LETTER TO THE EDITOR

Letter to Editor on: Surgical Practice in the Shadow of COVID-19 Outbreak

Dear Editor

We congratulate the authors for their publication on "Surgical Practice in the Shadow of COVID-19 Outbreak" (1). COVID-19 pandemic have forced the surgeons to continually evolve their clinical practices. Several leading organizations and studies have provided recent guidelines in this regard (2-5). The authors have duly summarized the tips for the prevention of Coronavirus infection for the surgeons and other staff. Regarding re-designing the operation theater a model of Rodrigues-Pinto et al. (6) for COVID-19 dedicated operating theatre (OT) should be followed. According to his model the complex is divided the into five zones: i) Entry dressing room, ii) Anteroom, iii) Operating Room, iv) Exit room, and v) Exit dressing room. The OT should have separate air-conditioning and humidification units with individual atmospheric air inlet and exhaust systems.

Authors have rightly pointed out that by wearing full Personal Protection Equipments (PPE) could interfere with personal communication. To anticipate these problems, we find that a team briefing, before the start of a case regarding the planning of surgical procedure, is of great help and must be used. Additionally, the surgical plan can be sketched out on the OT wall over a blackboard. The author's view of 'open surgery is superior to minimally invasive procedures is debatable and needs to be proved by future comparative studies. We believe that during the peri pandemic times, operative treatments requiring minimal invasion and shorter surgical times should be preferred (5). An open and maximally invasive surgery should be avoided to reduce the length of hospital stay and possible postoperative morbidity, thus reducing in-hospital spread of COVID-19.

The choice of anesthesia should be of a local or regional type, which can potentially reduce aerosolization and transmission of COVID-19 droplets. This type of anesthesia would also avoid postoperative nausea and vomiting associated with the general anesthesia. We agree that the aerosol generating procedures (AGP) during orthopedic surgery such as electric saw, pulse lavage, electric drill, and use of rasp/broach should be avoided. Wherever possible the use of hand drill, gigli saw, osteotome, charley spoon, pencil reamer and nibbler instead should be used to minimize AGP. The authors' view on the non-use of NSAIDs is not evidence based and debatable, as no severe adverse events with COVID-19 have been yet reported with the use of NSAIDs (7). The Coronavirus tends to survive for many hours on different surfaces and hence it is crucial that the OT is properly disinfected prior and in between the two cases (8). Various techniques can be used for disinfection like the use of 0.1% sodium hypochlorite, ethanol (62–71%), Hydrogen peroxide vaporization and OT equipment can be cleaned with quaternary ammonium chloride disinfectant wipes (9).

We are not convinced that the trainees should be entirely set aside from the clinical services during COVID-19 outbreak. We have used their services effectively in the emergency departments and in COVID-19-related wards. Trainees are a good force for health care activity everywhere. The continuity of surgeries and seeing patients in the emergency department will maintain a level of practical education in these trainees.

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