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Reopening after COVID-19 Lockdown: First 250 Cases

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Editorial

At the end of 2019, screen footage from a hospital in China was an exaggerated layout for many people, even for health professionals. Patient beds in corridors, doctors sleeping on desks with exhaustion resembled a scene from a bad Hollywood movie. However, the severity of the situation causing these images could be understood in just a few weeks. As of July 15th, there are over 13 million recorded cases with 600,000 casualties, with around 200,000 daily new cases [1]. With the presence of exceptions, countries have declared quarantine in order to suppress the pandemic curve and keep hospital occupancy rates at a certain level. Social events were cancelled, restaurants other than take-outs were suspended, shopping malls were closed and in some countries curfews were declared. The most comprehensive changes undoubtedly happened in healthcare. All elective surgeries were cancelled. Nearly all inpatient services were transformed to COVID (Coronavirus Disease) services. Doctors with other specialties, whom have little information about viral diseases or coronavirus, have started working in these COVID services. Plastic surgery was one of the most influenced specialties from the cancellation of elective surgeries. The number of cases had a substantial decrease, as only emergent hand surgery and maxillofacial surgery continued in this process. Quarantine measures surely helped controlling the pandemic. However, we have also seen that this situation is not very temporary. So, reopening was recently taken into the agenda. As of June 1st, Turkish Ministry of Health declared reopening can be started in healthcare services with certain precautions. These precautions include halving the number of cases, routine use of personal protecting equipment and COVID-testing pre-operatively and post-operatively, meticulous cleaning of the operation room between surgeries as if previous patient was positive (even if not), hospitalization in single rooms

Table 1: Summary of operated cases between June 1st and July 10th.

Operated Cases	**n**
Cranomaxillofacial Surgery	157
Cleft Lip	48
Cleft Palate	67
Cleft Lip – Scar Revision	6
Cleft Lip's Nose Rhinoplasty	3
Cranioplasty	7
Orthognathic Surgery	8
Maxillofacial Trauma	18
Hand & Microsurgery	41
Free Flaps	2
Replantation	5
Tendon & Nerve Repair	34
Aesthetic Surgery	29
Abdominoplasty	1
Blepharoplasty	2
Breast Reduction	6
Breast Augmentation	6
Rhinoplasty	14
Other	23
Biopsy	23
Total	250

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and minimization of admission period. Starting from June 1st, we have analyzed the first 250 cases that we operated in this reopening period (Table 1). In this process, we have seen that Craniomaxillofacial (CMF) surgery cases are performed more predominantly. Since emergency hand surgery has continued in the quarantine process, there was no accumulation in these surgeries in the reopening period. However, since CMF procedures involve respiratory tract and these surgeries were delayed in quarantine process, patient demand for surgery reached a substantial level. As a result, it was observed that these surgeries were the most common procedures in the re-opening period. Only 1 case was diagnosed with COVID postoperatively. This case had a suspected contact with an asymptomatic COVID carrier in the postoperative period, and preoperative COVID screening was negative. Screening of the surgical crew due to safety precautions resulted negative afterwards. Reopening calendar after COVİD quarantine is still being discussed worldwide. Increases in cases have been reported in countries such as Mexico, Germany and the UK after reopening [2]. However, the existence of patients waiting to be treated is also a fact [3]. Surgeons are trying to define algorithms to decrease transmission from/to patients [4]. Although online software's may help us during patient examination and follow-up, we still need to perform the surgery in the same room with the patient. There is a high rate of asymptomatic carriers among patients with COVID-19. For this reason, accepting every patient as infected during the operation and using FFP2/FFP3 masks, face protectors, applying throat packs after intubation and following strict dressing principles is necessary to protect health professionals. We'd like to emphasize that not only the surgery, but also dressing changes pose a serious threat to surgical staff, and personal protection is also vital during these interventions. Minimizing patient to patient contact is also crucial for spreading of any present infection. COVID surely changed the game, but we think the game can still be played with these new rules.

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