

# Reply to Comment on the article titled ‘Nosocomial SARS-CoV-2 transmission in postoperative infection and mortality: analysis of 14,798 procedures’ by Elliott JA et al.

Jessie A. Elliott and Paul F. Ridgway on behalf of the authors

Department of Surgery, Tallaght University Hospital, Dublin 24, Ireland (e-mail: ridgwayp@tcd.ie)

Dear Editor,

We thank Professors Agrawal and Sharma for their consideration of our paper. We note with their comments regarding the change in the level of fear of transmission risks to healthcare workers over time. Thankfully, in practice, we are not seeing significant transmission of SARS-CoV-2 to laparoscopic surgical teams, as was the fear early in the pandemic.

Our report centres on SARS-CoV-2 transmission risks in the perioperative patient. Since our paper submission, it is becoming clearer that our modeling, particularly around length of stay and complexity of procedures are valid and major factors for the improved laparoscopic outcomes. On that basis, we concur fully with the Professors’ assertions around the utility of Enhanced

Recovery after Surgery programmes to shorten length of stay, regardless of operative technique.

Defining COVID specific deaths while in theory is very desirable, in practice is very fraught. There are a significant number of confounding variables (time of acquisition, comorbidity type, associated complications etc). We believe that the exact additional risk conferred by acquisition of SARS-CoV-2 in the perioperative patient will be answered by large outcome datasets, and thus retrospectively. For now, we believe our study offers a pragmatic framework for clinicians to interpret risk for their patients for procedures in the context of the background virus prevalence (see supporting information in original article).

*Disclosure.* The authors have no conflict of interest to declare.