

COVID-19 Pandemic Disrupted Elective Surgery Routines

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In December 2019, a novel coronavirus disease termed COVID-19, caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), emerged in Wuhan, China [1]. The number of cases has increased all over the world and over 7,000 individuals have died during the early phase of the epidemic [2]. On March 11, 2020, the World Health Organization (WHO) has declared COVID-19 a global pandemic [1]. In an effort to control disease transmission and conserve personal protective equipment (PPE), non-urgent tests and elective procedures have been suspended and the medical community has faced one of the most drastic changes in the scenario of clinical and surgical practice [3-6].

A survey conducted by COVIDSurg Collaborative performed an analysis of 13 articles (12 from China and 1 from Singapore) and interviews with surgeons and anesthesiologists with experience in outbreaks of infectious diseases [5]. The study showed that suspensions and reductions of elective surgeries are quite complex and involve benefits that go beyond reducing exposure and risk of infection for surgical patients (and their companions), as well as the risk for them to transmit the virus [5]. The attitude of suspending or reducing elective surgeries during COVID-19 pandemic is also beneficial from an infrastructure perspective, as it promotes a substantial release of beds from general and ICU nurseries; and also allowing intensive care trained surgeons and anesthesiologists to be more available to work in emergencies [4,5]. This guideline establishes that most elective surgeries should be postponed, especially those that require intensive support [5]. However, interpreting the meaning of “elective” and balancing this definition with the patient’s health can become a challenge for even the most experienced surgeons [4]. Stahel (2020) highlights the importance of differentiating elective surgeries, suggesting to define them as essential or non-essential, in order to decide which surgical procedures could be postponed more safely and also considering the institutional capacity as well as pre and post-operative contexts of patients [2].

Outpatient clinics all over the world have also followed a similar recommendation, drastically reducing visits with the aim of preventing cross-infections and transmission of SARS-CoV-2 [5]. In this context, patients should be screened with as many telephone consultations as possible [5]. On the other hand, oncological surgeries present unique dilemmas, as late diagnosis and postponement of a definitive treatment can worsen cancer results and cause distress for patients and their families [5,6]. Thus, elective cancer surgery should be offered to as many patients as possible and radiological and endoscopic investigations for patients screened by telephone with high-risk priority symptoms should continue for as long as possible [5]. In the context of the postponement of definitive surgical intervention, high-risk patients may receive neoadjuvant treatment during this period, avoiding worsening of prognosis [5,6].

This scenario also demonstrates the importance of all specialties’ surgeons to be educated on personal protective equipment (PPE) and prepared to deal with COVID-19 in three main areas [5,7]. First, those admitted to the hospital for treatment of COVID-19 infection may develop additional problems that require surgical intervention, which can be particularly common among patients treated in the ICU who are at risk of complications [5]. Second, patients admitted with acute surgical pathologies that require intervention may have concomitant COVID-19 infection [5]. Such patients may present with gastrointestinal symptoms or fever, which is a common acute surgi-

cal presentation by itself [5]. Third, after surgery patients may develop respiratory symptoms or a fever of unknown origin, indicating possible nosocomial COVID-19 infection [5]. Therefore, healthcare teams must be trained for the immediate recognition and conduction in risk situations for COVID-19, seeking to preserve both the workforce and institutional capacity [5,7].

The biggest impact of postponing elective surgeries will be the accumulation of patients and the deterioration of time-sensitive conditions, which can be devastating [4-7]. As hospitals resume elective activities, patients with a benign course, but disabling conditions that potentialize within time, will probably not be prioritized, since clinical urgency will be taken into consideration [4]. Hospitals should plan how to deal with this situation effectively in order to ensure that elective patients have better outcomes. Healthcare teams must also be prepared for a high volume of surgical procedures to be performed.

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