SWA Preop Approach to COVID March 2022

IS THE PATIENT INFECTIOUS?

Anyone with COVID who:

- Does not have severe disease (hospitalized, RA SpO_2 < 94%, positive CXR)
- Is not immunocompromised

Cannot spread the disease 10 days after symptom onset, although the PCR can remain positive for months

Wait times to be considered non-infectious:

- Positive test, never symptomatic – 7 days
- Mild-moderate illness – 10 days from symptom onset and 24 hours without symptoms
- Severe illness – 20 days from symptom onset and improving symptoms

WHEN IS IT SAFE TO PROCEED WITH ELECTIVE SURGERY AFTER COVID ILLNESS?

Long-COVID can affect every organ system. If a patient has residual symptoms, there should be a consult for a cardiopulmonary evaluation for any major elective case.

Even without residual symptoms, there is still an increased risk of complications after COVID

Recommended wait times for elective surgery after COVID:

- After mild-to-moderate illness:
    - 4-6 weeks in those who were vaccinated
    - 7 weeks if unvaccinated
    - 8-10 weeks if immunocompromised
- After severe illness: 12 weeks

IS RE-TESTING NECESSARY AFTER A POSITIVE TEST?

Since re-infection can occur, re-testing should be done 90 days after a prior positive test, especially if there if the patient is symptomatic

PUI or COVID Patient Anesthesia Checklist, August 2020

Patient Preparation

- If the patient is in a negative pressure environment, intubate before transport whenever possible (since the OR is a positive pressure environment)
- If the patient is not in a negative pressure room, consider transport to a negative pressure anteroom for intubation

Transport

- Full PPE (hat, gloves, eye shield, N95, gown, shoe covers)
- Filter between ETT and AMBU or JR circuit
- Have a clean person (one not in contact with the patient or bed) to get doors, clear hallway obstructions, etc.

OR preparation

- HEPA unit in place and running
- SSE (surgical smoke evacuator) for selected cases
- COVID cart outside of room
- Remove all unnecessary equipment from OR including the anesthesia cart
- Cover other equipment as is practical

Anesthesia equipment preparation

- Hand sanitizer and wipes at the head of the table
- Make certain all circuit connections are tight to avoid mid-case disconnection
- Ensure that viral filters are on each circuit limb; have a viral filter/humidifier at the Y-connector; make certain that the capnograph line is distal to the filter
- In lieu of the anesthesia cart, utilize an anesthesia supply bag or tray. For further supplies, utilize an anesthesia tech as outside-of-the-room runner
- To avoid touching the Rx Station, ready all anticipated drugs before the patient enters the room

Anesthesia plan

- Regional anesthesia without sedation is ideal, however neuraxial anesthesia in an infected or febrile patient is a relative contraindication
- If patient is not intubated, GA will be with ETT placed with a rapid sequence induction using a Glidescope
- No LMA except for rescue
- No direct laryngoscopy except for rescue
- No MAC unless it can be performed with minimal sedation
- Consider use of Halo with clear plastic drape
- Do not use a Bair Hugger if not absolutely necessary

Anesthesia induction

- All staff in full PPE
- No unnecessary staff in room at induction
- Non-anesthesia personnel to maintain a safe distance from head of bed at induction
- Anesthesia to double glove: disposable outer glove, but surgical inner glove to ensure tight fit over gown sleeve
- Use antisialagogue
- Rapid sequence induction
- Cover ETT tightly with gauze as removing stylet, and connect circuit tightly
- Place dirty airway equipment directly into red box
- Remove outer gloves
- Wipe down all surfaces
- Other staff to return to OR after 10 minutes or more

Anesthesia emergence

- No PACU recovery
- Use maximal PONV prophylaxis
- Consider IV lidocaine or narcotic to decrease coughing
- If extubation is planned, it ideally should occur in a negative pressure room, not the OR
- Keep filter connected to ETT if disconnected while moving the patient
- At emergence, have all unnecessary staff exit room
- Minimize the number of suction attempts
- Have face mask is applied before extubation
- HEPA filter to run at least 1 hr after patient exits the room