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## Letters to the Editor

### Regarding “Understanding the ‘Scope’ of the Problem: Why Laparoscopy Is Considered Safe during the COVID-19 Pandemic”



To the Editor:

We read the editorial titled “Understanding the ‘Scope’ of the Problem: Why Laparoscopy Is Considered Safe during the COVID-19 Pandemic,” recently published in the journal, with great interest [1]. In recent weeks, anesthesiologists are at the frontline of the fight against coronavirus 2019 (COVID-19), particularly at the time of airway management. When we talk about surgery, surgeons and other operating room medical personnel are at risk of infection at the same time. Postponing all elective surgeries during the COVID-19 pandemic has become a standard of care today, but there are still many cases in which it is not possible to delay surgery. It makes sense that as much as we care about the patient, we care about the health of the staff too. Under normal circumstances, laparoscopic approaches may be of great benefit to the patient, but in a crisis caused by a respiratory infection, the situation will definitely be different. The major route of transmission of Severe Acute Respiratory Syndrome Coronavirus 2 is through respiratory droplets, and the most dangerous situation for healthcare workers is performing laryngoscopy and intubation. Therefore, avoiding general anesthesia, which requires airway management (e.g., intubation), is one of the most important ways to protect them [2,3]. Thus, local methods such as neuraxial blocks are superior to general techniques of anesthesia. Because most laparoscopic surgeries require procedures such as Trendelenburg positioning, which is best done under general anesthesia, laparoscopic approaches cannot be insisted on as much as earlier for surgeries.

On the contrary, we are at risk of the virus spreading because of the process itself. It is true that because of the restrictions on the feasibility of research, no case of virus transmission through surgical smoke plumes has been proven yet, but no research has been conducted that refutes such a possibility. The presence of the virus RNA in the stool has been proven in nearly half of the patients even after they have recovered [4]. Furthermore, the possibility of virus shedding in urine is another concern [5]. Thus, no space in the abdominopelvic cavity can be considered virus-free and importing a laparoscopic trocar to any point in this space carries the risk of spreading the virus throughout the operating room by gas insufflation. However, in the

interaction between the anesthesiologist and the surgeon, if the benefits of this technique outweigh the potential harm, laparoscopy can be performed by considering appropriate precautions, as mentioned in the article, to reduce the risk of virus transmission as much as possible.

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## Authors’ Reply

To the Editor:

Thank you for your thoughtful comments on our manuscript. We agree, and have previously stated, that the risk of transmission of severe acute respiratory syndrome coronavirus 2 is increased during aerosol-generating procedures such as intubation and extubation. We acknowledge that most laparoscopic procedures are performed under general anesthesia. In our manuscript, we recommended protecting operating room personnel with appropriate personal protective equipment to reduce the risk

