Neurosurgical Society of Australasia
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# Position Statement: COVID-19

Updated 31 March 2020

The COVID-19 crisis has significantly disrupted our clinical, training and selection activities and is a rapidly evolving situation. The health, safety and wellbeing of patients, the community, our members, trainees and applicants is our priority. This has required some difficult decisions to be made which we appreciate have far reaching implications for all involved. It is a rapidly evolving situation and will require very regular updating.

We will keep this updated as information is made available to us. The Board is meeting on a weekly basis at this stage and is in regular contact. We recognise that individual health jurisdictions and employers may have differing approaches to the issues raised. This information should not override that and is designed to be generic in nature to provide some support and suggestions to our members. This was initiated in response to the escalating situation and to two close calls in the last week where neurosurgical units were close to closing due to quarantine requirements.

We encourage all units to provide feedback and we will continually update this information with great ideas that come through. Please submit your feedback anytime at administration@nsa.org.au.

**Transmission during neurosurgical procedures**

There has been concern about transmission of COVID-19 during some routine neurosurgical operations, particularly those involving drills or endoscopes. Please see the following two articles:
https://www.dropbox.com/s/3b6sstymk7c5bfs/COVID-19%20Articles.pdf?dl=0

- COVID-19 has high viral shedding from the nasal cavity.
- Endoscopic endonasal surgery carries a very significant risk and should be avoided.
- Be mindful that international experience indicates N95 masks may not provide protection.
- Only perform pituitary surgery on the most urgent patients who cannot be deferred. Consider craniotomy over transsphenoidal surgery in emergency cases.
- Preoperative COVID-19 testing should be employed where possible. Ideally two tests should be done.
- Where surgery is necessary, consider methods which do not involve debriders and drills within the nasal cavity. A submucosal approach should be considered.
- As blood and CSF is not a recognised vehicle at this stage for COVID-19, most spinal and cranial procedures should be safe with routine face and eye protection.

**Resource Allocation**

- Prioritise elective procedures in consultation with your hospital and health departments to focus on the most urgent patients.
- Consider moving towards more heavily led consultant care. Consultant led care and morning ward rounds are critical to expediate treatment plans and discharges.
- Consideration should be given to transfers between hospitals being arranged consultant to consultant in order to minimise admissions particularly to ICU.
- Transferred patients should bypass the emergency department and be admitted straight to the ward, theatre or ICU for assessment by a consultant to expediate treatment plans.
- Only use ICU beds for cases requiring ventilatory support or invasive monitoring, not for postoperative observation.
- Consider upskilling of ward nurses now for care of patients that might have previously gone to ICU.
- Aim to minimise hospital stays where possible for elective patients. Consider day surgery where possible.
- Move outpatients to videoconferencing and telephone methods where possible.
- Ask for remote access to the hospital. Clinics and other work can be done via remote access from home.

- Special consideration should be given to those who are immunocompromised or high-risk patients requiring inpatient admission and plans for discharge expediated to the outpatient setting and teleconferencing or phone interview where feasible. High risk patients are people aged 60 and over with one or more chronic diseases especially hypertension, diabetes and heart or lung disease, anyone aged 70 and over, Aboriginal and Torres Strait Islander peoples aged 50 and over with one or more chronic diseases and people with pre-existing medical conditions such as asthma, diabetes, heart disease.
- At a state level, discuss with other hospitals contingency plans if a unit becomes unable to function due to COVID-19 quarantine or illness.
- Record the reasons why you may not be offering standard treatment to patients.
- Consider resorbable sutures rather than sutures that require health professionals to remove.
- Try not to bring patients to the hospital any more than necessary. Including avoiding preop admission.
- Consider those patients who would benefit most from neurosurgical care and prioritise.
- Staff who are well but self-isolating can still triage referrals, do telehealth clinics and take referrals.
- Consider postponing long term follow-up patients until the crisis has passed.
- Retired neurosurgeons could be considered for triaging, managing and directing on call remotely and potentially doing teleconferencing/phone consultations and consideration should be given to re-registration where appropriate.

**Management of Neurosurgical Emergencies**

- Reviewing the threshold for acceptance at your hospital. Ideally the decisions to transfer patients should be made consultant to consultant to avoid any unnecessary transfers.
- Share difficult decisions on resource allocations with another consultant
- Reduce multidisciplinary team meetings to just essential senior decision makers
- Subspecialty working will likely change and we may be expected to work outside our comfort zone either within or outside of neurosurgery

**Workforce**

- Preserving the functioning of neurosurgical services and healthcare systems is paramount.
- Designate a lead consultant whose job is to coordinate the team's response in each unit.
- Consider teams within the unit that have no crossover face to face time. Registrar teams ideally need separate offices and handover conducted between teams using a method that does not require face to face time.
- Where possible, structure teams with a mix of subspecialty interest.
- Minimise the number of non-surgical staff within your departments to minimise exposure (ie work from home).
- Ensure all consultants and trainees have refresher training necessary to undertake non-neurosurgical duties. Minimise face to face interactions within the department.
- Have a contingency plan if members of a team become infected or are required to self-isolate.
- Be prepared to assist and prioritise your assistance to the sick and injured even if it is outside the specialty.
- Have contingency plans if members of the neurosurgical department are undertaking duties outside the specialty.
- Be prepared to work extra shifts within your safe limits.
- Structure your rosters so there is backup available at all times
- Network with neighbouring neurosurgical units and be prepared to provide coverage for one another and make contingency plans.

**Out-patients**

- Use teleconferencing or phone consultations where possible.
- Triage your consultations to only high priority. Reduce "dwell time". Patients should not arrive early. Text the patient when ready so they can wait in their car. Schedule appointments so there is no face to face interaction between patients.

**Infection prevention**

- Follow the local guideline for personal protective equipment (PPE).
- Contact your hospital for physical or online training on PPE precautions.