Recommendations on restoring elective surgery Perioperative Expert Working Group

The National Cabinet has approved health services to recommence more elective surgery from Monday 27 April 2020, with up to 25% of closed / restricted activity to resume. The Perioperative Expert Working Group, Victorian Perioperative Consultative Council and Directors of Surgery recommend the following principles are adhered to in performing additional surgery:

Staged increase in elective surgery

- Clinical urgency remains the most important principle in this resource-limited time.
- Category 1 cases and urgent Category 2 cases whose condition will deteriorate should continue, with personal protective equipment (PPE) use following the latest PPE guidelines released 23 April.
- ESIS Category 2 cases should be reintroduced first. More urgent Category 3 cases that are becoming Category 2 cases may also be considered, particularly where these would improve function or ability to work.
- Review staged increases or decreases in elective surgery at two weekly intervals. A 25% increase at this stage does not mean resume normal activity, and is to be monitored on the volume of cases done.

Independent oversight of restoration of surgery

- At a health service or hospital level, the decision as to which cases should be done should be determined by a senior adjudication panel that includes the Directors of Surgery and Anaesthesia and the CMO or other senior, but independent, clinicians.
- This panel should oversee planned operative lists and consider the following:
    - urgency of cases (informed by the treating clinician) (see below for clinical urgency recommendations)
    - equity of access
    - definitions of low risk / high value procedures
    - compliance with specialty society guidelines
    - match to local capacity, PPE availability, reserve capacity and competing demands between specialties.
- This panel should be aware of PPE stock, security of resupply and projected burn rates in determining capacity to increase elective surgery (see below for consideration of PPE stock).

Clinical urgency recommendations

- ESIS Category 2 cases should be reintroduced first. More urgent Category 3 cases that are becoming Category 2 cases may also be considered particularly where these would improve function or ability to work.
- The capacity of the private sector to do public elective surgery needs to be maintained. The same urgency criteria should be used for both public and private cases.
- Prioritisation should consider equity of access to patients based on clinical need and low risk, high value to patient.
- Avoid non-urgent major cases where there is a high risk of complications.
- Residents of aged care facilities and other institutions should at this stage only be considered for surgery if there is a clear clinical urgency.

Consideration of PPE stocks

- Projected burn rate of PPE for additional elective surgery as well as possible COVID surge must be considered.
- Those planning and adjudicating elective surgery should be monitoring PPE stock levels daily. If PPE stock levels become low due to usage and lack of resupply, procedures may need to be postponed.
- Start reintroduction of additional elective surgery with procedures requiring standard contact or droplet PPE.
- Procedures requiring full aerosol and contact precautions should only be performed for Category 1 and Category 2a at this stage to preserve stocks of PPE.

- Procedures being approved should follow the PPE guidelines released 23 April to preserve stocks of PPE and be prepared for a surge.
- As per recent Australian Health Protection Principal Committee recommendations, the use of standard operating theatre attire and PPE, are adequate for the performance of aerosol generating procedures on low-risk patients who are neither suspected of, nor confirmed to have COVID-19, in the absence of another airborne-transmissible infectious agent. A P2 respirator is not necessary in this context.
- Health services should determine their PPE usage per case throughout the entire healthcare journey for the common procedures they plan to re-introduce to have accurate information on burn rates.

Preoperative screening

- All patients should be screened before and on admission for COVID-19 symptoms and epidemiological risk factors. Any patient screening positive for factors requiring COVID-19 testing should have their surgery deferred until they have been tested and/or undergone the necessary isolation/quarantine period.
- A checklist has been developed by DHHS to support health services undertake perioperative screening.

Local capacity and reserve to manage COVID-19 surge

- ICU input should be obtained prior to booking elective cases requiring intensive care units (ICU). Although ICU availability is a potential risk, current ICU capacity remains largely preserved across Victoria so it unlikely that restoration of elective surgery will rapidly consume all ICU beds.
- A certain number of ICU beds should be reserved based on the local COVID-19 plan, recognising that modelling suggests a one week grace period before a predictable surge in COVID-19 demand for ICU beds, which should allow time to reduce surgery.
- Surgery requiring ICU postoperative care should not be performed at hospitals with limited ICU beds, particularly where these may be needed for COVID-19 cases, or isolation is an issue.
- Medications, equipment and consumables stock and resupply should be considered.

Rehabilitation

- There is a need to consider rehabilitation availability, allied health support in hospital or at home, the patient's social circumstances, and any potential discharge planning problems.

Specific conditions

The Perioperative Expert Working Group has been asked to comment on the below specific conditions:

Cataract surgery

- Ophthalmologists should prioritise surgery for patients who have significant visual disability or visual symptoms due to cataract. Surgery should be deferred in other cases as resources do not yet allow 'business as usual'.
- Initially during this first stage of restoration, cataract surgery should generally be reserved for patients with corrected visual acuity of 6/12 or worse
- At the surgeon's discretion, cataract surgery may also be performed in cases where acuity is better than 6/12, including, but not limited to:
    - Significant anisometropia after first eye cataract surgery affecting safety, driving or ability to work
    - Requirement to perform a vital activity, such as driving or usual occupation
    - Combined glaucoma-lens surgery with uncontrolled intra-ocular pressure
    - Visual concerns in a patient with only one seeing eye

Gastroscopy

- All Category 1 or 2 elective patients for consideration of gastroscopy must meet at least one of the following criteria:
    - Clinically significant upper GI bleeding
    - Haematemesis and/or melaena
    - Dysphagia and or odynophagia which is new onset or worsening after imaging
    - Iron deficiency anaemia (any age)
    - Unexplained (marked) weight loss and possible malignancy
    - Severe upper abdominal pain especially if has required admission
    - Abnormal Imaging (suggestive gastric or oesophageal cancer)
    - Recent variceal bleeding (not surveillance gastroscopies for banding)
    - Upper GI obstruction
    - Diagnosis and/or assessment of upper GI malignancy where patient management will be altered
    - PEG placement/NGT/NJT placement when urgently required
    - EMR/ESD of known upper GI neoplasm and first follow up of EMR

Patients requiring surgery before accessing a transplant waiting list

- Elective surgery can be performed where a patient requires the surgery to be eligible for a transplant, providing the patient is not being put at risk due to their vulnerability.