Indian Journal of Surgical Oncology (March 2021) 12(1):124–126
https://doi.org/10.1007/s13193-020-01260-x

LETTER TO THE EDITOR

Reinforcing the Known Hygiene Practices for the Health Care Workers (HCW) Along with Working Guidelines for Managing Head and Neck Cancer Patients in the COVID Era

Shivakumar Thiagarajan[1] · Devendra Chaukar[1]

Received: 28 July 2020 / Accepted: 24 November 2020 / Published online: 7 January 2021

Dear Sir,

The COVID-19 pandemic has taken the world by storm and has influenced everyone's life tremendously. Treatment for patients with cancer needs to be delivered despite the existing pandemic. This puts the health care workers (HCW) at a higher risk to contract infection. More than 70–75,000 new cases are registered annually in our hospital, of which the majority comes from different parts of the country. More than 30% of these patients have head and neck cancer. Our hospital took many steps to reduce number of patients visiting the hospital and also to decrease the number of HCWs attending hospital, on rotation, without compromising essential cancer care services as the lockdown was made effective across the country. [1, 2] All patients were screened for symptoms suggestive of COVID-19, temperatures checked, and subsequently sent to their respective services. [1] Patients with prior appointments for hospital visits were contacted and offered teleconsultations. Only patients who were on active treatment or with notable clinical complaints were encouraged to come in person to the hospital. Head and Neck services, besides, laid down a set of working guidelines to be followed during this pandemic and for some time to come ("the new normal") regularly by its HCW (consultants/residents/fellows).

All HCW were advised to take ownership of their own health and safety in addition to the efforts put in by the hospital to ensure safe practices. They were advised to be very particular (obsessive) about the details mentioned in Table 1.

As cancer surgery was categorized as semi-emergency, it had to continue with appropriate personel protective equipment (PPE) [4]. Details of the workup of the patients before treatment are given in Table 1. Modifications were made to avoid unnecessary patient contact and procedures. Focus was reiterated to the HCW's in donning appropriate PPE provided to them while at work. Minor procedures, such as direct laryngoscopies, examination under anesthesia, etc., were also kept to the minimum necessary. The major surgeries were performed like before but in lesser numbers to shortage of manpower. During the initial days of the pandemic, we did not adopt routine COVID-19 testing before elective surgery. COVID-19 testing was done in patients with symptoms suggestive of COVID-19, history of travel from a hotspot, and history of high-risk contact with a COVID-19-positive patient. Given the subsequent increase in COVID-19 positive cases (both in the country and especially in our city, Mumbai) and an increase in the number of asymptomatic COVID-19-positive patients in the community, the policy was modified, and we started doing pre-operative COVID-19 testing before routine cancer surgery.

On the morning of surgery (after all due workup, Table 1), it was mandatory to record the patient's temperature and ensure that the patient is afebrile before shifting patients to the OT. As tracheostomy, elective/emergency, is a highly aerosol-

✉ Shivakumar Thiagarajan
drshiva78in@gmail.com

[1] Department of Head and Neck Surgical Oncology, Homi Bhabha National Institute (HBNI), Tata Memorial Hospital, Mumbai 400012, India

Table 1 Various working guidelines for the HCW'S

A. General instructions

1. Use of electronic medical records for viewing and patients' data entry
2. Physical distancing while examining patients (1 m) and also with colleagues whenever possible
3. Limiting the duration of contact to the minimum possible with patients
4. HCW to don PPE (surgical cap, N-95 mask, face shields, gown) while at work
5. Frequent hand washing and use of hand sanitizers after every contact with patients

B. Specific instruction

1. Keep index of suspicion high and ask history of travel, COVID-19 symptoms
2. Scopies (fiberoptic laryngoscopy, nasal endoscopy) to be done only if considered necessary
3. Patients with tracheostomy to be seen in a designated area in the OPD

C. Investigations

1. Biopsy reports from outside to be honored whenever feasible. Slide and blocks review can be considered if available
   a. Oral cavity: can be biopsied in OPD if needed
   b. Nasopharynx/oropharynx/larynx and hypopharynx: to consider FNA or Trucut biopsy of the node whenever possible for further management
   c. Direct laryngoscopy for larynx and hypopharynx primary to be considered only if deemed necessary for further management
   d. PNS: biopsies to be considered only if absolutely necessary for further management
2. Imaging: for primary and for distant metastasis workup, as per the existing guidelines
3. COVID testing: to be considered on case-to-case basis. A negative report (by RT-PCR) should not give a false sense of complacency (as the false negative rates are significant) [3]
   a. Testing is not mandatory prior to admission for patients, especially when admitted for nonsurgical reasons (optimization prior to surgery)
   b. When to operate in a COVID-positive patient (Fig. 1)

D. Ward

1. To consider nebulization only if absolutely necessary and not to be done routinely
2. Patients with tracheostomy to be kept together in a negative pressure ventilation room to be handled by designated staff only
   a. To cover the tracheostomy tube with a3-ply mask

E. Operation theater (OT)

1. To restrict entry into OT and minimize the number of staff inside the OT
2. While performing aerosol-generating procedure (e.g., marginal mandibulectomy), only surgeon with one assistant to be with the patient

generating procedure, it was done with all PPE donned. It was preferred to be done after intubation whenever possible; if this was not possible, it was advised to adequately anesthetize the tracheal mucosa with intratracheal injection of 4% lignocaine before making the tracheal entry to minimize coughing. Also using the double lumen cuffed tracheostomy tube was encouraged in order to delay early or frequent tube change.

Emergency surgeries such as tracheostomy for stridor/re-explorations in post-operative patients were to be done in the available theater (like before) during daytime, followed by appropriate sanitization of the theater and in emergency theater after working hours. In COVID-positive patients, the procedure was to be done in a designated COVID theater with full PPE as per protocol.

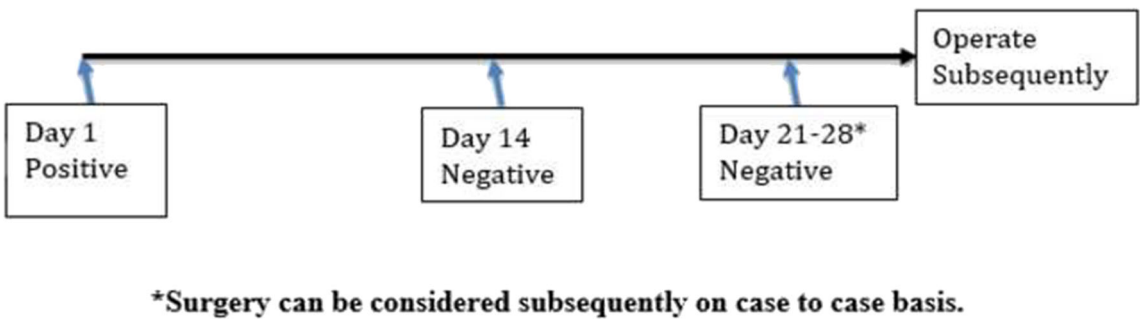

Fig. 1 When to operate on a COVID-19 positive patient

Conclusion

COVID-19 has disrupted the way we deal with life in all spheres. Cancer treatment has to continue during and beyond this pandemic. For this, we need to adopt certain time-tested old practices and some new ones. This will help to protect ourselves and our patients and provide uninterrupted cancer care.

References

1. The Tata Memorial Centre COVID-19 Working Group (2020) The COVID-19 pandemic and the Tata Memorial Centre response. Indian J Cancer 57:123–128
2. Pramesh CS, Badwe RA (2020) Cancer Management in India during Covid-19. N Engl J Med 382:e61. https://doi.org/10.1056/nejmc2011595
3. Kucirka LM, Lauer SA, Laeyendecker O, Boon D, Lessler J (2020) Variation in false-negative rate of reverse transcriptase polymerase chain reaction–based SARS-CoV-2 tests by time since exposure. Ann Intern Med. https://doi.org/10.7326/M20-1495
4. Moletta L, Pierobon ES, Capovilla G, Costantini M, Salvador R, Merigliano S, Valmasoni M (2020) International guidelines and recommendations for surgery during Covid-19 pandemic: a systematic review [published online ahead of print, 2020 may 23]. Int J Surg 79:180–188. https://doi.org/10.1016/j.ijsu.2020.05.061