COVID-19 and elective case triage for orthopedic surgery

The COVID-19 pandemic continues to challenge all the nations across the globe; even the ones with superior healthcare facilities. If we go by the projections, we are here for a long haul and probably not yet near the peak of the pandemic. The impact this pandemic will have on the healthcare and economic condition of our country is unknown. As surgeons, we have to be fully prepared and continue preparations as things change.

In the coming weeks, the COVID-19 cases are expected to sky rocket and hit a peak somewhere around April/May/June (we hope for the best). There will be variations in the case rates, timings, and peaks, and hence, we cannot accurately predict many aspects. However, the bottom line is, we all should be preparing!

In this regard, there is a global consensus that surgeons as an entity should be limiting "elective" surgeries as much as possible. The reason for the curtailing or limiting the amount of surgeries has potential benefits. The hospital beds, intensive care units, and the staff can be allotted to care for COVID-19 patients instead of routine surgical patients. With limited beds/million population even in the developed countries, it makes sense to keep hospital services ready for the pandemic. With supplies, even the basic ones such as mask and gowns in limited supply, it is of paramount importance that these be used for the frontline healthcare workers. Besides, we are also restricting the surgeons and other hospital staff from unwarranted exposure to COVID-19 patients. The laminar air flow and the air conditioning in the operation theaters are a good conduce for the virus. With regular surgeries, subsequent surgeons, staff, and even new patients are exposed to the virus.

Here are a few basic ground principles, we all surgeons must follow:

1. Patients must receive surgical care only in situations where life or part of the body is at stake. The judgment has to be based on clinical condition and the resources available
2. Consider nonoperative care whenever it is clinically appropriate
3. Avoid surgical procedures at night when there are few staff available and supplies not easily available
4. Aerosol-generating procedures (drills, reamers, burrs, electrocautery, saws, etc.,) increase risk to the healthcare worker but may not be entirely avoidable. In such situations, proper PPE, N95 masks, or air-purifying respirators must be used
5. Special care has to be taken while intubation/extubation procedures. Ideally, an anesthetist and a nursing staff must be the only two people inside the operation room (OR) during the same. Goes without saying, they must wear PPE and N95 masks
6. The surgery must be as minimally invasive as possible, with a short OR time, thereby minimizing risks to the surgeons and healthcare
7. Try and obtain proper history, COVID-19 test if possible, and a computed tomography chest for all surgical cases
8. Reduce the need for blood transfusions, wherever safe and feasible
9. Maintain negative pressure in OR, have a dedicated OR for the duration of the pandemic, and do not use laminar air flow
10. If exposed, stay in quarantine and get tested!

Success is not final, failure is not fatal; it is the courage to continue that counts

- Winston Churchill

When faced with a threat as pervasive as this virus, we must all do all part to protect not only ourselves but more importantly the ones we love who are at risk. However, it is also more important that we maintain calm and reason such that we do not burn down the very society that we are trying to protect. These are lessons from the past that we should remember.

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