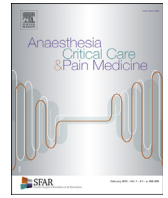




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Letter to the Editor

Answer to the letter by Niño et al.



Dear Editor,

We would like to thank Dr Niño and colleagues for their positive and relevant remarks on our guidelines on anaesthetic management during the SARS-CoV-2 pandemic [1].

We fully agree with the first comment on the interest of a pre-anaesthetic teleconsultation. It has indeed been proven by several groups that telemedicine in anaesthesia is a feasible practice, appreciated by patients, that is safe and does not lead to more cancellation of surgery than physical consultation [2]. At first glance, one might think that the use of telemedicine should be preferred for patients living in rural areas and/or living far from the hospital, but teleconsultation, even in the format of a simple phone call, remains the preferred method for patients regardless of the distance from their place of residence, their co-morbidities, and the cumbersome nature of the planned surgery [3,4]. So yes, we can! However, this enthusiasm of patients and certain practitioners for dematerialised consultation techniques should not be the tree that hides the forest. Indeed, the transition, even partial, from in-face to teleconsultation must be prepared and a minimum of prerequisites are necessary, such as: the availability of high-performance computer equipment; the availability of a secretariat to organise the call planning and the sending before the teleconsultation of the documents to be prepared by the patient; the use of secure applications to preserve the confidentiality of the medical data exchanged; or the training of anaesthetists in the institutional tools made available. Finally, the regulatory aspect should not be neglected, and it is important to check that a teleconsultation has the same medico-legal value and is reimbursed to the same extent by the national health insurance organisation as a physical consultation. In this sense, France is probably late in this area, and the first wave of the COVID-19 pandemic during Spring 2020 was certainly an opportunity to begin to make up for this delay. Indeed, the travel restrictions required by the health situation and imposed by the government during the lockdown have made it almost compulsory to use teleconsultation to anticipate the resumption of surgical activity after the first wave of the pandemic. This crisis therefore represented both an opportunity to implement a technology that was previously used only occasionally, and a constraint at a time when many anaesthetists who were also involved in the management of patients with severe forms of COVID-19 had little time to train in the technique and to organise the first teleconsultations, which inevitably wasted time before gaining

time later. Thus, although teleconsultation has been set up in many French centres, its success has been variable. As with any "technique" there is a learning curve, and time is still needed before this technique supplants physical consultation. Finally, it should be noted that teleconsultation is sometimes not possible, particularly with elderly patients, those who are not computer-literate or who are visually or hearing impaired, and that in all studies on the subject a small contingent of patients are excluded from teleconsultation groups; patients in whom in-face consultation will always be necessary.

Concerning the place of the SARS-CoV-2 PCR, we would like to point out that our management algorithm does not recommend carrying out a PCR before any scheduled surgery. We believe that this would be unnecessarily costly, binding for the patient, and would saturate the laboratory testing circuits, even more in the current period when the beginning of the second wave of the pandemic is leading to an increase in the number of PCR testing performed in symptomatic patients. We therefore recommend preoperative PCR in the case of a symptomatic patient and/or a patient at risk of a severe form of COVID-19 and/or major surgery with pulmonary and/or systemic inflammatory repercussions and/or surgery at high risk of aerosolisation (R3.1.4 and Figure 1). As this PCR must be carried out as close as possible to the surgery, we agree that the result cannot be available at the time of the anaesthetic consultation. In this sense, it is theoretically possible to equip the consultation staff with N95, NK95 or FFP2 respirators. However, the equipment availability should be taken into account. Respirators should not be lacking in intensive care units nor in the operating theatre because it would have been used in consultation. Moreover, surgical face masks significantly reduced detection of coronavirus virus RNA in respiratory droplets and aerosols and could prevent transmission of human coronaviruses from symptomatic individuals [5]. Finally, equipping the consultation staff with respirators is more expensive, more difficult to bear over a working day, and is probably an exaggerated precaution, provided that any symptomatic patient is immediately referred to the laboratory for COVID-19 testing, ideally before coming to the consultation area by a telephone call the day before, and at the latest as soon as he or she arrives at the consultation reception desk by filling in a self-questionnaire (R3.1.2 and R6.1.1 + Figure 3). In this sense, this recommendation follows the recommendations of the French government and scientific societies, which stipulate that "the use of FFP2 type masks should only be used for invasive medical procedures or for manoeuvres on the respiratory tract in COVID-19 patients, in any highly suspicious patient or in patients with proven contact with a COVID-19 patient, whether this procedure is carried out by a doctor, a non-physician caregiver, a dentist or a physiotherapist" [6,7]. In other cases (i.e. non-aerosol-generating care and no prolonged contact within one metre), the wearing of a simple surgical mask is recommended, including for the care of a proven COVID-19 patient.

DOI of original article: <https://doi.org/10.1016/j.accpm.2020.09.004>

<https://doi.org/10.1016/j.accpm.2020.09.006>

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Marc Garnier^{a,*}, Lionel Velly^b

^aSorbonne University, GRC 29, APHP Saint-Antoine Hospital, Department of Anaesthesiology and Critical Care Medicine, 75012 Paris, France

^bAix-Marseille University, AP-HM, Department of Anaesthesiology and Critical Care Medicine, University Hospital Timone, Aix-Marseille University, CNRS, Institut Neuroscience Timone, UMR7289, 13005 Marseille, France

*Corresponding author

E-mail address: marcgarnier@gmail.com (M. Garnier).

Available online 2 October 2020