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# AFNI Recommendations for Reopening of Outpatient Clinics and Elective Surgery During the COVID-19 Pandemic

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## I. Recommendations For Reopening of Outpatient Clinics During The COVID-19 Pandemic

In anticipation of the lifting of the Extended Community Quarantine in many areas of the Philippines, and the state of General Community Quarantine now in the rest of the country, most hospitals and stand-alone Outpatient Doctors' Clinics have already set protocols for the safe resumption of outpatient services. Each neurosurgeon should formulate his/her own clinic policies based on prevailing general principles of safety during this COVID-19 pandemic, with these clinic policies in line with the policies of the hospital and its Outpatient Department and Doctor's Clinics. The following recommendations for reopening of outpatient clinics, although not exhaustive, are summary of recommendations from various sources and are based on the PCS Guidelines on Post-ECQ Resumption of Elective Surgeries and Outpatient Clinics.

### A. Prior to Clinic Visit

1. Establish a Triage system at the out-patient department to screen patients before entering Doctors' Clinics. Patients who are COVID-19 suspects shall be referred to the hospital's Main Triage area for further evaluation[1] after proper coordination with the attending surgeon.[2]
2. A "No mask, No entry" policy should be implemented.
3. Check temperature of everyone entering the building.
4. Hand sanitizers/alcohol should be provided at the entrance of the building.
5. Physical distancing of at least one meter apart must be observed on the way to the surgeon's clinic.
6. For patients (including postoperative) not needing special assistance, only one companion is allowed. If assistance is necessary (e.g. wheelchair and stretcher-born patients), two companions are allowed.[2]

### B. Clinic Physical Set-up

1. The waiting areas and the clinic itself should be redesigned to provide physical barriers, distancing, and safe flow of people. Installation of visual alerts and reminders must be provided in the waiting areas.
2. Setting up appropriate plastic, acrylic or glass barrier between doctor/clinic staff and patient during interview may provide protection, but these can interfere with the physical assessment of the patient and is an added area that may be contaminated, and therefore should be disinfected.[3]
3. Air conditioning may be used but be sure to open the window/door or turn on the exhaust fan. Electric fans are not advisable.[3]

### C. Clinic Protocol

1. All clinics should follow the principles of social and physical distancing. Consultations, including postoperative follow ups, must be scheduled and should be on appointment basis to appropriately space patients' arrival and avoid crowding at the clinic and corridors. Optimize use of telephone/ telehealth/virtual visits when possible.[1]

2. Patients must be seated at least 1 meter apart.
3. Patient and companion/s must disinfect their hands either by proper hand washing or through hand sanitizers provided at the entrance of the clinic.
4. Only the patient and one companion are allowed inside the clinic's waiting area and doctor's consultation room.
5. Clinic schedules must be posted and updated, and should adhered to as much as possible, adjusting to in-patient rounds to avoid long waiting time.[2]
6. All patients must have records of full contact details indicating their complete address/ Barangay in order to quickly contact them for pertinent issues.[2] Date and time of consultation must also be recorded in patient's OPD card/ chart.
7. The clinic staff should be trained on all precautionary measures done to avoid the risk of infection.[1]
   Patients and their companions should also be asked for symptoms of possible COVID-19 infection (e.g. fever, cough, difficulty of breathing, body malaise), history of possible exposure to a COVID-19 infected person, and being actually tested for COVID-19 infection.
8. Disinfect clinic surfaces regularly and every after coming in contact with each patient using 0.05%[4] – 0.1% (1:100 dilution) hypochlorite or at least 70% ethyl/isopropyl alcohol. Alarms may be used as reminders.
   Cleaning of toilets, bathroom sinks and sanitary facilities need to be carefully performed, avoiding splashes. Disinfection should follow normal cleaning using a disinfectant effective against viruses (i.e. 0.1% sodium hypochlorite[4]). For sodium hypochlorite, the minimum contact time for surface disinfection is 1 minute. Sodium hypochlorite is known to be corrosive to metals, so wipe metal surfaces with water or ethanol after treatment.[5]
   Ethyl alcohol (ethanol) and Isopropyl Alcohol may be used to disinfect surfaces at 70% solution. The presence of water in the alcohol is required to denature proteins, as well as to increase the contact time on a surface while the alcohol is evaporating.[6]
9. Disinfection and change of linen should be done after every patient.[1]
10. Cover porous surfaces like BP cuffs and cloth upholstery with washable plastic/ leatherette.[2]
11. Clean the entire room at the end of clinic hours, wipe down all surfaces with disinfectant, may use UVC lamps for terminal cleaning.[3]

**D. Physician and Secretary**

1. All clinic personnel involved in direct patient care should wear disposable gloves, surgical mask (N95 or similar mask is ideal), face shield or goggles, and water repellant gowns/coveralls (optional). To minimize disease transmission, avoid wearing medical smock gown, necktie, watch and other pieces of jewelry. Wearing short sleeves is advised for easy hand washing.[1] Wearing closed shoes is preferred, shoe covers are not needed.[3]
2. Change gloves after every patient.[3]
3. Hand washing or the use of alcohol-based disinfectant should be done after examining the patient and after each consult.[1]
4. Consultation time should be minimized (less than 15 minutes per patient) as warranted.
5. Extreme care should be exercised when doing oral, rectal, internal examination, or minor surgical procedures. Ensure proper disposal of the contaminated gloves, and adequate disinfection of the reusable instruments or devices.
6. Maintain number of staff to the minimum necessary (1-2).[3]
7. Minimize patient's follow ups at clinics. Communicate through email, call or text and secure platform for laboratory results' follow up.[2]
8. Observe inter-clinic referral system. Communicate referrals with other clinic first prior to scheduling to avoid long waiting time.[2]

9. Minimize handling money through contactless payment transactions (i.e. card tap, Gcash, Paypal, Paymaya, bank transfer, etc.)[3]
10. Physicians with multiple clinics are advised to see patients in only one clinic.[1]

## II. Recommendations For Patients For Elective Surgery

The following are recommendations in preparing a patient for elective surgery and are mostly adopted from the PCS GUIDELINES ON POST-ECQ RESUMPTION OF ELECTIVE SURGERIES AND OUTPATIENT CLINICS dated April 20, 2020.

### A. Timing of Surgery

1. Any patient who has returned from travel outside the country or from high density COVID-19 community, should not have their procedure scheduled in the first 14 days following their return even if asymptomatic.
2. Any patient who has been in direct contact with a known confirmed COVID-19 positive patient should not have their procedure scheduled within 14 days of the contact even if asymptomatic.
3. Any patient who has been in direct contact with a person who is undergoing test for COVID -19 should not have their procedure until the results are confirmed negative even if asymptomatic.
4. Any patient who has influenza-like illness at the time they show up should not have their procedure until they have recovered.
5. Any patient who has unexplained new cough should have their procedure delayed until it has been investigated.

### B. Pre-operative Screening for COVID-19

1. Consider testing all patients with RT-PCR prior to their scheduled procedure. If there is a discrepancy between clinical findings and testing, if RT-PCR is indeterminate or negative in asymptomatic patient with history of contact with COVID-19 positive test result, a CT scan of the chest can be a quick adjunct to detect early and subtle lung changes, as well as diagnose pneumonia that may warrant further testing of these patients.
2. Patients with RT-PCR COVID-19 positive test result: defer the planned elective surgery until patient becomes COVID-19 negative. There are reported high morbidity and mortality rates in patients undergoing surgery during the incubation period of COVID-19 infection.
3. Stringent screening of patients is most important. Check whether a patient had been in contact with any COVID-19 confirmed, probable or suspect in the community. High morbidity and mortality in a subset of asymptomatic patients who were operated during their incubation period had been reported.
4. Patients should undergo cardiac and pulmonary risk assessment. Consider Infectious Disease Specialist (IDS) evaluation as needed prior to surgery.
5. Explicit patient's consent should be secured prior to the procedure including the possible risk of hospital-acquired COVID-19 infection during the duration of hospital stay.

### C. Special Recommendations for Patients Undergoing Elective Transsphenoidal Pituitary Surgery or Other Transnasal/ Transoropharyngeal Neurosurgical Approaches.

1. Transphenoidal surgeries in patients with SARS-Cov-2 virus have the higher risk of transmitting the virus to operating room staff than other surgeries.[7] A report from Wuhan, China showed that surgery done on elective patients during the incubation period of the SARS-CoV-2 virus has a higher mortality rate than surgery done on non-COVID-19 infected patients.[8]
2. Patients scheduled for elective surgery. It is recommended to cancel the surgery for at least one month[7], with a negative RT-PCR test prior to surgery.
3. For patients needing more urgent Transphenoidal surgery, it is recommended to do two (2)

COVID-19 (RT-PCR) tests, 24 hours apart, with the patient quarantined while waiting for the results of the tests. Surgery may proceed only if both tests are negative.[7]

4. The above recommendations for transphenoidal surgery are also advised for other Transnasal/Transoropharyngeal neurosurgical approaches, as procedures through the nasopharynx poses an inherent danger of SARS-CoV-2 virus transmission due to the high detectable viral titers in the said location.[9]

## References

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