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	Document Title:	**PROTOCOL FOR ENT SURGERY**

PURPOSE:

To prevent the spread of infections due to COVID 19 while performing ENT Surgeries.

OBJECTIVE:

To standardize operating procedures during Emerging and Re-emerging Infectious Disease Outbreak (Covid 19)

GENERAL GUIDELINES

- All Patients admitted in the Operating Room shall be considered PUIs/ Suspect / Probable/Covid 19 patient (PCS Memo) therefore **all staff and doctors** performing surgeries will use complete/ **Full PPE** to **ALL Operations** performed. (Until such time proven Negative via the RT-PCR Test)

- **Roles and Types of Covid Testing:**
  - As of this writing, two (2) kinds of tests are locally available for COVID 19. The viral RT-PCR test that confirms the presence of infection, and the rapid serology antibody test that may confirm previous infection. Serology antibody tests may not be able to show an existing infection, because it can take 1-3 weeks after infection to develop.
  - The American Academy of Otolaryngology- Head and Neck Surgery (AAO-HNS) recommends that patients should be screened at least once with COVID 19 RT-PCR test prior to the surgical date of an elective procedure unless delay caused by testing will result in harm to the patient.
  - Testing in Elective and Non-urgent Cases:
    - The timing of the testing prior to a procedure should be dependent on how long it takes to obtain the results of the test. After the patient is tested negative, the patient should remain self isolated until the procedure date (In-patient admission is therefore needed)

- In asymptomatic patients, the goal in pre-operative COVID 19 testing is to minimize elective and non-urgent and emergent surgery in patients who carry the infection.
- It is ideal to defer non-emergent procedures until the results of the test are available if one has been obtained
- Correlation of chest CT or Xray and RT PCR Test may be necessary in symptomatic patients and must be cleared by an Infectious Disease Specialist

- Testing in Urgent and Emergency Cases:
  - In patients undergoing urgent and emergent surgery, COVID 19 testing is helpful for determining the appropriate peri-operative precautions necessary for the physician, staff and facility (e.g post operative isolation vs. regular room)
  - For life-threatening emergencies for which pre-operative COVID 19 testing is not an option or is not available, the patient should be presumed to be positive for purposes of PPE Utilization and post-operative management

- Elective Surgeries will now be accepted depending on the PPE supplies. NO PPE NO Operation will be done. Thus elective operations will only be accepted depending on the availability of the PPEs.
- Recommended PPE for all personnel inside the OR. Level III – IV PPE, +PAPR or N95 for all otolaryngologic procedure.
- All patients (including watchers) for OR / ENT Surgery procedures shall pass thru the ER Triage Area for Preliminary Assessment. If Patient is found with respiratory symptoms or COVID-19 related signs and symptoms on the day of the scheduled procedure, the ER nurse should inform the operating room and the attending physician for final decision-making (Attending Physician made thorough assessment already of the patient prior to OR schedule and admission).
- It is imperative upon the attending physician(s) to screen candidates for ENT procedures as high or low risk for COVID-19 based on the Department of Health

(DOH) guidelines. Screening should be repeated before performing the procedure. Some patients with coronavirus present with diarrhea, nausea, vomiting, and/or abdominal discomfort even before respiratory symptom onset. These manifestations should alert professionals on the potential presence of infection with SARS-Cov 2 in those who have such symptoms.

- Confirm the compatibility of necessary accessory equipment (e.g. corrective lenses, surgical loupes, head light etc.) with the PPE and operating equipment (eg. Endoscope and microscope)
- Reduce aerosol particle distribution radius through surgical field coverage (e.g. draping, modified acrylic barriers, transparent plastic, sheets, etc), air evacuation (e.g. suction, plume evacuator) and limiting the use of high-powered instrumentation (e.g. oscillating saw, microdebrider, etc.) that theoretically may cause aerosolization.
- Lessen electrosurgical smoke. If applicable consider using additional local vasoconstriction and cold techniques during soft tissue dissection. Plume smoke evacuators and closed suction circuits can be used if available.

Prioritization Classification of Patients (based on time-sensitivity and urgency)

- **Group A** (Defines emergency cases and those who are deemed critical (unstable, unbearable suffering, and/or whose condition is immediately life threatening). There should be no policy conflict when dealing with these highly time-sensitive and emergent cases since these require immediate management and must be accommodate regardless of COVID 19 status. Under these circumstances, performing surgery on patients with unknown status may expose the entire healthcare team to infection and therefore must always be performed with the highest level of PPE and in a separate or designated OR . Example of these cases include, but are not limited to, the following:
    - **Emergency Airway** (e.g. difficulty airway/failed intubation, severe tetanus with trismus, cervical trauma etc)
    - **Intractable bleeding (e.g.** posterior epistaxis, tumor bleed, etc.)

- **Foreign Bodies** (e.g. foreign body aspiration and ingestion)
- **Open Facial injuries** (maxillofacial trauma, exposed or avulsed soft tissues or bone)
- **Life Threatening infection** (e.g. peritonsillar abscess, deep neck infection, Ludwig's angina, etc.)

- **Group B (**Defines Elective but urgent cases or those deemed to be initially non-threatening who can be deferred temporarily with strict monitoring and surveillance. These cases require crucial decision-making and should involve a multidisciplinary team. The decision to proceed with surgery should be based on individual factors related to the specific disease and general health condition of the patient. Because these conditions vary, timing and risk stratification are very important factors in the decision-making process. If at any point their priority changes, they must be moved up to Group A. Examples of these cases include, but are not limited to the following:
  - **Early-stage head and neck cancer (**e.g. compatible with complete tumor resection with good functional status)
  - **Complicated Infections (**e.g. Meningitis or brain abscess, from a complicated acute otitis media, rhinosinusitis or pharyngitis)
  - **Cranio-maxillofacial trauma (**e.g. mandibular, zygomaticomaxillary complex fractures for ORIF)
  - **Planned Tracheostomy**
  - **NOTE:** any delay in treatment of these cases may lead to critical, unstable or unbearable suffering, hence may progress to a life-threatening situation (Group A).

- **Group C (** Defines elective, non-urgent, and planned procedures. These cases can be delayed reasonably until the local COVID 19 burden is stable without causing worsened condition and risk to life. The decision, however must still be individualized considering the unique set up of the facility, the capability and availability of equipment and staff and the local COVID 19 burden in the region or

community concerned. Examples of these cases include but are not limited to the following:

- **Facial plastic surgery** (e.g. Rhinoplasty, Blepharoplasty)
- **Surgery for Rehabilitation of Hearing** (e.g. tympanoplasty, cochlear implant)
- **Sinus Surgery for controlled inflammatory diseases** (e.g. ESS, polypectomy)
- **Surgery for confirmed benign or low risk tumors** (e.g. Parotidectomy, thyroidectomy for colloid goiter)
- **Laryngeal procedures for benign lesions** (e.g. microlaryngeal surgery for vocal cyst)
- **NOTE:** Biopsy procedures for highly suspected malignancies must be moved up to either Group A and B depending on the comorbidities and patient's functional status. Since most head and neck cancers originate from the upper respiratory tract mucosa known to have the highest viral load for COVID 19, full PPE and aerosol precautions must be strictly practiced all the time.

- All other cases not on the list that needs emergency attention to contact/ communicate with the Chairman of the ENT Department or the Operating Room manager. High-risk patients (probable/suspect) should be scheduled last.
- Stepwise resumption of elective ENT procedures should be guided by control of COVID-19 in the local community, availability of manpower and equipment supply.
- Scheduling:
  - Scheduling will be on a "first come first serve basis". The first case schedule will be taken and the rest of the schedule for the day is to follow (TF). Schedules are also dependent on the availability of the OR rooms.
  - If an identified COVID + patient is for operation, it will be scheduled last (after all scheduled procedures in the OR has been done) unless otherwise an emergency case. If there is a COVID 19 + patient for emergency surgery/

ENT procedure, the next scheduled operation will be deferred to a later schedule to provide time for terminal cleaning misting and UV treatment (average time of 4 hours)

- Adult Patients needing Pre-operative assessment (Ex. CP Clearance) shall be referred to an IM doctor and will be referred accordingly to an Infectious Disease (ID) doctor if needed. Adult patients not needing IM consult shall be referred to an Infectious Disease doctor by the surgeon prior to surgery.
- Pediatric Patients needing evaluation shall be referred to a Pediatrician and will be referred accordingly to an Infectious Disease (ID) doctor if needed. Pediatric patients not needing Pediatric consult shall be referred to an Infectious Disease (ID) doctor by the surgeon prior to surgery.

- **Follow OR Decontamination Protocols**
- **No Visitors Directives**
  - All patients are allowed with (1) watcher only and should stay in the watchers designated area. Watchers will also pass thru the ER triage and will undergo interview and health assessment. All patients and watchers should wear mask.
  - Only Patients will be allowed inside the operating room. Watchers will be provided waiting area outside the OR complex.
  - Only one (1) watcher is allowed to enter at the recovery room if needed.
- **Donning and Doffing**
  - There will be a designated area for Donning and Doffing.
  - Donning Area 1: Doctors Lounge / Designated Donning Area 1
  - Donning Area 2: Entrance after the sterile area swing door.
  - Doffing Area: Scrub Room 1 (All N95 mask will be re-used (subject to re-use protocols). After removal please place it in the plastic and label it with your names (initial and last name)
  - There will be a Trained OBSERVER assigned during Donning and Doffing and a checklist will be used.
  - Staff / Doctors are not allowed to enter the restricted area without proper Donning. Likewise Staff / Doctors should do doffing before they exit the restricted area.

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PROCEDURES

A. ADMISSION

1. All patients including their watchers should pass thru the ER and will be attended by the triage team. Pre-assessment of patients will be done.
2. If Patient is found with respiratory symptoms or COVID related symptoms on the day of the scheduled procedure, the nurse should inform/communicate with the attending physician and the operating room.
3. ER / Station Staff calls the Operating Room for endorsement of the patient for admission. (once the criteria for OR Admission is met, example – admission sheet / Philhealth)
4. Before patient is sent to the OR, the staff prepares the team and needed equipment and supplies and will start donning of their PPEs.
5. Once all the staff and the doctors are present with their complete PPEs on, the OR staff will call the station or ER to transport the patient to the OR.
6. Patient will be transported to the OR following transport protocols.
7. Donning and doffing
    a. There will be a designated area for donning and doffing.

B. TRANSPORT

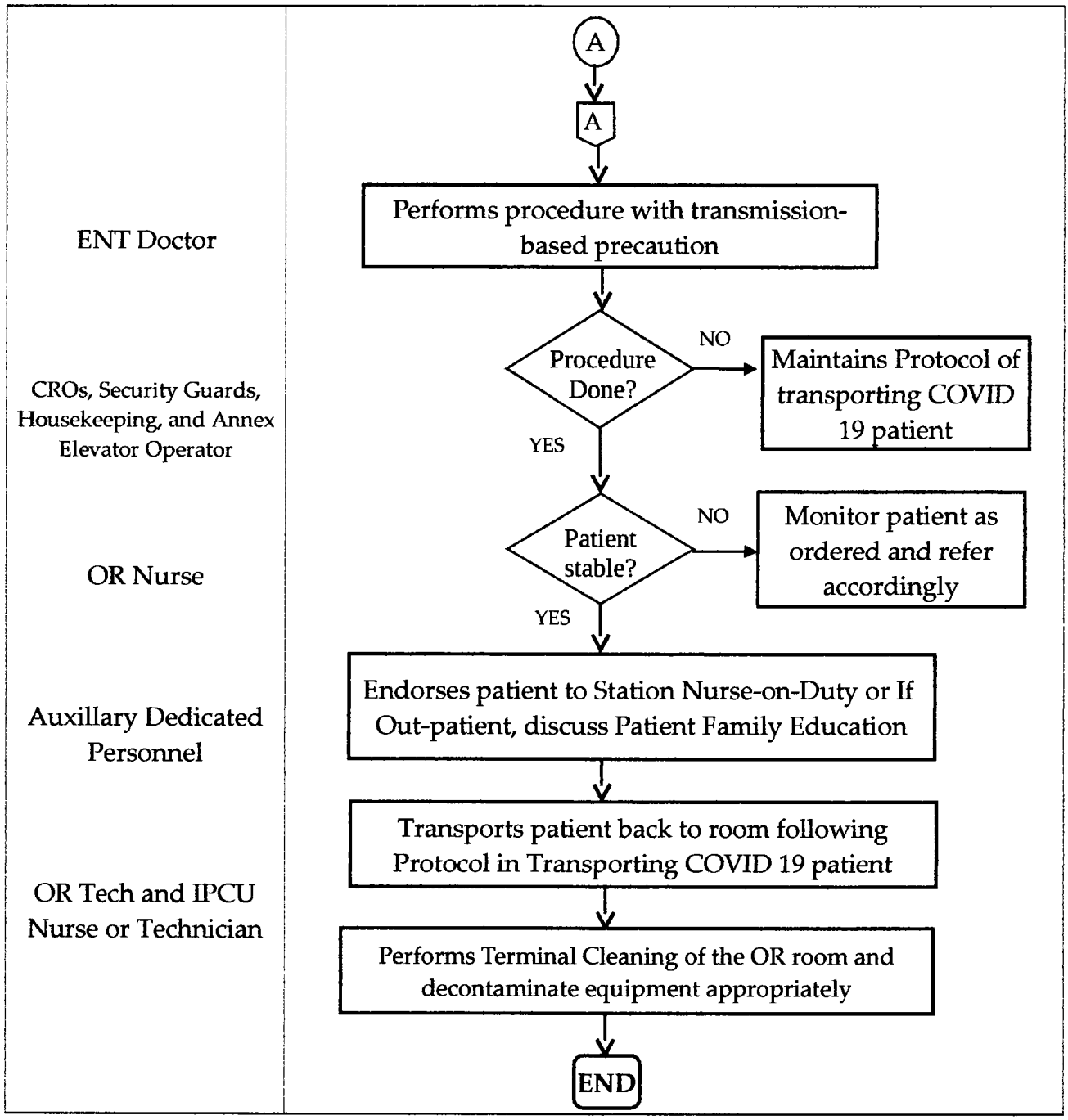
1. The stretcher/wheelchair used outside of the OR will only be until the inner door and the patient will be transferred to a designated stretcher/ wheel chair only used inside the OR.
2. If the patient is COVID (+) the same transport stretcher will be used until the patient is transferred in the OR.

RMCI Operating Room
PPE Levels

Basic PPE	Level 1	Level 2	Level 3
Staff at the Nurses Station, Work Station – Ex. Head Nurse, OR Manager, OR Clerk, Stock Room (no direct patient care)	EGD – Endoscopist Runner Staff in the restricted area but is not inside the OR room	ALL staff inside the OR room during the operations or with direct patient care, Recovery Room, EGD Nurse / Staff, Observer, Ophtha Anesthesiologist, Ophtha Attendant or Ophtha Circulating Nurse, Housekeeping (Terminal cleaning)	Surgeon, Assistant Surgeon, Anesthesiologist, Assistant Anesthesiologist, Ophthalmologist, ENT Doctors, Residents, OR Tech /Scrub Nurse
• Face mask • Face Shield/ Googles • Surgical Cap • Scrub Suit	• Face Mask • Face Shield / Goggles • KN95 / Face mask • Surgical Cap • Scrub Suit • Reusable Gown(apron) / Reusable Patient Gown • Clean Gloves / Sterile Gloves (single / double) • single booties	• Face Mask • Face Shield / Goggles • KN95 / Face Mask • Surgical Cap • Scrub Suit • Reusable Coverall • Reusable Gown/apron • **Sterile Gloves (double)** • **Double booties**	• Face Mask • Face Shield / Goggles • KN95 / Face Mask • Surgical Cap • Scrub Suit • Reusable Coverall • Reusable Gown/apron • **Reusable Impermeable sterile gown** • **Sterile Gloves (Triple)** • **Double booties**

FLOWCHART

PERSON RESPONSIBLE	ACTIVITY
	START
ER Nurse/Staff Nurse	Calls the Operating Room for endorsement of the patient for Admission. (Criteria for OR Admission should be met) (If patient is a COVID 19 confirmed, suspect or probable the OR Nurse must also be informed.
OR Nurse	Prepares the team and the needed equipment and supplies and will start donning of their PPEs
Auxillary Dedicated Personnel	Transports patient to the OR when the OR calls the station for the scheduled procedure. Transmission-based precaution must be observed and patient shall wear a surgical mask while being transported.
OR Nurse	Follows the approved protocol in transporting COVID 19 Confirmed, Suspect, or Probable patient
	A
	A



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