVID-19 infection. EClinicalMedicine. 2020 Apr 5:100331. doi: 10.1016/j.eclinm.2020.100331. https://www.thelancet.com/pdfs/journals/eclinm/PIIS2589-5370(20)30075-4.pdf
4. Stahel, P: How to risk-stratify elective surgery during the COVID-19 pandemic? Patient Safety in Surgery, 2020 March 31.