Re-Starting Elective Surgery During COVID19 Health Crisis - Africa Perspective

Dr. Philomena Akoth Owende-Wandayi
FIGO-MAS Committee
Demographics

- Number of Countries: 54
- Current population: 1.3 Billion
- COVID 19 (16th July 2020)
  - Confirmed: 644,333
  - Deaths: 14,047
Introduction

So all a man could win in the conflict between plague and life was knowledge and memories.” Albert Camus French writer and philosopher in “The Plague” 1947.

• COVID-19 pandemic is approaching the peak incidence in Africa and has also highlighted the state of regional health disparities in the world

• Recovery and emergency plans including re-initiation and rescheduling the hundreds of postponed surgical procedures are underway

• As MAS surgeons in Africa, it is imperative we evaluate our potential to either perpetuate or mitigate longstanding regional disparities as we restart elective surgeries
Global consensus of Electives

“What will be like before after this pandemic,” …virus will not completely disappear from our societies.*

- Is elective surgery advisable on infected patients at all or should be generally postponed?
- General consensus: postpone elective, non-urgent surgery on COVID-19-positive patients.
- When and how should we start carrying out elective, non-urgent surgery on COVID-19-negative patients?

Limitations for reintroduction of MAS in Africa:

• Lack of human and material resources
• Need for technological support
• Challenges with training

Resolve: Rebuild our system to promote health equity

• Promote accountability and action at the level of:
  • Individual surgeons
  • Surgical departments
  • Entire healthcare delivery system
Example from Kenya: Considerations for Resumption of Elective Surgeries

5.3 Considerations for Resumption of Normal services and elective surgeries

Timing of resumption: There must be a sustained reduction in rate of new COVID-19 cases in the relevant geographic area for at least 14 days before resumption of elective surgical procedures and normal services, and the facility shall have appropriate number of intensive care unit (ICU) and non-ICU beds, personal protective equipment (PPE), ventilators and trained staff to treat all non-elective patients without resorting to a crisis standard of care.

The following should be considered:

- Does the facility have appropriate number of ICU and non-ICU beds, PPE, ventilators, medications, anesthetics and all medical surgical supplies?
- Does the facility have available numbers of trained and educated staff appropriate to the planned surgical procedures, patient population and facility resources?
- Can the facility perform planned procedures without compromising patient safety or staff safety and well-being?

www.health.go.ke Kenya Interim Guidance on Continuity of Essential Health services during the COVID19 pandemic
Surgeon level Actions

• Asymptomatic patients: Only patients without respiratory symptoms unexplained by concurrent illness will be offered elective surgery. Surgery will be deferred for COVID-19 positive patients

• Testing: All elective surgery patients will be tested within 24-48 hours prior to surgery. Patients will need to self-quarantine between the time of their test and their surgery
Testing strategy

*All elective patients should be tested prior to scheduling surgery*

- RT-PCR 1 week before surgery
- Optional RT-PCR 48–72 h before the surgery
- Home self isolation for 24-48hrs

Patients who pass both RT-PCR tests should be requested to self-isolate in their homes during the following 24–48 Wear a facemask and enforce social distancing
Surgical Department and Practice level Actions

1. Prevention and management of aerosol dispersal
   • Keeping instruments clean of blood and other body fluids
   • Attention at establishment of pneumoperitoneum, hemostasis, and cleaning at trocar sites or incisions to prevent any gush of body fluid caused by air leakage
   • Avoidance of untimely and unfiltered release of pneumoperitoneum
   • Liberal use of suction devices to remove smoke and aerosol during operations

2. Management of artificial pneumoperitoneum: keeping intraoperative pneumoperitoneum pressure and CO2 ventilation at the lowest possible levels

3. Reduction of Trendelenburg position time as much as possible to minimize the effect of pneumoperitoneum on lung function and circulation, in an effort to reduce pathogen susceptibility

4. Operation techniques: The power settings of electrocautery to as low as possible. Avoidance of long dissecting times on the same spot by electrocautery or ultrasonic scalpels to reduce the surgical smoke.

5. Operating staff protection: Raising awareness of the occupation protection on operating staff, including surgeons, anesthetists, and nurses and all possible transiting persons in the OR.
Prioritization and Scheduling of Elective Surgeries

Tier 1
ASA 1: No comorbidities, BMI<40, < 70 years, Surgery< 2 hours, Can be done as day care/1 day hospital stay 1 day

Tier 2
ASA 1: No comorbidities, ASA 2: BMI<40, well controlled DM/HTN < 70 years, Surgery< 3 hours, Inpatient, short LOS 1-2 days

Tier 3
ASA 3: 1 or more moderate to severe diseases or ASA1/2, >70 years, Surgery> 3 hours, LOS > 2 days

Tier 4
High risk comorbidities, Assumed ICU admission, LOS>4 days

Up-tiering: Any patient presenting more than two times to ER for Diagnosis Requiring Surgery should be considered Tier 1 if LOS< 4 days or Tier 2 if LOS> 4 days
Any patient requiring Surgical Treatment requiring Surgical Treatment prior to consideration for organ transplantation
Elective Diagnosis that becomes urgent/emergent
Health System level actions

Collaboration between private and public health institutions to address health disparities and increase access to MAS in Africa

• Systems-level actions:
  • Creation of regional surgical collaborations to mitigate disparities in access to minimal surgical services *e.g. Hysteroscopy Africa Forum, AFOG*
  • Build community based partnerships that reduce financial and non-financial barriers to MAS *e.g. Hysterectomy and Hysteroscopy Guided learning pathways, an initiative of partners*
  • Establishment of relationships with public health and insurance agencies to assess referral networks, geographical distribution of sub-specialists, and utility of telemedicine to improve access to MAS
Conclusions

Surgery should be prioritized during the COVID-19 era weighing the risks of infection against the benefits of surgery.

Consideration of consumption of resources beyond the individual surgeon in this unprecedented time of public health stress.
References

• Africa CDC; John Hopkins; NCoVAfrica
