ESAPS
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EUROPEAN ASSOCIATION OF SOCIETIES OF AESTHETIC PLASTIC SURGERY
The Voice of Aesthetic Plastic Surgery

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EASAPS ESPRAS considerations on clinical activity with Covid-19

Introduction

With the partial lifting of the lockdown we all look forward to getting back to work. Although different countries impose different rules there are a lot of commonalities as well. Besides fear for the disease, the insecurity of what is allowed, when it is allowed and under what circumstances weighs on all of us.
This guideline describes what is considered safe practice based on the scientific knowledge we have today. We will adjust when new information is released.

Most hospital administrations will impose rules as to the use of consultation- and operation-room facilities on their premises. Government regulation addresses regular healthcare first and foremost. This leaves a lot of uncertainty for private practices, ambulatory surgery facilities and private clinics. On top of this, Aesthetic procedures are being considered non-essential and as such are on the bottom of the list of procedures being allowed in general hospitals. Also, we have to take into account that we have a fragile reputation in the eye of the general public, so avoiding complications and being perceived as a serious medical specialty puts extra stress on everything that we do.

Goals

This guideline will concentrate on the 4 daily life situations:

1. Consultations and clinical examination
2. Non-surgical procedures
3. Surgery under local anesthesia in an ambulatory setting
4. Surgery under general anesthesia (in a private clinic and a public hospital)

We will focus on the changed circumstances as a result of the Covid-19 pandemic, so assume that all follow the regular guidelines as described in regional and National laws as well as in European Standards.
For the above-mentioned daily life situation, we will give recommendations on the following areas:

A. Pre-screening
B. Organization
    a. Consent form adjustments
    b. Legal implications
    c. Insurances
C. Infrastructural adjustments
    a. Social distancing measures
    b. Hygiene measures
D. PPE Personal Protective Equipment for
    a. Doctor
    b. Patient
    c. Personnel

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Ch 1 Consultations and clinical examination

Prescreening

Prescreening of patients with symptoms (fever, respiratory distress, coughing, contact with Covid-19 positive patients)
If possible, interviewing for possible symptoms should be performed by phone if no emergency is present

Organization

Patients should be scheduled with gaps of 15 minutes between appointments to avoid full waiting rooms and time for cleaning

Infrastructure / room

Staff at registration should be protected with protective barrier
If possible, several waiting rooms with a minimum distance of 2 meters between waiting chairs
Patients should be provided with multi – layer face masks upon entrance
Telemedicine should be used to reduce face – to – face contact as much as possible
Prescriptions and sick certificates should be sent out by mail if requested by phone

PPE

Covering nose and mouth using multi – layer face masks at all times (patient and doctor/staff) to reduce potential spread of the virus
Maintaining distance, if possible, of 2 meters between doctor and patient/staff
For wound dressings, rinsing and other manipulations during examination that will eventually cause the release of aerosols FFP2 masks or higher should be worn by all staff and combined with face shields when droplet formation is probable. Due to close proximity to the patient doctors are advised to always wear FFP2 masks during physical examination.

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Ch 2 Non-surgical and minimally invasive procedures

Prescreening

Prescreening of patients with symptoms in ambulatory setting (fever, respiratory distress, coughing, contact with Covid-19 positive patients)

Mandatory Covid-19 screening of patients that require a treatment (consent to perform test needs to be obtained)

If possible, interviewing for possible symptoms should be performed by phone if no emergency is present

Commentato [IvH1]: This is over the top, for bx and fillers this is not needed.

Organization

Patients should be scheduled with gaps of 15 minutes between appointments to avoid full waiting rooms and time for cleaning

For minimally – invasive procedures and non-surgical procedures that legally require a consent, increased risk of Covid-19 infection should be mentioned and included

Infrastructure / room

Staff at registration should be protected with protective barrier

If possible, several waiting rooms with a minimum distance of 2 meters between each chair

Patients should be provided with multi – layer face masks upon entrance

Covid positive patients should not have non-surgical and minimally invasive procedures performed until they are cured and fully recovered

PPE

Covering nose and mouth using multi – layer face masks at all times (patient and doctor/staff) to reduce potential spread of the virus

Maintaining distance, if possible, of 2 meters between doctor and patient/staff

For procedures that will eventually cause the release of aerosols FFP2 masks or higher should be worn by all staff and combined with face shields when droplet formation is probable

Ch 3 Surgery under local anesthesia in an ambulatory setting

I Public Hospitals (treating covid positive and negative patients)

Prescreening

Prescreening of patients with symptoms in ambulatory setting (fever, respiratory distress, coughing, contact with Covid-19 positive patients)
If possible, interviewing for possible symptoms should be performed by phone if no emergency is present
For patients requiring operations on the nose or mouth a negative PCR test or chest CT scan is recommended

Organization

Increased Covid-19 risk needs to be mentioned in the consent form
Outpatient operation theatre needs to be separated from operation theatres and wards treating Covid positive patients
The surgeons and staff treating covid negative and positive patients should not be the same
During surgery minimum of required staff within the operation theatre

Short waiting times before surgery should be timed and waiting rooms should allow for spacing between patients of at least 2 meters
Patients need to wear a mask that covers mouth and nose at all times except during the operation when surgery is performed on the face
Operating time should be kept to a minimum.
After surgery, the amount of time that the patient stays in the hospital should be kept to a minimum

Infrastructure / room

Elective surgery can only be performed if the hospital has sufficient resources of PPE and utilized material (local anesthesia, surgical instruments, gauzes etc.)
The operating room should have adequate ventilation ensuring the minimal turbulence and promotion of aerosol
Smoke evacuation should be available when electrocautery other smoke generating equipment is used.
The operating theater must be cleaned between operations with viricidal cleaning solutions.
Minimize unnecessary equipment and supplies in the OR

PPE

The staff should wear multi-layer surgical masks and face shields and surgical gowns that need to be changed between procedures.
For procedures that will eventually cause the release of aerosols FFP2 masks or higher and face shields should be worn by all staff

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II Private offices, clinics and hospitals

Prescreening

Prescreening of patients with symptoms in ambulatory setting (fever, respiratory distress, coughing, contact with Covid-19 positive patients)
If possible, interviewing for possible symptoms should be performed by phone if no emergency is present
For patients requiring operations on the nose or mouth a negative PCR test or chest CT scan is recommended, but they should be avoided at this moment, if possible

Organization

Increased Covid-19 risk needs to be mentioned in the consent form
The surgeons and staff treating patients should not be working with covid positive patients in public hospitals at the same time
During surgery minimum of required staff within the operation theatre

Short waiting times before surgery should be timed and waiting rooms should allow for spacing between patients of at least 2 meters
Patients need to wear mask that covers mouth and nose at all times except during operation when surgery is performed on the face

Infrastructure / room

Elective surgery can only be performed if the hospital has sufficient resources of PPE and utilized material (local anesthesia, surgical instruments, gauzes etc.)
The operating room should have adequate ventilation ensuring the minimal turbulence and promotion of aerosol
Smoke evacuation should be available when electrocautery or other smoke generating equipment is used
Short duration time of surgeries and time of the patient spent in the hospital should be kept to a minimum

PPE

The staff should wear multi-layer surgical masks and face shields and surgical gowns that need to be changed between procedures.
For procedures that will eventually cause the release of aerosols FFP2 masks or higher and face shields should be worn by all staff

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Ch 4 Surgery under general anesthesia

I Public Hospitals (treating covid positive and negative patients)

Prescreening

Prescreening of patients with symptoms in ambulatory setting (fever, respiratory distress, coughing, contact with Covid-19 positive patients)

If possible, interviewing for possible symptoms should be performed by phone if no emergency is present

Preoperative tests and preparation for general anesthesia should be done before the testing for Covid.

For patients undergoing procedures under general anesthesia a negative PCR test or chest CT scan is recommended prior to admittance to the hospital

Organization

The patients should be admitted to the hospital maximum one day before surgery.
The wards and operating theaters treating Covid negative patients have to be separated from wards and operating theaters used to treat Covid positive patients.
The surgeons and staff treating Covid negative and positive patients should not be the same
Protocols must be in place to ensure that there is a safe way to distribute medications, equipment, food and linen to both Covid positive and negative parts of the hospital with no or minimal interaction.
Intensive – Care unit capacity should remain at 25% for Covid-19 patients
Hospitals should be able to increase capacity within 72 hours
Increase of surgical capacities should be averaged at 10% per week
If 90% of surgical capacity are reached, intensive care unit capacities for Covid-19 patients should be reduced by 5% every 3 weeks (subject to change, as Covid-19 cases might increase again)
Increased Covid-19 risk needs to be mentioned in the consent form
Creation of a committee consisting of surgeons, anesthesiologists, infectiologists and nurses that decides upon prioritization of surgeries. Discharge management should be activated prior to surgery to allow for fast transfer to rehabilitation facility or home in order to minimize duration of hospital stay
Consider a post-op social isolation period to reduce incidence of a new exposure and infection as feasible, excluding needed post-op visits.
Only elective surgery with a low complexity and low complication rates should be planned
Start with short operations in low-risk patient categories
Regional Anesthesia should be prioritized whenever possible
Planning of surgeries must take in account, at all times, the current status of Local and regional Hospitalization and ICU Capacity
Elective Surgical procedures on the face (including or not oral and nasal area) can produce aerosols and should only be carried out if strictly necessary
Prefer operations with early mobilization

Infrastructure / room

Hospitals need to create an environment for elective surgery, in which evidence – based prevention techniques, access control, work flows and distancing protocols are in place.
Wards:
The beds in the room should be spaced so that there is 2 m between patients

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The dressing changes should be done preferably in the patient's room with nurses bringing in only the material needed for a single patient.
If possible, the bathrooms and sanitary facilities should be in the patient's room to minimize the number of users with regular cleaning using viricidal cleaning solutions
Operating room:
The operating room should have adequate ventilation ensuring the minimal turbulence and promotion of aerosol.
Smoke evacuation should be available when electrocautery or other smoke generating equipment is used.
The operating theater must be cleaned between operations with viricidal cleaning solutions.
The number of personnel required in the theater during surgery must be reduced to a minimum.
Know aerosolization time based on air-exchange rate in the operating room
Minimize unnecessary equipment and supplies in the OR
Standardized handover protocols to optimize workflow

PPE

The staff should wear multi-layer surgical masks, googles and face shields and nonpermeable surgical gowns that need to be exchanged between procedures.
For procedures that will eventually cause the release of aerosols FFP2 masks or higher and face shields should be worn by all staff
For staff and doctors on the ward multi-layer surgical masks should be worn at all times, and single use gowns should be used when nursing or examining a patient.

II Private offices, clinics and hospitals

Prescreening

Prescreening of patients with symptoms in ambulatory setting (fever, respiratory distress, coughing, contact with Covid-19 positive patients)

If possible interviewing for possible symptoms should be performed by phone if no emergency is present

For patients undergoing procedures under general anesthesia a negative PCR test or chest CT scan is recommended prior to admittance to the hospital

Organization

Only elective surgery with a low complexity and low complication rates should be planned
Regional Anesthesia should be prioritized whenever possible
Start with short operations in low-risk patient categories
Planning of surgeries must take in account, at all times, the current status of Local and regional Hospitalization and ICU Capacity
Elective Surgical procedures on the face (including or not oral and nasal area) can produce aerosols and should only be carried out if strictly necessary
Prefer operations with early mobilization

Elective surgery can only be performed if the hospital has an environment for elective surgery, in which evidence – based prevention techniques, access control, workflows and distancing protocols are in place, with sufficient resources of PPE for the procedure and care.
The surgeons and staff treating patients should not be working with Covid positive patients in public hospitals at the same time

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Discharge management should be activated prior to surgery to allow for fast transfer to rehabilitation facility or home in order to minimize duration of hospital stay
Consider a post-op social isolation period to reduce incidence of a new exposure and infection as feasible, excluding needed post-op visits.

Infrastructure / room

Wards:
The beds in the room should be spaced so that there is 2 m between patients single bed rooms are preferable.
The dressing changes should be done preferably in the patient's room with nurses bringing in only the material needed for a single patient.
If possible, the bathrooms and sanitary facilities should be in the patient's room to minimize the number of users with regular cleaning using viricidal cleaning solutions
Operating room:
The operating room should have adequate ventilation ensuring the minimal turbulence and promotion of aerosol.
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The operating theater must be cleaned between operations with viricidal cleaning solutions.
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Minimize unnecessary equipment and supplies in the OR
Standardized handover protocols to optimize workflow

PPE

The staff in the operating should wear multi-layer surgical masks, googles and face shields and nonpermeable surgical gowns that need to be exchanged between procedures.
For procedures that will eventually cause the release of aerosols FFP2 masks or higher and face shields should be worn by all staff
For staff and doctors on the ward multi-layer surgical masks should be worn at all times, and single use gowns or should be used when nursing or examining a patient.

If during or after a consultation, non-surgical and minimally invasive treatment, operation under local or general anesthesia a patient shows symptoms and is proven to have an infection with SARS-Cov-2 virus the patient must be referred to a hospital that is intended for treating these patients following the National protocols that are in place

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Conclusion

Covid-19 has changed our world, now up to us to adapt to the new circumstances. This guideline will help you to do so.
In case of doubt about performing or not of a clinical act, the principle
primum non nocere should prevail, that is, in case of doubt about any non-urgent procedure it should be postponed until there is total information that allows its conscientious realization

Patient safety and working ethically are mandatory in our specialty. Informing our patients about the impact of Covid-19 on aesthetic procedures belongs to that. Besides this guideline we will inform the public on this via our patient information website realplasticsurgery.eu Make sure you are listed there and refer your patients to this website for proper controlled reliable information on plastic, reconstructive and aesthetic surgery.

As an organization we have worked diligently to control this guideline to be based on evidence-based medicine and to be in line with most laws and standards. However, your Regional and National regulations might be different on parts of this guideline, in this case your regional and national laws will always take precedence over this text.

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