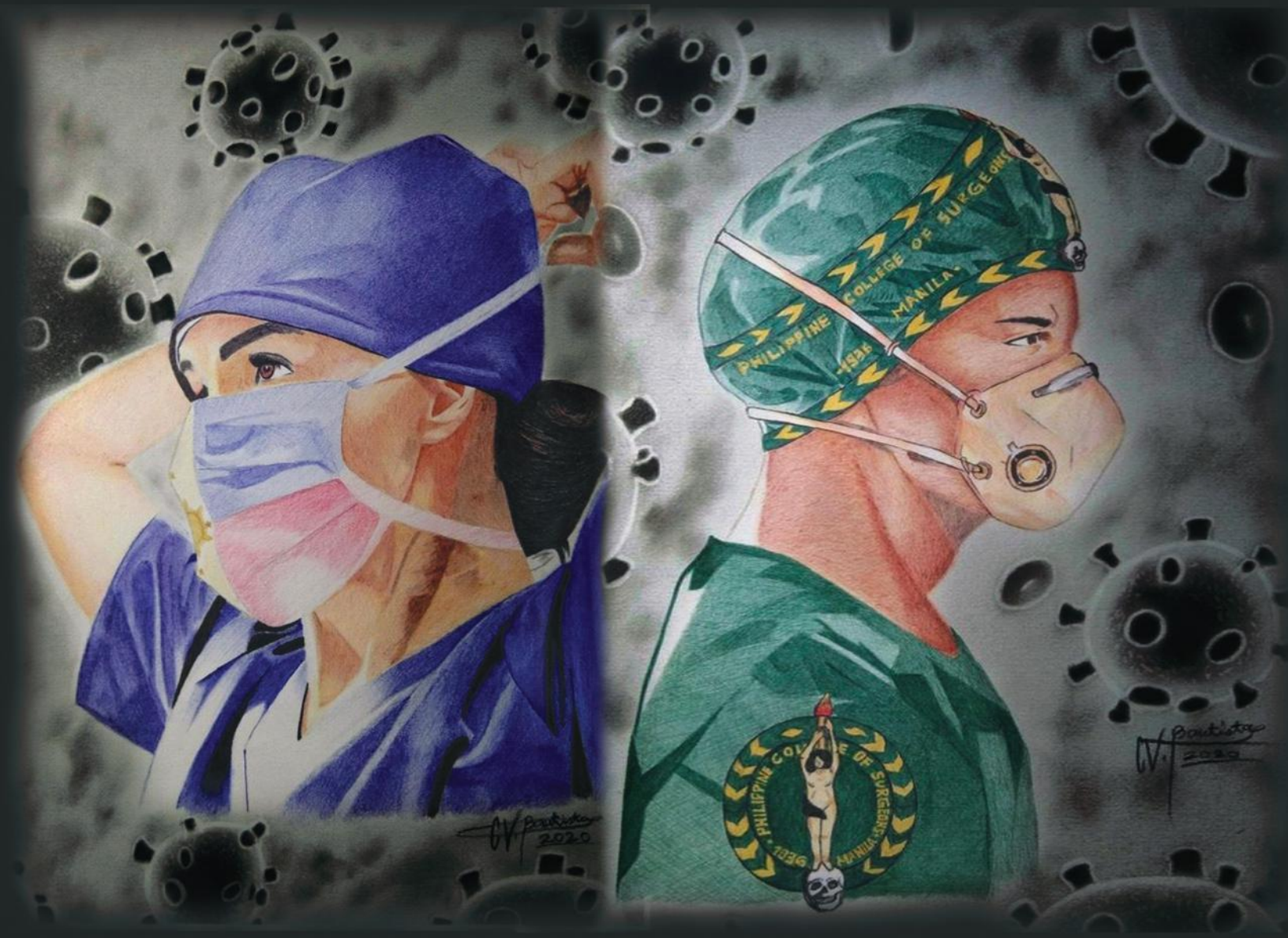
Incisions

The Newsletter of the Philippine College of Surgeons

Volume 40 Number 1 Supplement • pcs_1936@yahoo.com/ph/www.pcs.org.ph • April 2020



Special COVID-19 Issue

Incisions
The Newsletter of the Philippine College of Surgeons

Marcus Jose B. Brillantes, MD
Editor-in-Chief

Esperanza R. Lahoz, MD
Regent-in-Charge

Vietriz PD. Abella, MD
Joy Grace G. Jerusalem, MD
Marwin Emerson V. Matic, MD
Peter Raymund M. Quilendrino, MD
Jose Benito A. Abraham, MD
Tamarah P. Cristobal, MD
Members

Nelson P. Cayno
Emma V. Infante
Editorial Assistants

Incisions, the PCS newsletter, is a triannual publication of the Philippine College of Surgeons, 992 EDSA, Quezon City 1005, Tel. No. 928-1083. Comments and feedback indicating the writer's full name, address, contact numbers and e-address are welcome. Letters to the editor may be edited for reasons of clarity and space. E-mail to pcs_1936 @yahoo.com.ph

In This Issue

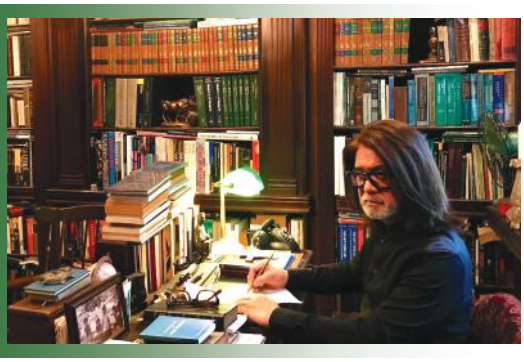
On the Cover

by CVT Bautista

Carl Vincent T. Bautista, 19/M, is a graduate of the Tañong High School and is planning to take an Animation course in college. The artist can be contacted in Instagram: binscentarts or in Facebook.

FROM THE EDITOR'S DESK

Marcus Jose B. Brillantes, MD, FPCS



COVID, *QUO VADIS?*

Like many of you, we're all struggling to comprehend and desperately trying to come to terms with a far different world we knew a mere shade of two months ago. It seems almost overnight, with the swift turn of unsuspecting events in surrealistic fashion, a "new normal" has been thrust upon us exempting no one. Who could have ever imagined a global catastrophe to reach such biblical proportions in a matter of weeks? What is the inner message? What path will this pandemic lead us to?

The usage of terms which most of us weren't familiar with or were hardly in general knowledge are now in common utilization: ECQ, lockdown, social distancing, PPE, hazmat suits, novel coronavirus, nCov, aerosolization, front liners, N95 masks, cough etiquette, aerosol boxes, acrylic barrier, HEPA filter, contact tracing, thermoscans, flattening the curve, Zoom videoconferencing, telemedicine, herd immunity, etc. And though our individual experiences may vary vastly in comparison to what others may be going through, we can be certain that each of us have been affected profoundly and that we will definitely come out of this universal ordeal a changed person. We simply have to look around. This singular event and its intimately personal impact, though may seem relatively minuscule on individual terms when placed alongside the experiences on a worldwide scale, can nonetheless be considered historic.

Deeply concerning are the social, economic and public health consequences of this near-total meltdown of normal life as we knew it – businesses and schools closed, hospitals running on skeletal force, absolute disruption of training, only emergency surgeries allowed, public gatherings banned, city avenues empty, the palpable fear, a look of distrust – will prove to be calamitous and possibly extract a graver toll than the virus itself. The stock market will bounce back in time eventually. But a number of businesses will never recover.

As countries, still reeling from the health crisis, introduce unprecedented measures to stem the spread of COVID-19, one of the most alarming conclusions from an infectious-disease viewpoint is that no clear exit strategy is in sight. As of date, we can surmise from the Chinese and South Korean pandemic experience how a combination of community surveillance – testing and contact tracing – strong social distancing and swift clinical care intervention reduces infections, complications and death. But we don't know how long these measures should last, or whether easing up the restrictions will allow a resurgence of the novel coronavirus. There have been alarming reports of viral resurgence in these areas. And if we do succeed in slowing the spread of COVID-19 from deluge to dribble, when does the worldwide tribulation end? When can society resume the normal? The alarming cost is too staggering to contemplate.

There are numerous possible answers but likely one is certain: We don't know. Because this novel virus to date has undergone 6,000 mutations and patients who have previously been documented as positive for the virus may still relapse to reinfection, herd immunity at this period is distantly remote. No vaccine can be developed within the year despite its warp speed development in several centers worldwide.

The aim of the initial response of the Philippine College of Surgeons to the health crisis onslaught was to prepare hospitals in providing care for the expected high volume of COVID-19 patients, while maintaining

> 4

a limited delivery of surgical care to emergency and high priority elective cases. All non-essential surgical services were reduced or suspended. Several guidelines were issued by the PCS in succession in March that covered the management of elective cases, the conduction of cancer surgeries, health care systems planning for COVID-19, precautionary measures in emergency surgery and the rational and effective use of PPE in surgery.

Attention has also turned towards the potential risk not only to the surgeon but to the staff as well to exposure to the novel coronavirus during specific surgical procedures based on data showing that human immunodeficiency virus and human papilloma virus can be detected in surgical smoke. In particular, the use of minimal invasive surgery in COVID-19 patients is concerning, as viral particle concentration in smoke generated during laparoscopy is higher compared to open surgery.

For complex cancer patients, surgeons have commenced the difficult task of using alternative therapies such as systemic chemotherapy and radiation therapy where appropriate to buy more time until the patients can be scheduled for their procedure.

Further to the clinical and operational effects of COVID-19, the crisis also presents a challenge to the ongoing education and training for all surgical programs. The residents' exposure to adequate case numbers will be severely limited for a sustained period of time and redeployment to directly assist in the COVID-19 response has already taken priority. There is talk of possible extension in the residency training programs.

The disruption caused by COVID-19 extends to having a detrimental impact on the well-being of surgical staff at all levels and across all disciplines. This includes widespread distress and heightened anxiety being felt for a range of personal and organizational related reasons.

The response to the COVID-19 pandemic in surgery is evolving rapidly and the number of confirmed cases is expected to continue to rise. Strategies to address the challenges are being implemented as quickly as possible in an attempt to minimize the impact of COVID-19 on surgical services. However, we are sailing into 'uncharted waters' with minimal data or past experiences on which to base decisions.

For the meantime, aside from practicing social distancing, frequent hand washing, personal hygiene and donning protective gear, we focus our resources on testing and isolating the subset of people that data indicate are particularly vulnerable to severe infection: the elderly, patients with chronic diseases and the immunologically-compromised. And while mortality is highly concentrated in a select group, it doesn't stop there. Medical bulletins and updates come up with new data on COVID-19 almost every other day which make the guidelines for treatment strategies for this novel coronavirus in evolution. Certain paradigms and practices acceptable as recently as three months ago may no longer be applicable in this new world order in flux. There are recent reports of death due to CVA of COVID-19 patients among young adult for inexplicable reasons. Pediatricians are noticing that a number of COVID-19 infected children are presenting in intensive care units with a range of unusual and varied symptoms akin to Kawasaki Disease.

In all likelihood, a lasting exit strategy to this apocalyptical predicament will have to come from the ranks of medical science. This includes research on the virus structure, the clinical features of the disease, potential drug targets and the development of that elusive vaccine.

At the beginning of the COVID-19 pandemic, there seemed to be a non-stop, sensationalized, negative newsfeed. The hoarding of masks, alcohol, hand-santizers, defiance to the lockdown directives focused on the irresponsible and selfish behavior. But then, a few weeks into the crisis, media started to shift their stories toward a more positive light. Time and again, individuals, communities, organizations and companies have displayed how the worst situations can bring out the best in others. Amid the rising number of novel coronavirus cases in the country, some of the biggest names in businesses and religious organizations have provided aid to frontliners, employees, and vulnerable communities affected by the uncontained epidemic. Groups donated personal protective equipment (PPE) and medical supplies to health care workers and hospitals, while countless citizens pledged financial assistance to employees affected by the extended community quarantine. Various sectors and private individuals also provided food and other goods to the poorest of households.

These stories of compassion, of moving displays of courage and the accounts of leadership in the midst of uncertainty and darkness, shed numerous points of guiding light, leading us along the path to our true nature and noblest calling.

FROM THE PRESIDENT

Jose Antonio M. Salud, MD, FPCS

Today, May 18, I write this article as the ECQ has been lifted to a modified version and I am worried about the distinct possibility of a second wave of patients getting infected as I see pictures on social media of numerous cars on the road and people moving about in large numbers in malls and public establishments. Understandably, after being cooped up in one's home for the past 2 months and absolutely not allowed to move about, at the first chance to get free, that is to be expected. We now know how it feels to be an animal in a zoo. Nakatakas sa hawla is an expression in the vernacular that can best describe the phenomenon. "The economy has to get moving" and "think of people's human rights" are just a few of the arguments we hear but it appears most people are not aware that the virus is still lurking around and can just as easily cause more infections to surge soon. We have to be prepared.

Atul Gawande, in an article in the The New Yorker, shared the four pillars of his hospital's strategy to reduce re-infection and ensure safe reentry after the lockdown is lifted – hygiene, distancing, screening and masks. Its application in any area of the world where lifting of the quarantine is being considered makes a lot of sense and in fact is what we have been doing already. Perhaps screening using the available tests is the one thing we may lack but the other 3 aspects can easily be carried out by any Filipino. As health professionals, we can help in implementing this in our workplace and in our community. We have to accept that this will be the expected behavior for everyone from hereon - the "new normal" as has been often stated. Fresh standard, novel custom …. whatever you want to call it, this will be the convention and is here to stay and we have to accept it for the foreseeable future. No ifs or buts about it.

Some hospitals will start doing select elective operations already particularly those related to cancer operations. Many surgeons will encounter resistance with their hospital administrators and IDS consultants regarding the need for pre-op testing in such patients who are asymptomatic as regards COVID as well as the need for appropriate PPE. Even the DOH has said testing isn't necessary for the asymptomatic patient (considering we lack enough testing kits). But you cannot maintain distancing inside the Operating Room. They are also not the ones exposed to patients for hours at a time inside the OR. Even the Philippine Society of Anesthesiologists recommends testing, if available, prior to an elective operation in their Guidelines for Post-ECQ Elective Surgeries.

So how de we proceed? Best to start slowly, do relatively short procedures initially and be cognizant always of the measures needed to protect one's self, the surgical team and the patient. Team huddles and meetings will need to be done seriously prior to and after each procedure. Doing surgery wearing full PPE is no joke. It may look good on FB and Instagram but it's very uncomfortable and not a pleasant experience to be using enhanced PPE for surgeries exceeding more than an hour. If you are not keen on experiencing this difficulty, then don't do surgeries yet. If you decide to proceed, then you need to be careful and be prepared. Perhaps document your experiences because years from now, we can all look back at this astonishingly extraordinary period in our lives and tell our grandkids how it was like in the summer of 2020. Regardless of what will follow from here on, I know the resilient spirit of the Filipino, especially the Filipino surgeon, will help us move forward with hope, positivity and assurance of a better working environment and a better life for all.

#newnormal

• Joy Grace G. Jerusalem, MD, FPCS •

You will never know how resilient you are until something totally upends your status quo and forces you to change beyond the limits of your comfort zone. Who would have thought that something as miniscule as a virus could effect such a transformation transcending all aspects of our lives?

When the Extended Community Quarantine was enacted to contain the COVID-19 infection, healthcare workers across the country might have shrugged at the workplace shutdowns, thinking it would be business as usual as we are wont to do. But when news of deaths caused by COVID-19 among our colleagues started to occur, many might have paused to acknowledge that slight tickle down their spines. Was it fear or a knowing apprehension that this might be something serious? Reports of physicians contracting the virus would spread across social media posts and group chats at lightning speed followed invariably by queries about where they could have been infected. Conventions and conferences were postponed, outpatient clinics were closed and elective surgeries were canceled. Healthcare workers manning emergency rooms and areas designated for care of Persons Under Investigation would be hailed as frontline workers while others would remain on-call for emergencies. Training programs would come to an unwelcome halt with the dearth of outpatient consults and elective cases. Training committees would shift to teleconferencing to keep up with department requirements for perioperative census, journal clubs and Mortality and Morbidity Conferences. Physicians would wait with bated breath for new guidelines expediently released by their respective societies on how to adjust their practices with the threat of COVID looming over their heads. Suddenly, the prospect of going to the hospital would fill many a physician's mind with doubt. Many would opt out, fearing they would carry the virus into their homes; affecting spouses, children and elderly relatives. Some would reluctantly wait out the two-week intervals, hopeful that in the end it would just go away, and they would go back to their routines. While others, with medical conditions themselves, albeit controlled, would remain hesitant to risk infection in a silent game of Russian roulette. For those who would take the challenge of venturing to the once familiar places, would do so clad in protective equipment. Facemasks, goggles, face shields, isolation gowns and hazmats would complete their ensemble. Surgical specialties would meticulously follow the proper work flow protocols for donning and doffing of multilayered PPEs, operating drenched in sweat and stopping ever so often to defog their eye protection. Regular baths in the hospital and outside their homes would be de rigueur as well as the incessant spraying of disinfectant on anything brought from outside. Two weeks would soon evolve into months with no room for certainty on how long this state of new normal would last.

Days into the possible lifting of the extended community quarantines and lockdowns would inspire both relief and doubt. While we plan for the resumption of our clinics and surgeries on our non-COVID cases, we cannot help but wonder, will we survive, succeed or falter? How will we find ourselves at the end?

Herd Immunity: A Dangerous Strategy For COVID-19

• Marcus Jose B. Brillantes, MD, FPCS •

The global outbreak of the novel coronavirus early this year has left many wondering how to stem its spread and formulate strategies to combat this disease. Herd Immunity has been heatedly debated on and derided from Western Europe to the United States. Early last March, the British government for example controversially claimed it was hoping to reduce the impact of the virus by allowing it to "pass through the entire population so that we acquire herd immunity." Although this was later denied by another government spokesperson with a follow-up comment that "herd immunity is a natural by-product of an epidemic." Sweden, on the other hand, is currently pinning its hopes on herd immunity to stop the transmission of the virus. But recent reports have revealed that Sweden's top epidemiologist is now uncertain if the relaxed approach is working.

Herd Immunity has been flung around as a possible solution to this devastating virus that has been ravaging countries across the globe. (Certain experts prefer the term "population immunity" because "we are not livestock.") But what exactly is Herd Immunity and is it a possible exit strategy amid the COVID-19 pandemic?

Herd Immunity is "a simple epidemiological concept that describes the state where enough people are immune to a disease that it stops spreading in the population." Another definition of herd immunity is that "when enough people in the community are vaccinated against a disease, this can make it more difficult for the disease to spread to susceptible individuals who have not been or cannot be vaccinated." The goal is to remove the possibility of a sustained transmission.

The problem with herd immunity is that it really hinges on vaccination. Without a vaccine developed, the singular manner to gain immunity to a disease is to contract it and, if it be a lethal strain, survive. This makes the strategy an exceedingly fatal experiment for COVID-19.

Initial estimates place the herd immunity threshold for the novel coronavirus – the proportion of people who need to be immune for the disease to stop spreading – at 60-70% of the population (although recent data from the CDC indicate a higher percentage at 90%). The dilemma is most countries affected by COVID-19 have not surpassed the 1% mark and less than 10% of the world population has been exposed to the virus as of this writing.

The Herd Immunity strategy has been criticized by the World Health Organization, which has stated far greater action is required. Other health experts say the approach is "experimental at best and dangerous at worst."

The best course to expeditiously develop herd immunity is through vaccination. But while a vaccine is unavailable, it is considered dangerous, irresponsible and highly unethical to rely on this untested method to counter the viral disease.

First, intermediate and long term consequences of the novel coronavirus are not yet known. Scientist do not have sufficient data about the science of the virus which leaves numerous unanswered questions of the virus' capability in immunological terms. Secondly, though majority of the population who contracts the disease exhibit mild symptoms and recover, under a herd immunity strategy, a subset of vulnerable patients who contract the lethal strain develop severe complications and are at greatest risk of dying from it. Some degree of population immunity may be gained from such dangerous stratagem but at an unacceptable cost in terms of human lives. With a 2.3% fatality rate and a 19% rate for severe disease, this may result to millions of death in any given country, not counting the remaining millions needing critical care.

The safest public health strategy is to stem the spread of COVID-19 through the time-tested strategy of community quarantine - border controls, self-isolation, banning of public gatherings and contact tracing of confirmed cases. This prevents the health care systems from being overwhelmed and affording hospital and personnel in not being inundated.

Life will not return to normal until a vaccine is available. In facing an unseen enemy never encountered before, it is important to be vigilant and understand how vulnerable we remain. It should be clear that the COVID-19 pandemic is only beginning to unfold.

References:

1. Bethune ZA and Korinek A. (2020). COVID-19 Infection Externalities: Pursuing Herd Immunity or Containment? Covid Economics, Vetted and Real-Time Papers 11, 29 April.
2. D'Souza G and Dowdy D (2020). What is Herd Immunity and How Can We Achieve it With COVID-19?, Johns Hopkins Blomberg School of Public Health, 10 April.
3. Altman DM, Douek DC and Boyton RJ. (2020). What Policy Makers Need To Know About COVID-19 Protective Immunity, 27 April.
4. Kwok KO, Lai F, Wei IW, Yeung S, Tang JWT (2020). Herd Immunity – Estimating the Level Required to Halt the COVID-19 Epidemics in Affected Countries. J Infect 2020; 80: e32-e33, 18 March.
5. COVID-19 Situation in the WHO European Region, World Health Organization; 2020.

Grab MDs at your service: Moving Donations For You

• Joy Grace G. Jerusalem, MD, FPCS •

It started simple enough, a group of off duty doctors, bringing much needed supplies to their hospitals during the quarantine period. But when news of physician and health worker deaths gradually increased, the "simple" scheme evolved into a passion project, fueled by the strong desire to put a stop to the unnecessary loss of life among our health care colleagues due to exposure on the frontlines. Not wanting to leave anyone behind, a group of physicians banded together to transport essential supplies to hospitals faced with inadequate PPE for their frontline workers.

While on a supply run to a hospital, Dr. Mariam Grace Delima, a fellow of PATACSI and PCS, jokingly referred to what they were doing as akin to Grab drivers, a popular transportation network vehicle service network in Metro Manila, but with medical supplies. To which Dr. Lara Alentajan-Aleta, a prominent immunologist and fellow Grab MD, suggested that they be called Grab doctors instead. To date, the Grab MDs now have an extensive list of physicians spanning NCR and the provinces in the Visayas and Mindanao, transporting much needed PPE and other supplies from donors to hospitals in need. Their services are provided free, dependent on their free time and proximity to donor and delivery sites. The network has expanded necessitating the creation of a coordination hub where details regarding type and number of medical supplies needed, donors, recipients, etc. are posted and shared with all members; similar to the Grab "booking system". Not limited to donations, Grab MDs have also partnered with local industries to fabricate multifunction aerosol boxes, prone pillows, face shields and ear savers, to name a few.

Apart from taking full advantage of physicians' mobility during the quarantine period to move donations, it helps that as doctors, they would know first hand what particular supplies and specifications are needed. More than the physical act of transporting donations, what particularly touched the members of Grab MDs was the overwhelming response to their call for donations, from private individuals, fellow doctors, corporate entities, NGOs and foundations. Such an outpouring of help gives us hope that together, we can overcome.


MANILA BULLETIN BUILDING
Muralla corner Recoletos Streets, Intramuros
Manila
Telex 40240
Tel. 527-81-21
STAND
Be Fully Informed
MANILA BULLETIN


Face Mask
Face Mask

Protecting Healthcare Workers' Well-Being During the COVID-19 Pandemic

• Joy Grace G. Jerusalem, MD, FPCS •

Frontline healthcare workers and first responders are being hailed as heroes here and around the world for their services during the COVID-19 pandemic. The support, both in kind and acknowledgment, has been overwhelming. But despite the high praise, healthcare workers in the country are beset with a multitude of challenges: from separation from family for an extended period of time, physical/ mental and emotional fatigue, lack of appropriate personal protective equipment and remuneration to the very real risk of contracting the disease itself.

Physicians, nurses and paramedical staff are used to being called upon during times of crisis, be it in a disaster situation, natural calamity or epidemic. More than just possessing the necessary training and skill for healthcare, it has been instilled in their collective mindsets to go the extra mile despite limitations and difficulties with the well being of patients at the forefront. Whether it is a tacit expectation or a self-imposed burden, health workers will always put a premium on toughness, in all aspects, even at the expense of their emotional or mental stability.

As we face the gradual lifting of the extended community quarantine (ECQ) throughout the country, we face the possibility of a second wave of infection, due to inordinate numbers of people trooping out to the malls and highways, unmindful that the threat of COVID-19 is still very much present. As if the current state of overworked staff due to quarantined personnel was not enough, stress levels in the workplace can only be expected to increase. There are several sources of stress to healthcare workers brought about by the current pandemic: the imminent threat of infection and death and concomitant loss of livelihood; the lack of PPEs and adequate testing facilities; the burden of witnessing death in increased numbers of affected patients and even colleagues; guilt over real or imagined failure in patient management; loss of support systems due to separation from family; and fear of transmitting the disease to others. Workplace trauma may manifest immediately, with workers refusing to return to work, or at a later time, as post-traumatic stress syndrome. In extreme cases, it may result in death from suicide, like those reported from the US, Italy, China, Iran, Russia, and Indonesia.

Emotional and mental health issues are usually overlooked sequelae of large-scale disaster situations. Studies on healthcare workers' well-being after crisis-calamity settings have shown increased rates of emotional distress, posttraumatic stress disorder, depression, violence (domestic and child abuse), suicidal ideation and addiction. High mortality rates, overburdened healthcare system and physical distancing all contribute to breakdowns in the mental health status of doctors, nurses and frontline personnel.

Measures to ensure healthcare worker wellbeing must be in place in both the institutional and national levels. Dzau, MD, et al in their article, *Preventing a Parallel Pandemic — A National Strategy to Protect*

iStock

> 11

Clinicians' Well-Being, published in the New England Journal of Medicine, recommend five strategies to protect the emotional well being of physicians during the COVID-19 pandemic (see Table).

Table: Five High-Priority Actions to Protect Clinicians' Well-Being During and After the Covid-19 Crisis.[1]

Organizational Level
• Integrate the work of chief wellness officers or clinician well-being programs into Covid-19 "command centers" or other organizational decision-making bodies for the duration of the crisis.
• Ensure the psychological safety of clinicians through anonymous reporting mechanisms that allow them to advocate for themselves and their patients without fear of reprisal.
• Sustain and supplement existing well-being programs.
National Level
• Allocate federal funding to care for clinicians who experience physical and mental health effects of Covid-19 service.
• Allocate federal funding to set up a national epidemiologic tracking program to measure clinician well-being and report on the outcomes of interventions.

Physical distancing used to prevent and mitigate the transmission of the virus invariably results in social isolation that may further aggravate the problem. In an article published in JAMA Internal Medicine, Dr Sandro Galea, et al, propose three interventions to proactively prevent the increase of mental disorders and its chronic effects during the COVID-19 pandemic: develop interventions to overcome the isolation brought about by the physical distancing or prolonged periods of quarantine via digital technology, online substitutes for daily work and leisure routines, etc.; create mechanisms for surveillance, reporting, and intervention, particularly, when it comes to domestic violence and child abuse; and strengthen our mental health system in preparation for the inevitable challenges precipitated by the COVID-19 pandemic.[2] Similar methods were recommended in another article published in JAMA Psychiatry by Dr Mark Reger, et al. to prevent suicide rates from increasing: implement physical, not social distancing; include provisions for mental health in telehealth platforms; increase access to mental health care; develop distance-based suicide prevention programs; and media reporting on suicide prevention and support.[3]

In our country, there remains some hesitance to address mental health disorders due to the stigmatization that often accompanies its acknowledgment. This is true in the medical field, where clinicians are often looked up to for their mental and emotional resilience. But Dr. Shauna Springer, a licensed psychologist and trauma-recovery expert at the Stella Center in Illinois, has an interesting take on the matter. She recommends not calling healthcare workers heroes as it feeds into the belief that they must be superhuman. She adds: *"We mean well when we call them heroes, but there's an invisible pressure that comes with that. People are resilient until they're not. And so people who are called out as resilient are often more reluctant to acknowledge human struggles and to reach out when they need help."*[4] The issues on mental health and clinician self care are complex and multifactorial. Solutions must include providing them with a stable and safe work environment to allow them to work efficiently. Support during times of crisis should be of utmost concern and must be worked into administrative work flow protocols. It has been sometime since we witnessed a pandemic of this proportion; a modern day plague with no cure or vaccine in the horizon. COVID-19 pandemic will continue to claim many lives in its wake. We must take the essential steps to preserve our frontline health workers from being wounded warriors and a critical resource.

References:

1. Dzau VJ, Kirch D and Nasca T. Preventing a parallel pandemic — A National strategy to protect clinicians' well-being. New Eng J Med 2020.
2. Galea S, Merchant RM, Lurie N. The mental health consequences of COVID-19 and physical distancing: The need for prevention and early intervention. JAMA Intern Med Published online April 10, 2020.
3. Reger MA, Stanley IH, Joiner TE. Suicide mortality and coronavirus disease 2019—A perfect storm? JAMA Psychiatry. Published online April 10, 2020.
4. Mahbubani R and Mosher D. Suicide is killing frontline medical workers, but mental-health experts say the situation is far from hopeless. Business Insider April 29, 2020
5. COVID-19 kills in many ways': The suicide crisis facing health-care workers; Caroline Orr; Canada's National Observer/ Analysis; April 29th 2020
6. Elwafaii O. Why are COVID-19 doctors committing suicide?; CGTN World; 29-Apr-2020

COVID-19 Pandemic: My Personal Journey as a Patient

• Victor K. Gozali, MD, FPCS •

As everyone knows, the COVID-19 (SARS COV-2) started in Wuhan, China late December 2019 and has since spread rapidly by infecting and claiming the lives of thousands of people in a short period of time. In the 2 weeks after its spread, a total lockdown was imposed by the Chinese government to contain it. The rest is history, but the disease has indeed gone beyond borders and reached over 200 countries.

In the Philippines, the first reported case of a patient who was confirmed to have COVID-19 (PH-001) was sometime around February 2020 in Metro Manila. Our government has then created the task force IATF-EID (Inter-Agency Task Force on Emerging Infectious Diseases), which are co-headed by the Secretary of Health and the Secretary of Interior and Local Government.

In the early afternoon of March 13, 2020, I received a text from a reliable source that stated the government will be declaring a Luzon-wide Enhanced Community Quarantine (ECQ) starting March 15, 2020 until April 14, 2020 to contain the spread of the disease. I closed my clinic at 4:00 pm and went to the supermarket to buy food and other necessities for the house. Lo and behold, there were so many people PANIC BUYING, grabbing anything and emptying the shelves of the necessities, dry goods and dry foods, canned goods, etc. Though some people were wearing masks, many of them were not. With the shear number of people lining up at the cashier, which in my case lasted for 3 hours, I started to worry that I may get infected with COVID-19 myself (community-acquired).

I stopped and closed my clinic starting March 14, 2020 and cancelled all my scheduled elective surgeries beyond March 14, 2020 in two different hospitals (as per hospital policies, only emergency surgeries were permitted). I only came back to the hospital on March 18, 2020 to see one patient (by appointment) to remove 2 JP drains and to check the condition of the patient, S/P Mastectomy for Breast CA. The encounter lasted for 10-15 minutes, and we were both wearing surgical masks and gloves.

Everything was fine until March 25, 2020. I started to have occasional dry cough and shortness of breath, though no fever. I dismissed it as simply my lack of activities and exercise. Too much watching NETFLIX! Unfortunately, it worsened; I would occasionally wake up in the middle of the night to sit up because of my shortness of breath. I was worried, thinking it may be a prelude to some serious heart problems (as I have been hypertensive for the past 15 years).

In the morning of March 28, 2020, my wife, who is a doctor also, was so worried and auscultated me in the chest. She said that I had "rales" on the right lower lung field. I listened myself, but said there was "none". She advised me to go to the hospital for a check up, but I refused. (We, doctors, are the worst patients, aren't we?). She begged me to go to the hospital and called up the head physician at the Emergency Room (ER) to anticipate my arrival. I finally agreed to go, thinking that if I continue to refuse, she will not be at peace. I was also worried of my condition and, in case

> 13

I was infected, I would be spreading the infection to my children and employees at home. However, I was confident and believed that I was going home after visiting the ER.

On arrival at the ER of the hospital, I was immediately separated from the assigned COVID-19 area in order to not mix me with other suspected patients. Chest x-ray, blood tests and ECG were done. Unfortunately, I was informed by the head ER physician that I had PNEUMONIA and my blood tests showed elevated inflammatory markers— CRP 5x normal, LDH 2x normal, Ferritin 3x normal. My ECG result was normal.

It was decided that I should be admitted, especially since I am now suspected to have COVID-19. Further testing such as the nasal and throat swabs for RT-PCR, ABG etc… were done. I also informed my family that I will be admitted and asked them to please pray for me to get well soon and be united with them again. In my mind, I was scared and did not really know what the outcome of my confinement will be. My medications given were Hydroxychloroquine 400mg BID, Azithromycin 500mg OD, Ceftriaxone 2 grams, IV, OD, Zinc Gluconate 70mg BID, Ascorbic Acid 50mg BID and to continue my anti-hypertensive medications. I was admitted at the COVID-19 wing.

On the 2nd day at the hospital, I was informed of the results of the initial swabs — POSITIVE. A repeat ECG and chest X-ray tests were done and showed progression of the lung condition; now, it showed bilateral lung infiltrates, with involvement of the apical portion. I was really scared!!! It was getting worse.

I was instructed to lay in bed in prone position for 8-12 hours and to practice deep breathing exercises. But I could not do them for that long, so instead, I did it for 15-30 minutes frequently and in installment.

On the 4th day at the hospital, a repeat chest X-ray showed minimal improvement in the lung infiltrates, but this time with minimal pleural effusion on the right lung. One can only imagine how frustrated and scared I was then, knowing in spite of being in the hospital and being treated aggressively, my condition was worsening. I also knew some doctor colleagues who were admitted in the same hospital. Three of them entered the hospital with only a fever and cough, and within 12 hours or so, they were intubated and transferred to the ICU. I did not want those things to happen to me, and as I realized it then, once someone is intubated, chances for recovery become really slim.

I prayed and prayed, attending virtual Mass on the ETWN-Catholic channel several times a day and even joining virtual Rosary and Divine Mercy prayers etc… I never did these in my entire life — to spend almost half of my waking hours in a day praying. My family asked their prayer warriors to include me in their special intentions and even had strangers pray for me. In short, we stormed HEAVEN to spare me and bring me back to recovery. I had blood tests, 2D Echo, ECG, chest X-ray, nasal and throat swabs everyday or every other day.

On the 6th day at the hospital, repeat chest X-ray results for the 4th time was finally NORMAL — there were no more pleural effusion and infiltrates. WOW, God listens to our prayers! A MIRACLE indeed! The inflammatory markers from my blood test were still elevated but lower than the admission results. However, the RT-PCR swab results still showed POSITIVE for the third time.

On the 8th hospital day, on Palm Sunday, the 5th chest X-ray was done and it CONFIRMED that my LUNGS are CLEAR - NORMAL already. On the 9th hospital day, a repeat 4th swab test was done. Only on the 13th day of my hospital stay did I find out the results, which were still POSITIVE (the delay was a result of the delay from the specimen being sent to RITM). I also asked the Infectious Disease attending physician of my official number in the DOH data. I am patient PH2286, officially registered positive for COVID-19.

On day 14, the 5th nasal and throat swabs were done. Then Day 15 arrives. It was a glorious Easter Sunday. At 3:00 pm, at the very hour of Divine Mercy, my attending physician called and informed me that the results were finally NEGATIVE for the first time. PRAISE THE LORD! I cried, called up my family on FaceTime, and we all cried tears of joy together. HOW GREAT THOU ART!!! This was no coincidence. GOD wanted to show my family and me that HE and ONLY HE is the DIVINE HEALER, choosing HIS GLORY OVER SICKNESS on Easter Sunday to heal me.

On Day 17, a repeat 6th nasal and throat swab tests were done in the morning. A little past midnight, 0030H, my attending physician called me and informed me that the result of the 6th swab tests were once again NEGATIVE (two negative tests as required by protocol). I am going home!!! On Day 18, I was discharged from the hospital and was told to continue 14 days more of self-isolation and home quarantine.

I am doing well as of this writing, but the experience is overwhelming. I really did not know what the outcome will be when I entered the hospital for confinement. I knew there were only one of two outcomes — either I will be going home to see and be reunited with my family OR I will be going Home to my CREATOR. GOD gave me the first option.

What is next? Am I now safe? Do I have immunity? Can I be re-infected? Only GOD KNOWS. We do not have all the answers!!! GOD BLESS YOU!

My Pandora's Box in the COVID-19 Pandemic

• Tamarah P. Cristobal, MD, DPBS •

Bilateral lobar infiltrates and consolidation. Pneumonic Process

Two lines that were to change two weeks of my life. And just like that, I was placed under quarantine. And it was not even my scan. I was exposed to my patient without the proper protective gear. And so even if I didn't want to, I had to subject myself into isolation. It was a mixture of emotions bordering on paranoia, anger, panic and fear. I wanted to get mad because I was not in control of my situation and it felt like there was an injustice done to me that I had to suffer for two weeks just because of someone else. Then it dawned on me how this virus, this miniscule, invisible thing brings out the worse in us. From being a concerned physician, I was suddenly transformed into becoming the most apathetic and insensitive person inside the room. Am I really getting mad at someone because the possibility of him dying from a vicious virus means that I will lose two weeks of my freedom to move around? Is that how shallow I've become in a matter of seconds? Getting the virus myself did not even cross my mind. It was more of all the inconvenience that I was going to experience brought about by my patient's condition. I was focused on myself and forgot about the sick and possibly dying person in front of me. It's upsetting how in the most taxing situations, we resort to being self-absorbed creatures instead of choosing to be kind. While I worried about what I was do in the safety of my own room, my patient was worrying if he will still be able to go home alive. While I worried about things to do to alleviate possible boredom, my patient was worrying if he still had some time left to spare to just exist. While I wondered what I was going to do the following day in the confines of my room aside from sleeping the entire day, he was probably anxious of sleep in fear that he might not wake up. While I worried about missing my family for those two weeks, he was probably thinking if he was to be missed forever once he's gone. It's staggering how this pandemic can bring out our shameless side. And so, for the entire two weeks, I planned on reconnecting with myself and contemplated on how I want to deal with this situation. The first few days were daunting and the pressure and the stress that this pandemic brought to the table made me forget about what I wanted to achieve with my isolation. Instead of reconnecting with myself, I reconnected with social media and ended up picking fights over people I didn't even know, and it took a few days and a lot of migraines for me to realize that my time alone was not being well-spent. Then it became apparent to me that I was not just waiting for the 14 days to be over. I forgot that I could have symptoms and that I could be infected as well. And then what? What memory and legacy will I leave behind if I spent the possible last two weeks of my life thinking of what to do instead of what I did to make a difference in someone else's life? I placed myself in my patient's shoes and thought about how, based on how I treat people, will I be remembered when I'm gone. I think of myself as fairly a good person with the usual fits and if that is enough for anyone to be sad or disappointed if I disappear permanently. Will people be just glad if I don't come out of quarantine because I am such a difficult person to be around with or will they be sad because I have been a pleasant person to everyone I come across with? I thought about the last few days and wished I did everything differently. I tried to remember if all I did was worry about disinfecting my things and instructing my family what to do instead of telling them I love them and that I am sorry if I ever failed to say that every single day. I thought about the last few days when I nagged my daughter about her online classes and tried to recall if in those occasions, did I ever tell her that I loved her so much and that I was proud of her no matter what were her academic achievements.

Emotions run high when we are placed in a stressful environment, but it is not an excuse to act upon those emotions with negativity and worry. And so, I promised myself that if I came out of this mandatory quarantine alive and well, I was to treat it is a second chance at life to do things differently. To be more appreciative of what I have, be more content with what I can afford at the moment, and to be thankful to God every single day that I wake up unscathed and breathing. My patient's test turned out to be negative and since I had no symptoms, I was never tested. The day I received the news that he was negative was probably one of the happiest days that I had ever since this pandemic started. I was back to work and taking on cases because there is a sense of a false security that since I had no other health problems and that I was fairly healthy and strong, I could probably be invincible to this disease and get away with it with my fancy gears and all.

I thought that my isolation made me change how I viewed my life and it made me focus on what I will do once I finish it. The sense of a mandatory quarantine is

> 15

mixed with feelings of anticipation, excitement, and a new hope that I can do things differently. But soon I was to learn of what it means to be isolated and creating a different perspective depending on the reason why you are forced to spend time alone.

Four weeks after my mandatory quarantine, exactly 5 days from today as I'm writing this, the tables turned and I found myself suddenly gasping for air and clutching my chest due to a severe crushing sensation that could not even make me walk straight. I waited for a few minutes to see if it will spontaneously go away on its own but I found myself clutching my chest even more that it was now starting to spread to my left upper back and I was doing fast shallow breaths as if taking a bit of air was both a relief and a torture simultaneously. We all have experiences of different types of pain and we know when it is familiar to us and when we are experiencing it for the same time. And for me, this unusual discomfort was enough to make me bring myself to the hospital. I have always been very composed and used to the toxicity of everyday life and my residency days have been there firsthand to experience the havoc that I wreak every time I go on duty. I have learned to be calm at times when I needed too and to be composed and hold it together as much as I can when others just could not get their act together. I have a mantra that everything will fall into place and you just have to sit back and let life unravel before you and just enjoy the ride. As doctors, we all have our favorite lines that we use with our families and mine has always been, "Don't panic especially when you don't see me panicking. You can only panic when you see me panic." At that moment, I was seriously panicking. I could feel my hands turn very cold and pale, and beads of sweat was coming out of my forehead and the first thing that I thought of was, "Am I going to die? I don't want to die." I've had two major operations in my lifetime and I couldn't remember being that scared and alone. I knew that if I had to go to the hospital, I will have to be alone because I could not afford to risk my family's safety. I never even told my parents where I was going because I know they would panic and they had the right to, because my favorite line was just not going to be credible this time. The last thing I did before I left home was to knock on my daughter's door and to hug her as tight as I could like it was the very last time that I would see and hold her that close. I told her how much I loved her and that I was just going to the hospital for a bit while choking back tears. The lump that I felt on my throat was both from having difficulty in breathing and holding back my voice from cracking and telling her that it could be the last time we were to see each other. At that swift moment, my chest was hurting even more not because of any physiologic problem but because of the emotions that I was feeling. I forgot that I was a doctor who immediately transformed to an anxious patient. I wanted to cry like a kid and just tell her that I loved her so much and that if I didn't come back, I wanted her to always remember to be kind to everyone. I knew I was going to be subjected to another quarantine but this time, I felt more like a human being digging deep into my darkest fears and clinging on to the happiest memories that I had. Isolation from being exposed felt less of a burden than being isolated because it could possibly be your last days alive. Instead of making plans, being sick immediately gave me feelings of regret. Regret that I could have been a better mother, daughter, doctor, and a friend. And that was just my feelings while driving to the hospital. Upon entering the emergency room, tears just rolled down my face because it was getting too real. And seeing my heart rate beyond 100 and my O_2 saturation not go up beyond 95% was like seeing a horror movie filmed before my very eyes. It was the scariest that I had ever been because not only was the pain was so unfamiliar to me, but the very disease that I am so scared of having was also unfamiliar to us doctors. In a span of 1 hour from the time I first felt my chest tighten, the idea of being a victim of this virus opened a pandora's box of emotions for me. I was not strong enough to say I am ok if I had to go or that I have lived a full life, because truth be told, I really was not. I thought I was such a strong and fearless person but it turns out I cry like a baby when faced with the possibility of an untimely demise. There were things that I thought that I could handle that turned out I could not. The thought of having this virus opened up a lot of emotions and feelings that I did not know that I had. It made me forget that I am a physician and that made me feel more of a human being showing vulnerability to the unknown.

I was admitted alone without any companion and had a lot of tests done including a swab and stayed in for two days before I was discharged. I had findings on my 2D- Echo that could probably have been the cause but I was assured that it was nothing serious. As of writing, I finished my second quarantine and my results turned out to be negative of which I am thankful for. But the anxiety that I had while waiting for my own test was nothing compared to what I felt while waiting for my patient's test. It gave me a deeper appreciation of what these patients have to go through whether they are positive or not, or whether they are in pain or not. It gave me a better understanding of the things that I have to do in life and to appreciate every little moment be it good or bad. To express humility with the things that I don't know and accept that I have to let other people take care of me and

> 16

My Pandora's Box... from page 15

trust them even if they are faced with the unfamiliar.

This pandemic teaches a lot of things in different ways to other people and I must say that my experience has been a great teachable moment. There are so many things that isolation can make us feel, and bouncing back from a daunting experience, I can say that I have developed a bigger appreciation of life during my time alone when I was at my most vulnerable as compared to my life when I had the freedom to do anything I want.

My experience made me reminisce about a great passage from one of my favorite books by Anne Morrow Lindbergh titled Gift from the Sea –

"It is a difficult lesson to learn today --- to leave one's friends and family and deliberately practice the art of solitude for an hour or a day or a week. For me, the break is the most difficult. Parting is inevitably painful, even for a short time. It is like an amputation, I feel. A limb being torn off, without which I shall be unable to function. And yet, once it is done, I find there is quality to being alone that is incredibly precious. Life rushes back into the void, richer, more vivid, fuller than before. It is as if in parting one did actually lose an arm. And then, like the star fish, one grows it anew; one is whole again, complete and round – more whole, even, than before, when the other people had pieces of one."

LAUGHaroscopy... from page 32

- Doctor: Your COVID test came back positive
  Patient: That can't be correct, I have 300 roles of tissue paper at home…

Babies born during this pandemic:
- Covid Bryant
- Corona Santos
- Covid Marie Cruz
- McCovyd
- Twins: Corona (boy) Covid (girl)

Even worse baby names…
- Sonny Tizer
- Alcho Gel
- Loch Down
- Kua Rantine
- Korona Lyn

Worst baby names?
- Ko'rona Vyress
- Coviduvidapdap
- Quarantina
- Pan-Demia
- Veerus

Most interesting name during this pandemic: Soshal Dystan Singh

All outstanding prayers have practically been answered with the lockdown:

Kids: I wish we had no school and could play all day. DONE

Women: I want the undivided attention of my husband. DONE

Husbands: I'm sick of this traffic, I wish I could work from home. DONE

Working Moms: I wish I could spend some quality time with my kids and read. DONE

Students: I wish I had no exams. DONE

Old parents: I wish our kids could spend more time with us rather than being busy every day. DONE

Employees: I'm slogging too much, I need a break. DONE

Employers: I have no life of my own, I wish I could relax. DONE

Mother Earth: I can't breathe, I wish I could get a break from all this pollution and chaos. DONE

Parents: When do we stop getting junk foods for our kids? We wish we could get some quality time for preparing quality food. DONE

Teens: I wish weekends were longer than weekdays. DONE

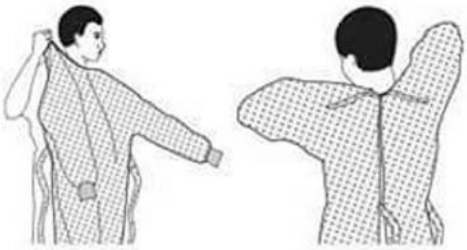
BEWARE OF WHAT YOU WISH FOR — You might just get it!

SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist



2. MASK OR RESPIRATOR

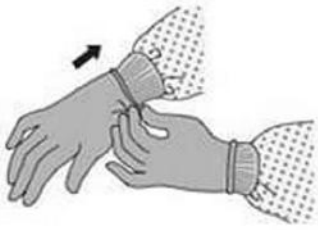
- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator

3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit

4. GLOVES

- Extend to cover wrist of isolation gown



USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

- Keep hands away from face
- Limit surfaces touched
- Change gloves when torn or heavily contaminated
- Perform hand hygiene

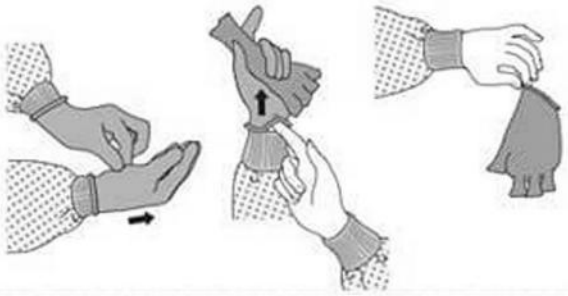
CS250672-E

HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

1. GLOVES

- Outside of gloves are contaminated!
- If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
- Discard gloves in a waste container

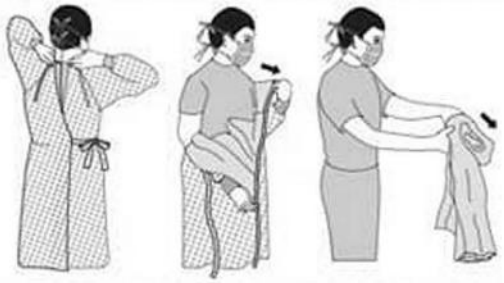


2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band or ear pieces
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container

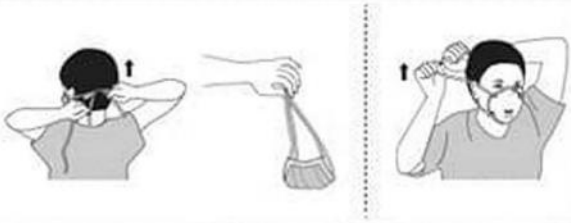
3. GOWN

- Gown front and sleeves are contaminated!
- If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
- Pull gown away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard in a waste container



4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — DO NOT TOUCH!
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container



5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE

PERFORM HAND HYGIENE BETWEEN STEPS IF HANDS BECOME CONTAMINATED AND IMMEDIATELY AFTER REMOVING ALL PPE

CDC

CS250672-E

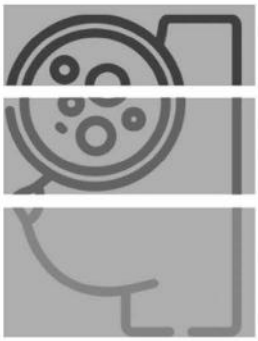
Cancer in the time of Covid-19

Breast Cancer Surgery Guidelines

Defer surgery for at least three (3) months for atypia, prophylactic/risk reducing surgery, reconstruction and benign breast disease.

DCIS:

- Defer for 3-5 months
- Treat ER+ DCIS with endocrine therapy
- Monitor monthly for progression
- Untreated DCIS high priority for surgery when safe/ORs available



ER+ INVASIVE BREAST CANCER (STAGE I-III):

- Treat with endocrine or chemotherapy in a neoadjuvant fashion as deemed appropriate by multidisciplinary tumor board recommendations

POST-NEOADJUVANT CHEMOTHERAPY:

- Delay post-chemotherapy surgery for as long as possible (4-8 week window) in those patients for whom adjuvant systemic therapy is unclear/not indicated.

TRIPLE NEGATIVE / HER2+ INVASIVE BREAST CANCER:

- Treat with neoadjuvant chemotherapy for T2+ and/or N1+ disease
- Consider primary surgery as urgent if patient unable to undergo chemotherapy or tumor is small and surgical information could inform chemotherapy decisions.

UNUSUAL CASES / SURGICAL EMERGENCIES / SPECIAL CONSIDERATIONS:

- Patients with progressive disease on systemic therapy, angiosarcoma and malignant phyllodes tumors should be considered for urgent surgery and should not be delayed.

The recommendations above represent generalized opinions from experts in their fields, but decisions must be made on a case-by-case basis

PCS CANCER COMMISSION

Source: SSO Cancer Surgeries in the Time of COVID-19

Cancer in the time of Covid-19

Colorectal Cancer Surgery Guidelines

- Defer surgery for all cancers in polyps, or otherwise early stage disease.
- Operate if obstructed (divert only if rectal) or acutely transfusion dependent.
- Proceed with curative intent surgery for colon cancer.
- Consider all options for neoadjuvant therapy including utilization of TNT for rectal cancer and to consider neoadjuvant chemotherapy for locally advanced colon cancer
- Delay post-TNT rectal surgery for 12 to 16 weeks.
- Utilize 5x5 Gy pelvic radiotherapy and defer further surgery for locally advanced rectal cancer patients.

The recommendations above represent generalized opinions from experts in their fields, but decisions must be made on a case-by-case basis

PCS CANCER COMMISSION

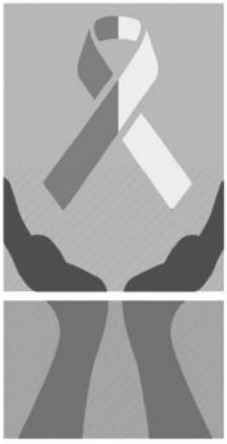
icanserve FOUNDATION INC.

Source: SSO Cancer Surgeries in the Time of COVID-19

Cancer in the time of Covid-19

Endocrine / Head and Neck Cancer Surgery Guidelines

- Most uncomplicated endocrine operations can be delayed.
- Diseases and presentations that might qualify for more urgent surgery (i.e., within approximately 4-8 weeks during the current pandemic), include:



THYROID:

- Thyroid cancer that is a current or impending threat to life, those that are threatening morbidity with local invasion (e.g., trachea, recurrent laryngeal nerve), aggressive biology (rapidly growing tumor or recurrence, rapidly progressive local-regional disease including lymph nodes)
- Severely symptomatic Graves' disease that has failed medical therapy
- Goiter that is highly symptomatic or is at risk for impending airway obstruction
- Open biopsy with diagnostic intent for suspected anaplastic thyroid cancer or lymphoma

ADRENAL:

- Adrenocortical cancer or highly suspected adrenocortical cancer
- Pheochromocytoma or paraganglioma that is unable to be controlled with medical management
- Cushing's syndrome with significant symptoms that is unable to be controlled with medical management
- Generally, functional adrenal tumors that are medically controlled and asymptomatic non-functional adrenal adenomas can be delayed

PARATHYROID:

- Hyperparathyroidism with life-threatening hypercalcemia that cannot be controlled medically

NEUROENDOCRINE:

- Symptomatic small bowel NETs (e.g., obstruction, bleeding / hemorrhage, significant pain, concern for ischemia)
- Symptomatic and/or functional pancreatic NET that cannot be controlled medically
- Lesions with significant growth or short doubling times
- Cytoreductive operations and metastasectomy should generally be delayed but should be considered on an individual basis

The recommendations above represent generalized opinions from experts in their fields, but decisions must be made on a case-by-case basis

PCS CANCER COMMISSION

Source: SSO Cancer Surgeries in the Time of COVID-19

Cancer in the time of Covid-19

Hepato-Pancreato-Biliary Cancer Surgery Guidelines

- Operate on all patients with aggressive HPB malignancies as indicated.

- Pancreas adenocarcinoma, gastric cancer, cholangiocarcinoma, duodenal cancer, ampullary cancer, metastatic colorectal to liver
- If responding to and tolerating neoadjuvant chemotherapy, then continue and delay surgery.

- Use ablation or stereotactic radiosurgery instead of resection for liver metastases where possible.
- Consider ablation or embolization over surgical resection for HCC.
- Defer surgery for asymptomatic PNET, duodenal and ampullary adenomas, GIST, and high risk IPMN's, unless delay will affect resectability.

- Postpone elective and non-urgent surgical and endoscopic cases.
- Postpone all non urgent in person clinic / office visits.
- The greater majority of electives and non-urgent cases need to be defined. We encourage you to make clinical judgement and discernment based on patient's underlying medical conditions and their exposure to risks in your respective hospitals during this time of COVID-19, against progression of disease especially cancer, to determine level of urgency.

- Categorize levels of necessity for surgical procedures (Fig 1. proposing a risk urgency decision matrix2) in relation to threat to life and patient needs, taking into consideration your hospital's resources and capacity.

Fig 1. Risk Urgency Decision Matrix

- Furthermore, for procedures that are urgent and necessary, consideration is to be made regarding the use of energy devices. Surgical smokes produced contain bioaerosols with viable and non-viable cells posing a risk of infection. For the safety of the OR team and patients, adequate personal protective equipment should be available for the OR staff.

The recommendations above represent generalized opinions from experts in their fields, but decisions must be made on a case-by-case basis

PCS CANCER COMMISSION

Source: SSO Cancer Surgeries in the Time of COVID-19
PAHPBS Recommendations in time of COVID-19 Pandemic

Cancer in the time of Covid-19

Melanoma Surgery Guidelines

- Delay wide local excision of in-situ disease for 3 months and, as resources become scarce, all lesions with negative margins on initial biopsy. Efforts should be made to perform procedures in an outpatient setting to limit use of OR resources.
- Surgical management of T3/T4 melanomas (>2 mm thickness) should take priority over T1/T2 melanomas (≤2 mm thickness). The exception is any melanoma that is partially/incompletely biopsied in which large clinical residual lesion is evident. Gross complete resection is recommended in this case.
- Sentinel Lymph Node biopsy is reserved for patients with lesions >1mm and, as resources become scarce, set aside for 3 months.

- Manage clinical Stage III disease with neoadjuvant systemic therapy. If resources permit and patient is not suitable for systemic therapy, consider resection of clinical disease in an outpatient setting.Metastatic resections (stages III and IV) should be placed on hold unless the patient is critical/symptomatic or unresponsive to systemic therapies (assuming surgical resources are available).

The recommendations above represent generalized opinions from experts in their fields, but decisions must be made on a case-by-case basis

PCS CANCER COMMISSION

Source: SSO Cancer Surgeries in the Time of COVID-19

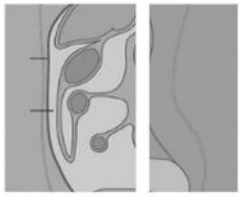
Cancer in the time of Covid-19

Peritoneal Surface Malignancy Surgery Guidelines

- Operate on patients with malignant bowel obstruction if a palliative procedure is feasible.
- As CRS/HIPEC can take unique levels of resources, special consideration should be made for proceeding with these cases.
- Defer CRS/HIPEC for low grade appendiceal mucinous neoplasms except in extreme circumstances
- Consider systemic chemotherapy for peritoneal metastases from high grade appendix cancer, gastric cancer, colorectal cancer, high grade mesothelioma, ovarian cancer and desmoplastic small round cell tumors.

If patients are completing neoadjuvant chemotherapy and are ready for surgery, consider continuing chemotherapy if responding and tolerating therapy. For those who cannot continue neoadjuvant chemotherapy then consider delaying surgery for:

- 4-6 weeks in patients with high grade appendiceal, colorectal, mesothelioma, or ovarian cancer.
- 2 to 4 weeks in patients with gastric cancer or desmoplastic small round cell tumors.



Defer surgery for peritoneal metastases from rare low-grade malignancies such as neuroendocrine tumors and gastrointestinal stromal tumors.

The recommendations above represent generalized opinions from experts in their fields, but decisions must be made on a case-by-case basis

PCS CANCER COMMISSION

Source: SSO Cancer Surgeries in the Time of COVID-19

Cancer in the time of Covid-19

Sarcoma Surgery Guidelines

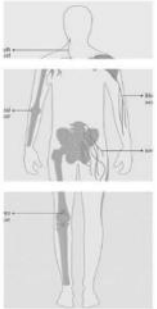
A primary soft tissue sarcoma without metastatic disease on staging that needs surgery will be prioritized for the OR.

- Deferring the surgical treatment of newly diagnosed truncal/extremity well-differentiated liposarcoma/ALT and desmoids for at least 3 months or more. Reassess at that time.
- Resection of other low-grade lesions with known indolent behavior (e.g., retroperitoneal well-differentiated liposarcoma) and low metastatic risk (e.g., myxoid liposarcoma, low grade-fibromyxoid tumor) can be deferred for short intervals depending on available resources.
- Consider short interval deferral of re-excision for R1 margins in extremity/truncal lesions if OR resources are limited.

If there is an indication for radiation therapy, plan to do it preoperatively (already do that anyways). This can be administered in a lower risk outpatient setting and will push out the timing of surgery for about 3-4 months.

Use of neoadjuvant therapy for high grade sarcomas or recurrent disease can be considered if it can be safely delivered in an outpatient setting as a means of deferring surgical intervention.

Active observation protocols or low-toxicity systemic options can be considered for patients with recurrent disease. Surgery for recurrent disease can be offered to patients who:



- are likely to have relatively high chances of obtaining long-term disease control in the context of complete gross resection (e.g., long disease-free interval, solitary site of recurrence)
- require immediate palliation (e.,g., due to bleeding, obstruction), and
- who do not have indolent histologies (e.g., well-differentiated liposarcoma in the retroperitoneum) that can be managed with active observation.

The recommendations above represent generalized opinions from experts in their fields, but decisions must be made on a case-by-case basis

PCS CANCER COMMISSION

Source: SSO Cancer Surgeries in the Time of COVID-19

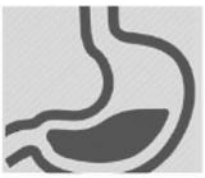
Cancer in the time of Covid-19

Upper Gastrointestinal Cancer Surgery Guidelines

- Most gastrointestinal cancer surgery is not elective.

GASTRIC AND ESOPHAGEAL CANCER:

- cT1a lesions amenable to endoscopic resection should preferentially undergo endoscopic management.
- cT1b cancers should be resected.
- cT2 or higher and node positive tumors should be treated with neoadjuvant systemic therapy.
- Patients finishing neoadjuvant chemotherapy can stay on chemotherapy if responding and tolerating treatment.



- Defer surgery for less biologically aggressive cancers, such as GIST unless symptomatic or bleeding.

The recommendations above represent generalized opinions from experts in their fields, but decisions must be made on a case-by-case basis

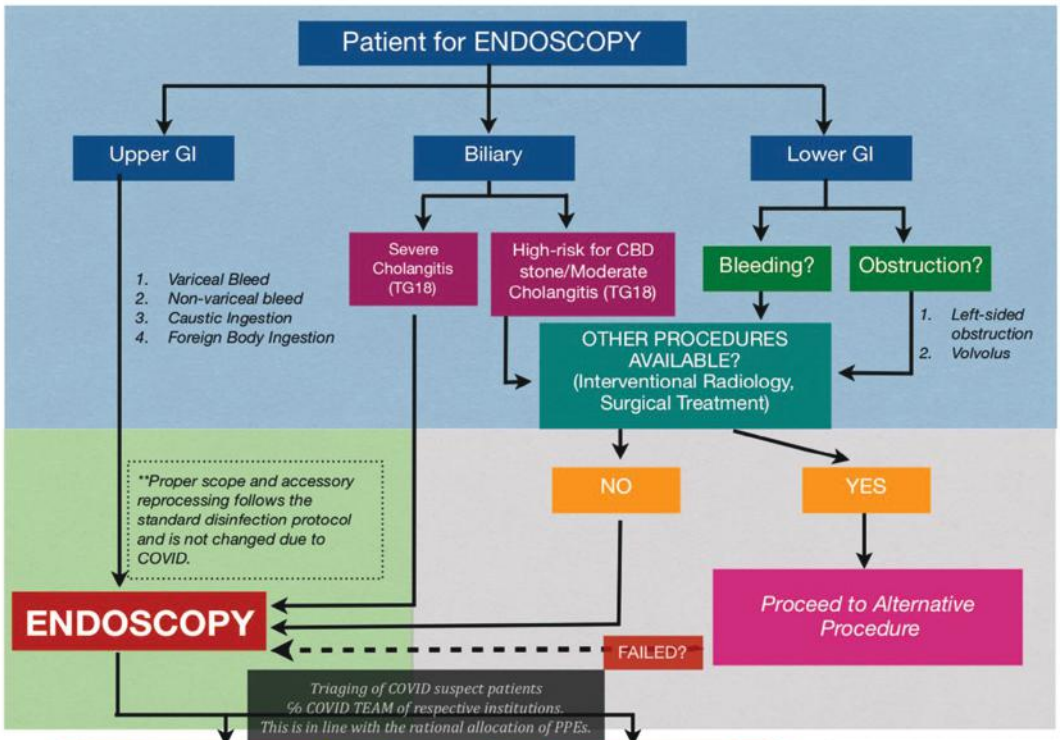
PCS CANCER COMMISSION

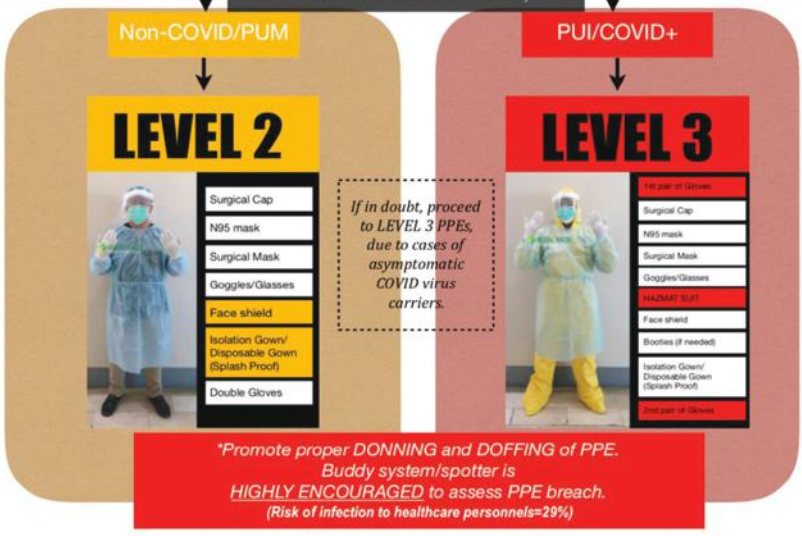
Source: SSO Cancer Surgeries in the Time of COVID-19

ALGORITHM FOR COVID-19 GUIDELINES IN TRIAGING EMERGENCY/URGENT ENDOSCOPY CASES

*All ELECTIVE endoscopic procedures should be SUSPENDED for now.
** It is HIGHLY RECOMMENDED that PUIs/COVID positive patients should use a separate TOILET (especially those who had bowel preparation for colonoscopy)
*** Proper room decontamination should be STRICTLY ADHERED TO every after procedure.

NOTE: THIS ALGORITHM IS SUBJECT TO CHANGE.





NOTE:
1. All ENDOSCOPY Cases are considered as AGP (Aerosol-generating procedure) hence at least LEVEL 2 PPE is required. **(REMEMBER!!! Viable virus stays-3hrs in aerosols and 3 days in surfaces)**
2. LEVEL 1 PPE (consists of N95 mask, facemask, goggles//glasses/gloves) are REQUIRED for low-risk exposure (OPD consultation/Non-PUI exposure

*Promote proper DONNING and DOFFING of PPE.
Buddy system/spotter is
HIGHLY ENCOURAGED to assess PPE breach.
(Risk of infection to healthcare personnels=29%)

Sources:
1. Soetiko, et al. 2020. Considerations in performing endoscopy during the COVID-19 pandemic.
2. ASGE Joint GI Society Message: COVID-19 Clinical Insights for Our Community of Gastroenterologists and Gastroenterology Care Providers
3. SAGES Regarding Surgical Response to COVID-19 Crisis
4. CDC's Interim US Guidance for Risk Assessment and Public Health Management of Healthcare personnel with Potential Exposure to in a Healthcare setting to patients with COVID-19
5. American College of Surgeons: COVID-19 and Surgery
6. ESGE and ESGENA Position Statement on gastrointestinal endoscopy and the COVID-19 pandemic
7. Yafei, et al. 2020. Suggestions of Infection Prevention and Control in Digestive Endoscopy During Current 2019-nCOV Pneumonia Outbreak in Wuhan, Hubei Province, China
8. Tokyo Guidelines on Acute Cholangitis 2018
9. ASGE Guidelines on Management of Choledocholithiasis

RIZAL MEDICAL CENTER

Laparoscopic Surgery in COVID-19

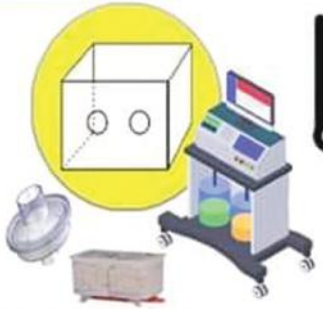
Philippine Association of Laparoscopic and Endoscopic Surgeons

OPERATING ROOM SET UP

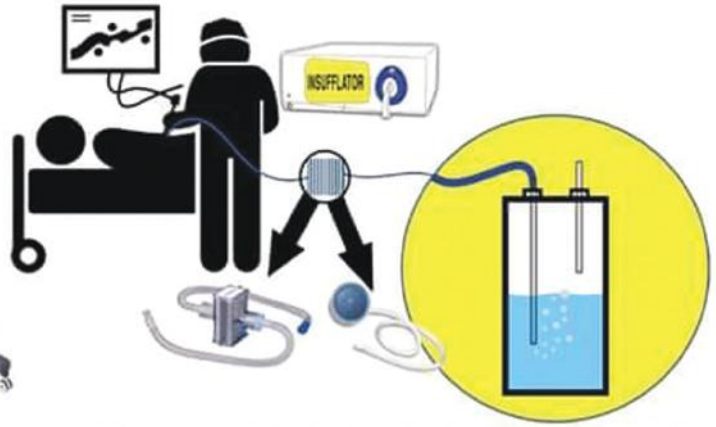
- PPE is imperative
- Donning and more importantly Doffing must be properly maintained, with a Donning Quality officer.
- Maintain integrity of PPE at all times.

*Watch a video on proper Donning and Doffing.

- DO NOT reuse trocars
- Appropriate sized incision for trocar sites to avoid gas leak.
- Keep instruments blood free.
- Minimize changing of instruments.
- Set electrosurgical power settings to a minimum.
- Use suction liberally to reduce surgical smoke.
- Minimize trendelenburg position.



- Ensure high efficiency hydrophobic filter placed between facemask and breathing circuit
- Heat and Moisture Exchanger (HME) filter should be placed on the expiratory limb of the circuit.
- Both HME filters and the soda lime are changed after each case.
- Use of aerosol boxes

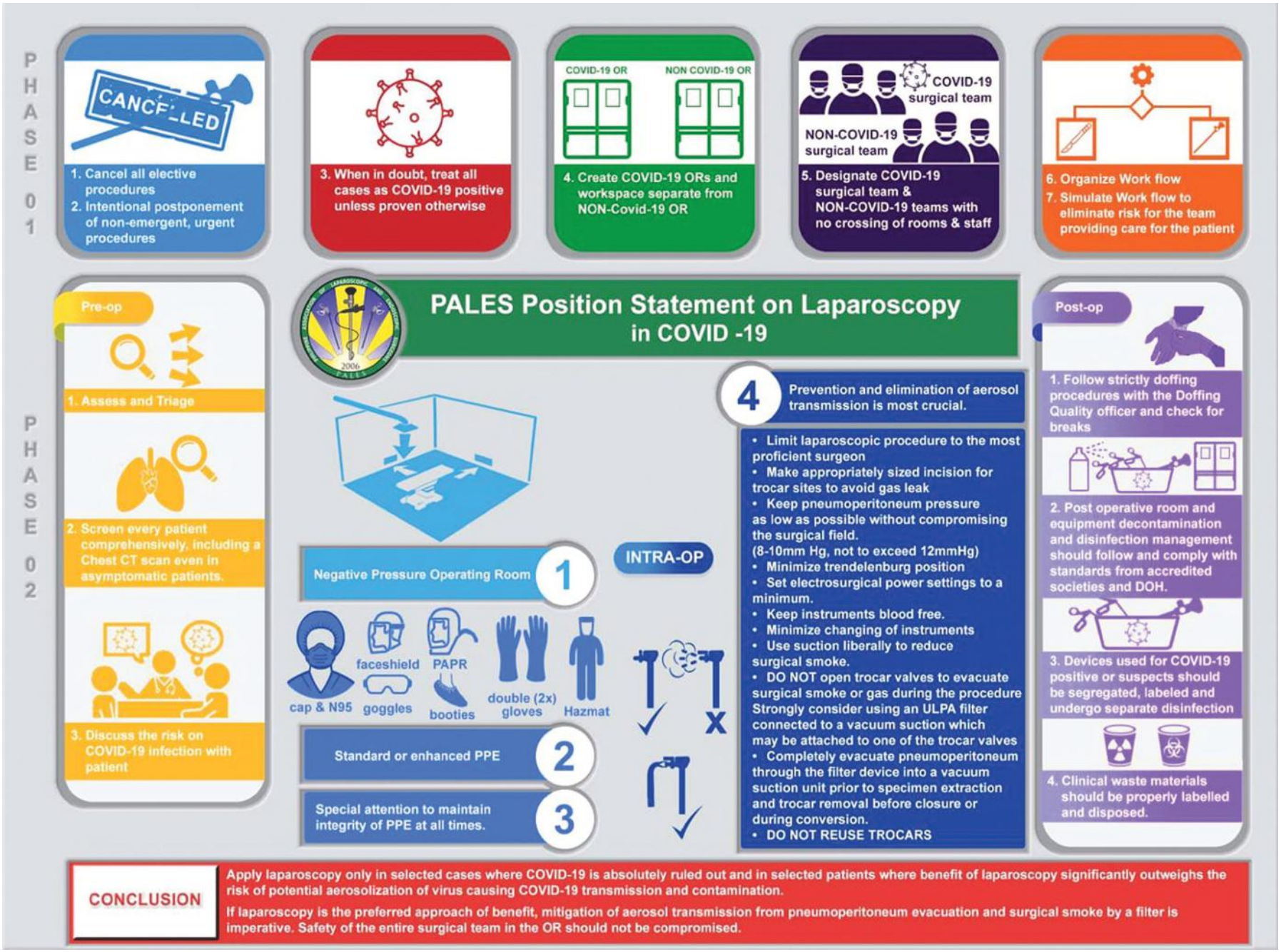


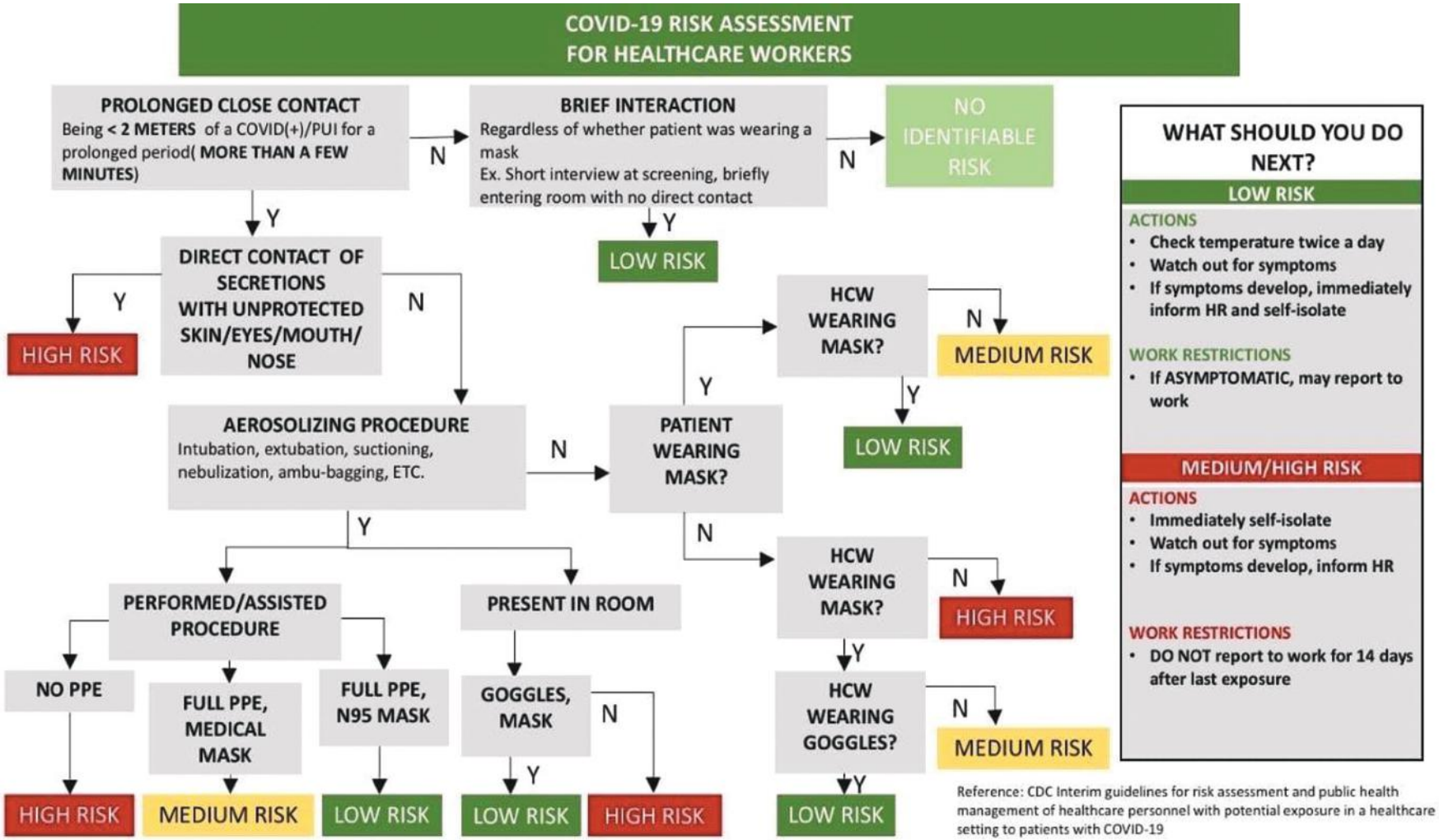
- Strongly consider using an ULPA filter connected to vacuum suction unit attached to the trocar valve.
- Complete evacuation of pneumoperitoneum through the ULPA filter before specimen retrieval, conversion or removal of trocars.
- DO NOT evacuate surgical smoke thru the trocar valve without a smoke evacuator system or a closed ULPA filter vacuum suction system.
- Maintain intra-abdominal pressure **as low as possible.**

*8-10mmHg, not to exceed 12mmHg.

- It is strongly recommended to apply laparoscopy only in selected cases where COVID-19 is absolutely ruled out and in selected patients where benefit of laparoscopy significantly outweighs the risk of potential aerosolization of virus causing COVID-19 transmission and contamination.

For more information: www.pales.ph pales_06@yahoo.com 09176002073


PHASE 01
CANCELLED
1. Cancel all elective procedures
2. Intentional postponement of non-emergent, urgent procedures
3. When in doubt, treat all cases as COVID-19 positive unless proven otherwise
COVID-19 OR
NON COVID-19 OR
4. Create COVID-19 ORs and workspace separate from NON-Covid-19 OR
COVID-19 surgical team
NON-COVID-19 surgical team
5. Designate COVID-19 surgical team & NON-COVID-19 teams with no crossing of rooms & staff
6. Organize Work flow
7. Simulate Work flow to eliminate risk for the team providing care for the patient
PHASE 02
Pre-op
1. Assess and Triage
2. Screen every patient comprehensively, including a Chest CT scan even in asymptomatic patients.
3. Discuss the risk on COVID-19 infection with patient
PALES Position Statement on Laparoscopy in COVID -19
Negative Pressure Operating Room
1
cap & N95
faceshield
goggles
PAPR
booties
double (2x) gloves
Hazmat
Standard or enhanced PPE
2
Special attention to maintain integrity of PPE at all times.
3
INTRA-OP
4
Prevention and elimination of aerosol transmission is most crucial.
• Limit laparoscopic procedure to the most proficient surgeon
• Make appropriately sized incision for trocar sites to avoid gas leak
• Keep pneumoperitoneum pressure as low as possible without compromising the surgical field.
(8-10mm Hg, not to exceed 12mmHg)
• Minimize trendelenburg position
• Set electrosurgical power settings to a minimum.
• Keep instruments blood free.
• Minimize changing of instruments
• Use suction liberally to reduce surgical smoke.
• DO NOT open trocar valves to evacuate surgical smoke or gas during the procedure Strongly consider using an ULPA filter connected to a vacuum suction which may be attached to one of the trocar valves
• Completely evacuate pneumoperitoneum through the filter device into a vacuum suction unit prior to specimen extraction and trocar removal before closure or during conversion.
• DO NOT REUSE TROCARS
Post-op
1. Follow strictly doffing procedures with the Doffing Quality officer and check for breaks
2. Post operative room and equipment decontamination and disinfection management should follow and comply with standards from accredited societies and DOH.
3. Devices used for COVID-19 positive or suspects should be segregated, labeled and undergo separate disinfection
4. Clinical waste materials should be properly labelled and disposed.
CONCLUSION
Apply laparoscopy only in selected cases where COVID-19 is absolutely ruled out and in selected patients where benefit of laparoscopy significantly outweighs the risk of potential aerosolization of virus causing COVID-19 transmission and contamination.
If laparoscopy is the preferred approach of benefit, mitigation of aerosol transmission from pneumoperitoneum evacuation and surgical smoke by a filter is imperative. Safety of the entire surgical team in the OR should not be compromised.



Reference: CDC Interim guidelines for risk assessment and public health management of healthcare personnel with potential exposure in a healthcare setting to patients with COVID-19

MANAGING COVID-19 IN SURGICAL SYSTEMS

Prepare for a rapidly evolving situation: re-evaluate frequently

Educate all staff on PPE and COVID-19 management

Postpone elective operations immediately, save personnel & PPE

Decrease health care staff exposure: Limit to most experienced

Develop a clear plan for providing essential operations

OR/RR may need to be converted to ICUs as landscape changed

Develop A dedicated COVID operating space

- Specific room for all COVID operations
- No unnecessary items inside
- Minimize traffic in and out
- Recover in OR until ready for isolation room
- Keep transport pathways clear
- Specific care pathways should be developed for each site

Reference: M. Brindle & A. Gawande, Managing COVID in Surgical Systems. Annals of Surgery 2020. Pre-publication

Surgical LAUGHaroscopy: Comedy in the midst of the pandemic

• **Jose Benito A. Abraham, MD, FPCS, FPUA** •

DISCLAIMER: *Some of these are mine, but some I just picked up over the course of this quarantine… Here's something to lighten up the pandemic gloom…*

Prediction during the ECQ: There will be a minor baby boom in nine months, and then one day in 2033, we shall see the rise of the **Quaranteens**.

The scariest in this pandemic: Working in a bank, and then two guys come in… with (ski) masks…

The Corona beer has decided to change their name to avoid association with the COVID pandemic, they decided to name it Ebola…

The paradox: People who normally stayed at home before the pandemic are the same exact guys who are itching to go out on the streets during the ECQ…

Quite unusual: During the quarantine, children are now yelling at their parents for going out…

Be like Darth Vader in this pandemic: He wears a mask, is emotionally and socially distant, doesn't visit his relatives and he follows orders

Best movies during the Pandemic: Home Alone, Home Alone 2, Home Alone 3

Dreaded movie to watch out for: Home Alone (with Chucky!)

Even more dreaded movie to watch out for: Home Alone (with Freddie!)

Most dreaded movie to watch out for: Going Home Alone (on the Train to Busan!)

Biggest question I have: Why do other people have Netflix, while I have to attend to countless Webinars?!

Biggest realization during pandemic: Now I know why my dogs are excited to go for walks daily!

Biggest excitement: April 30 marks the end of lockdown…

Biggest frustration: May 1 is the beginning of the extension…

Biggest surprise: The government sent my husband a warning that given the COVID situation, he is at highest risk for an infection because of his underlying condition. Personally, I seriously doubted that. He's been dead four years!

Seen over Viber: President Akufo-Addo saying " We know how to bring the economy back to life, what we don't know is how to bring the dead back to life…" (Stay at Home)

To parents: If you are worried about your children watching too much TV during the ECQ, just MUTE the speakers, turn on the subtitles (or CC) and BOOM! They are now reading…

The Department of Health is looking to hire couples who have been married for 7 years or more to educate people on social distancing…

Siguro i-lift na lang ang ECQ sa June 12...Araw ng Kalayaan...
Para damang dama tapos sabay nating pupunitin ang Quarantine Pass!!! Mabuhay ang Pilipinas!

Of COVID and toilet paper:

- If you need 144 toilet paper rolls in 14 days, you should have been seeing the doctor before the COVID-19 pandemic.

> 16