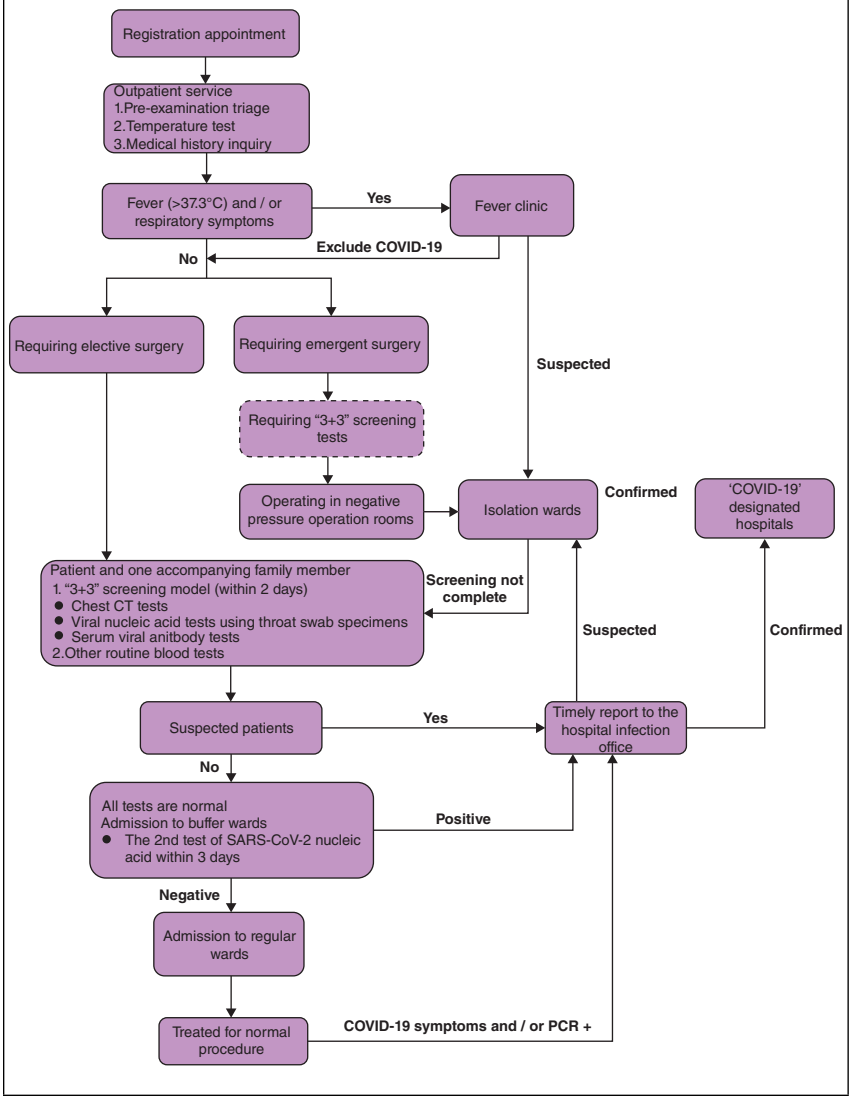
Demobilization strategy for general surgery departments during the recovery period of the COVID-19 pandemic: experience and recommendations from frontline surgeons in Wuhan

Editor

With the recovery from the COVID-19 epidemic in some countries or regions, a demobilization strategy is urgently needed to direct normalization of routine medical services, while effectively protecting the safety of our medical staff and patients against COVID-19 infection. Here, we introduce our demobilization experience of the general surgery department of Wuhan Union Hospital, China (*Fig. 1*).

In regular outpatient clinic visits of general surgery, patients make clinical appointments and fill out epidemiological information. Outpatients are required to wear masks[1] and are subject to pre-examinations at a triage station, including checking health code, temperature testing and medical history. Patients presenting with fever or respiratory symptoms are sent to the designated fever clinics for further testing. Patients with normal body temperature and no respiratory symptoms may enter the clinic. If the patient needs to be hospitalized for elective surgery, they and one of their accompanying family members both receive three COVID-19-related examinations: chest CT examination + viral nucleic acid testing + serum viral antibody testing within 2 days prior to admission (referred to as '3+3' screening model). The wards for inpatients needing elective surgery are categorized into three types based on patients' infection risk and corresponding personal protection levels: buffer wards, regular wards and isolation wards. If the 3+3 results are positive in suspecting or confirming COVID-19, healthcare workers should immediately report and transfer this individual an isolation ward or "COVID-19" designated hospital[2]. If the 3+3 results are normal, they are admitted to a single room in the buffer ward for the second testing of SARS-CoV-2 nucleic acids within the following 3 days. If test still remains negative, this patient is transferred to a regular ward. If the test is positive, the patient is transferred to an isolation. In addition, after elective surgery, patients in regular wards who develop COVID-19 symptoms with nucleic acid testing positive are also transferred to isolation wards.

Fig. 1 Demobilization strategy for general surgery departments during the recovery period of COVID-19 pandemic



For patients requiring emergency surgery, if COVID-19-related tests are not completed prior to surgery, they should be regarded as suspected cases and the operation carried out in negative pressure or special operating rooms[3]. All clinicians involved in operations should adopt at least level II personal protection equipment (PPE). After emergency surgery, patients are transferred to the isolation wards for further screening examinations and treatment. Given the reported COVID-19 infection rate in medical staff in Wuhan[4], it is now mandatory for all healthcare workers to receive chest CT, nucleic acid testing and serum antibody testing before returning to clinical work[5]. Moreover, it is still recommended to keep using appropriate PPE during daily clinical practice.

Contributions

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