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## CORRESPONDENCE

### Re: Strategy for the practice of digestive and oncological surgery during the Covid-19 epidemic



Dear Editor,

We would like to draw your attention to the article published in your journal by Tuech J-J et al. highlighting the recommendations regarding surgeries including laparoscopy during the Covid-19 pandemic [1].

Various surgical societies are issuing guidelines recommending the use of balloon laparoscopic ports in the era of Covid-19 crisis. Whilst we can commend their reflective and pro-active efforts, we should mention that:

- that the authors' recommendation could expose the OR staff to a risk of face splash in case of abrupt balloon deflation;
- the Covid crisis highlights how lightly the risk of staff contamination during laparoscopy has been dealt with so far [2].

There is no friendly germ in the OR: hence protecting patients and staff in the OR from Covid should differ little from other active pathogens present in the respiratory, digestive, urinary or blood system. A survey in the UK revealed only 3 of 98 surgeons used dedicated smoke extractors, despite the fact the majority felt that, currently, inadequate precautions were taken to protect staff and patients from surgical smoke. The benefit of wearing protective masks in the operating room was still disputed until recently in the literature [3]. This is despite overwhelming evidence of the presence of toxic chemicals and organisms in the smoke [4]. Indeed, recently it has been confirmed that SARS-CoV-2 may be present in peritoneal fluid as well [5].

The best of the balloons will always remain a fragile element that can deflate at any time or burst after puncture or thermal damage [6]. It results in an abrupt and uncontrolled deflation of the abdomen exposing the team to face splash.

Reflecting on and avoiding commonly observed practices such as:

- lack of face protection;
- skin incision following the rule of thumb;
- unsecured port stabilization;
- use of port technology leaking abundantly at each instrument change;
- standard high abdominal pressure;
- inconsistent use of gas (smoke/plume/spray) evacuation filters;
- removing trocars before full abdominal deflation without caution.

We therefore support the following:

- adjusting the size of the skin incision precisely to the size of the port, with systematic marking;
- avoiding the use of a port with a smooth surface, which is not secured to the abdominal wall layers and rather

choosing a port with any sort of grip surface that limits them from sliding;

- securing trocars safely rather than relying on balloon-tip ports, that may or may not burst;
- no re-use of trocar seals that can be damaged by needles and using only high-quality disposable seals or full disposable ports;
- no use of ports that do not allow a gas tight insertion of an instrument;
- tailoring insufflation at the lowest possible abdominal pressure;
- evacuation of the smoke from any energy devices as soon as it is produced to avoid accumulation in a gas tight abdomen, by use of automated devices or hand activated suction device;
- maintaining a low and controlled flow of gas evacuation, with an automated insufflator/evacuator or a filter at the end a simple tubing;
- deflating the abdomen prior trocar retrieval using filters and/or special gas evacuation medical device.

#### Disclosure of interest

The author declares that he has no competing interest.

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