

American Society of Anesthesiologists (ASA) classification of the post-COVID patients: Separate sub-class needed?

Sir,

With extensive vaccine outreach, the pandemic caused by the severe acute respiratory syndrome coronavirus (SARS-CoV)-2 is nearing the end. The pandemic has pushed the dates for elective surgical procedures from weeks to years in several countries in

the past two years and there is insufficient published literature, guidelines, or protocols regarding the perioperative management, morbidity and mortality of coronavirus disease (COVID)-19-recovered patients.^[1] To address this backlog, the number of interventional procedures need to go up and consequently, we have been encountering several patients in their post-COVID-19 phase with varying functional capacities. Although 80% of these COVID-19 recovered patients had had no or minimal symptoms when they were diseased, this does not translate to a risk-free perioperative course. Even patients with a history of asymptomatic COVID-19 or those who had experienced mild COVID-19 without hospitalisation are known to be at risk of COVID-associated perioperative complications.^[2] Post-COVID syndrome

has been defined as persistent residual symptoms beyond 12 weeks after recovery from COVID-19. The most common symptoms include anosmia, ageusia, fatigue or shortness of breath seldom complicated by pulmonary fibrosis, impaired diffusion capacity, cardiac arrhythmias and pulmonary hypertension. These patients are at high risk of catastrophic complications like bronchospasm, rapid desaturation, thromboembolic events (deep venous, pulmonary and cerebrovascular), need for postoperative mechanical ventilation and prolonged hospital stay. Inflammatory markers like D dimer, C-reactive protein and serum ferritin have been known to remain elevated for 6–8 weeks and hence do not possess a significant prognostic value.^[3]

For the last 60 years, the American Society of Anesthesiologists (ASA) physical status classification has been the gold standard to stratify the risk of morbidity and mortality in perioperative patients. This classification ranges from ASA I, posing the least concern, to ASA VI being brain dead patients with special mention of emergency surgeries denoted as E. There have been regular amendments in the classification system to include more comorbidities and rectify the drawbacks.

With the recent pandemic affecting hundreds of millions of people, the need of the hour is to create a separate class or subclass or labelled suffix such as post-COVID (PC) or COVID-recovered (CR) for these patients. Although initial studies have been pointing towards a poorer perioperative outcome in post-COVID patients, there is still a lack of sufficient data to prognosticate the perioperative risk that increases with the history of COVID-19.^[4] A clear protocol including radiological investigations like compression ultrasound, echocardiography, haematological investigations such as inflammatory markers and pulmonary function tests needs to be formulated for special concerns during the preoperative evaluation of such patients.

In conclusion, using a separate classification for post-COVID patients may aid better documentation, and data collection which can be used as the basis for larger multicentric studies to ascertain the added risk of mortality and morbidity and hence a refined understanding of the disease. This uniformity in

documentation can lead to better research with robust data that can be used to identify better prognostic markers of perioperative and long-term outcomes in post-COVID patients. This may further inform the need for preoperative optimisation before elective surgical procedures and consequently reduce the incidence of postoperative complications. With a changed global outlook post-pandemic, this may be a stepping stone for better perioperative care and hence the overall outcome of surgical illnesses. Documenting a separate category may help us to anticipate problems and provide focused perioperative care to such patients. This will avoid surprise events as we can be better prepared to face such complications as corona warriors, relieve stress and strengthen morale.^[5] Thus, COVID-19 disease in the past may not be adequately risk stratified by the ASA PS risk stratification for future documentation. However, we feel this is a preliminary observation and may need a future paper for validation.

Financial support and sponsorship:

Nil.

Conflicts of interest

There are no conflicts of interest.

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Submitted: 07-Jun-2022

Revised: 05-Oct-2022

Accepted: 07-Oct-2022

Published: 19-Oct-2022

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Access this article online	
Quick response code	Website: www.ijaweb.org
	DOI: 10.4103/ija.ija_497_22

How to cite this article: Singh A, Patel G, Ganesh V, Naik BN, Soni SL. American Society of Anesthesiologists (ASA) classification of the post-COVID patients: Separate sub-class needed? *Indian J Anaesth* 2022;66:747-9.

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