



ASOHNS GUIDELINES ADDRESSING THE COVID-19 PANDEMIC – THE RE-INTRODUCTION OF ELECTIVE SURGERY

The Minister for Health, The Hon. Greg Hunt MP announced on Tuesday 21st April 2020, the easing of elective surgery restrictions imposed on the 26th of March 2020. The Australian Government, States and Territories, have made this decision after close consultation with peak surgical bodies and key stakeholders including The Australian Society of Otolaryngology, Head and Neck Surgery.

This decision is made recognising the effect on the lives and well-being of patients who have had their elective surgery deferred. The planned re-introduction of elective surgery is to be conducted in a staged and controlled process. It will balance the need to maintain capacity to treat COVID-19 patients with the need to increase the availability of elective surgery in a safe and equitable way, taking into account the well-being of patients and health care workers.

ASOHNS continues to monitor the daily progress of the pandemic and its impact on the community. In conjunction with the Royal Australasian College of Surgeons and with regular consultations with the office of the Chief Medical Officer, the Society reviews the evolving scientific information related to the virus and the threats it poses to patients, its members and trainees.

Alerted by the international experience with COVID-19, which has been grave with high incidence of disease and serious morbidity and mortality, the Australian Government introduced a range of restrictions and public health policy.

The rapid and effective response of the people of Australia to abide by rules of social distancing, hand and surface hygiene and quarantine when advised, has led to excellent levels of virus containment.

Public Health data shows that the prevalence of the SARS Covid-2 virus in the Australian community at present is about 6 per 100,000 of population. The advice from the office of the Chief Medical Officer suggests that these are very low levels and that using triage symptoms to assess patients will very accurately predict the ability to identify a patient with COVID-19 disease. The risk of a patient with no triage symptoms, subsequently developing COVID-19 positivity is estimated at 1 per 100,000.

However, the office of the Chief Medical Officer has acknowledged the concerns of surgeons, anaesthetists, theatre nurses and other hospital staff, and supports conducting a study into asymptomatic carriage of COVID-19 in elective surgery patients to further inform testing policy.

In lieu of this current low prevalence of disease the office of the Chief Medical Officer has recommended that there is no indication to conduct COVID-19 testing preoperatively in patients with no triage symptoms of COVID-19.

However, we recommend that all hospitals, day surgeries and practices should have established risk management procedures to identify any patients that have respiratory symptoms that may indicate COVID-19 such that surgery or procedures are deferred where possible and COVID-19 testing requested.

Personal protective equipment is a critical element of staff safety and the use of PPE should be in accordance with national guidelines. In summary these are:

- In asymptomatic patients standard universal precautions and a standard surgical mask worn well with careful donning and doffing techniques is sufficient for all procedures.
- Current evidence suggests that viral load in aerosol generating procedures is low and droplet precautions with standard surgical masks is sufficient.
- Patients with acute respiratory symptoms either fever > 38 degrees OR acute respiratory symptoms (eg. Cough, shortness of breath, sore throat)
- COVID-19 positive patients should have surgery deferred until they recover from COVID-19 disease.

- COVID-19 positive patients having aerosol generating procedures should have maximal PPEs, which include N95 masks and eye protection and PAPR where available and staff are trained and supervised in their use.

ASOHNS encourages members to consider either innovation or modification of techniques to minimise aerosol exposure. For example, advice from international experience is regularly provided including a 2 Microscope Drape method to reduce aerosolization in mastoid surgery from ENT UK.

<https://www.entuk.org/sites/default/files/Safer%20FESS%20in%20the%20COVID%20Era%20for%20ENTUK%20.pdf>

The Australian Government recognises that the selection of patients to undergo elective surgery will ultimately be a clinical one.

The following guiding principles have been recommended by the Australian Health Protection Principal Committee (AHPPC) and endorsed by National Cabinet:

- **Procedures representing low risk, high value care as determined by specialist societies**
- Selection of patients who are at low risk of post-operative deterioration
- Children whose procedures have exceeded clinical wait times
- Assisted reproduction
- Endoscopic procedures
- Screening programs
- Critical dental procedures.

We recommend you access guidelines produced by the Department of Health, including “Restoration of Elective Surgery” due for release on 23 April 2020.

The executive of ASOHNS agree with government that that the selection of patients to undergo elective surgery will ultimately be a clinical one. ASOHNS encourages members to understand disease prevalence in their region and be aware of and alert occurrence of new clusters of COVID-19 and incorporate public health messages into their clinical judgement and decision making.

ASOHNS, in response to enquiries from members, has widely consulted with the presidents and representatives of the various sub-specialty societies. These include the New Zealand Society of Otolaryngology, Head and Neck Surgery, the Australia & New Zealand Society of Paediatric Oto Rhino Laryngology, the Australasian Rhinologic Society, Australasian Academy of Facial Plastic Surgery and the Australia and New Zealand Head and Neck Cancer Society.

The following guidelines are provided as procedures considered to represent low risk and high value care:

PAEDIATRICS

Category 1

Urgent airways including foreign bodies
Malignancy
Bleeding not controlled with conservative treatment
Infection not responding to conservative treatment

Category 2

Chronic suppurative otitis media with complication /cholesteatoma
Tonsillectomy / Adenoidectomy for moderate-severe OSA
Middle Ear Ventilating Tubes +/- adenoidectomy for protracted hearing loss
Cochlear implant - following meningitis or after failed implant
Parotid, Thyroid, other head and neck lumps

Category 3

Infective or Inflammatory Disease treatable by medication
e.g. Recurrent Acute Tonsillitis / Sinusitis / Allergic Rhinitis

OTOLOGY

Category 1

Malignancy involving Temporal Bone

Category 2

Chronic suppurative otitis media with complication /cholesteatoma
Middle Ear Ventilating Tubes for protracted hearing loss

Category 3

For patients over 18 category 3 cases would include
Surgery for implantable hearing assistive devices

RHINOLOGY (SINO-NASAL SURGERY)

Category 1

Paranasal sinus malignancy,

Examples:

- SCC/ adenocarcinoma/ adenoidcystic carcinoma
Inflammatory disease with complication or at high risk of complication.

Examples:

- Orbital abscess, brain abscess, mucocoeles
- Trauma e.g. Fractured skull and CSF leak
- Fungal sinusitis in immunocompromised patient

Category 2

Sinus conditions that cause disability or could compromise the health of the patient if left for longer than 90 days;

Examples:

- Benign tumours of the paranasal sinuses e.g. Inverting papilloma/JNA
- Unilateral disease with suspicion of malignancy
- Sphenoid sinusitis
- Inflammatory disease-causing disabling pain or discomfort and/or compromising overall health and wellbeing of a patient

Examples:

- Facial pain requiring regular potent analgesia
- Severe sinusitis in brittle asthmatic
- Nasal obstruction in patient OSA and unable to use CPAP
- Functional rhinoplasty to facilitate use of CPAP in patient with OSA

Category 3

For patients over 18 category 3 cases would include
Long standing Septal deviation
Turbinate surgery
Surgery for recurrent acute sinusitis without complications.
Cosmetic rhinoplasty

LARYNGOLOGY, HEAD & NECK SURGERY

Category 1

Endoscopy for suspected malignancy
Surgery for Malignancy of the Upper Aero Digestive Tract
Airway obstruction
Bleeding from Head and Neck lesion
Infective/ Inflammatory diseases requiring surgical drainage

Category 2

Surgery for benign Head and Neck Lesions
e.g. Parotidectomy / Thyroidectomy / Removal of benign lesions

Category 3

Procedures of a cosmetic nature
e.g. Revision of scar, Cosmetic rehabilitation of facial palsy

These guidelines will be regularly reviewed and will be subject to change depending on the COVID-19 disease prevalence, the impact on health and safety of members and the impact on health facilities having to deliver elective surgery and maintain public health measures such as social distancing and hand and surface hygiene.

This first stage of reinstating elective surgeries will require health administrators to monitor supplies of personal protective equipment (PPE), ICU and bed capacity, while preparing for the next phase. To limit the volume of procedures performed, the government has asked that facilities cap operating lists volumes at 25 per cent of volume prior to 26 March 2020. Members are asked to liaise with their local health facilities.

The Australian, states and territory governments have put in place clear timeframes to monitor and review the situation.

An overall review will be undertaken at two weeks and at four weeks based on:

- The number of positive cases, in both healthcare workers and patients, linked to increased activity
- PPE use and availability
- The volume of procedures and hospital/system capacity.

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