

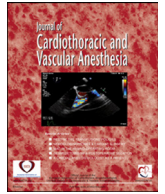


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Editorial

Perioperative Echocardiography During the Coronavirus Crisis: Considerations in Pediatrics and Congenital Heart Disease

THE CURRENT coronavirus crisis is now a pandemic, presenting multiple challenges to the conduct and practice of echocardiography, including the risks of infection.^{1–3} The management of perioperative echocardiography in suspected and infected pediatric patients requires careful consideration of this infectious risk, including personal protective equipment.^{3,4} These significant considerations recently prompted specific statements for echocardiography in these settings from the American Society of Echocardiography, the British Society of Echocardiography, and the Italian Society of Echocardiography and Cardiovascular Imaging.^{5–7} The unique considerations for echocardiography in pediatrics and congenital heart disease now also have received due attention.⁸

The purpose of this freestanding editorial is to provide perspectives on this important disease for the perioperative echocardiographic community with respect to pediatric and congenital heart disease patients. The indications, venue, and approaches for imaging are discussed for these settings to offer a framework to navigate these compelling considerations in pediatric practice. These recommendations are examined from the perspective of the cardiovascular anesthesiologist and perioperative echocardiographer to encourage best practices in this clinical arena. The provided references also can assist policy leaders in their management of the pandemic at their institutions.

Consider the Indications for Imaging

Pediatric echocardiography, including transthoracic, transthoracic, and fetal imaging, has established indications and procedures.^{9,10} Based on published appropriate-use criteria for pediatric echocardiography, the indication for an echocardiographic examination is considered appropriate when the expected incremental information, combined with clinical judgment, exceed the expected risks to an acceptable and reasonable degree.^{10,11} Furthermore, an indication for echocardiographic imaging has been classified into 1 of the following 3 categories: generally appropriate (as reflected by a median panel score of 7-9), may be appropriate (as reflected by a

median panel score of 4-6), and rarely appropriate (as reflected by a median panel score of 1-3).^{10–12} The goal of this scale of appropriate-use criteria has been to minimize echocardiography examinations in pediatric practice for rarely appropriate criteria.^{10–12}

With the advent of the coronavirus crisis and the potentially life-threatening risks of infection, the imaging indication in pediatric echocardiography should be screened carefully, with a preference for delaying examinations that are either elective or rarely appropriate in accordance with institutional practice.^{8–12} Emergency examinations in pediatric echocardiography with strong indications therefore have a high priority to proceed. Given that the intensity of the coronavirus crisis is variable and dynamic, the triage of echocardiography examinations must remain agile and responsive to local conditions.¹³ This management process also should focus on strict infection control.^{1–3}

Fetal echocardiography also should be triaged based on published levels of risk.¹⁴ A fetal echocardiogram for a low-risk patient typically will have a low-risk referral indication in the setting of a normal cardiac screening examination and as such has a low priority for additional consideration during the peak of the coronavirus crisis.^{8,14} A fetal echocardiogram for a moderate-risk patient typically will be indicated by a moderate-to-high risk referral indication with a gestational age greater than 24 weeks or by confirmed congenital heart disease with a gestational age less than 34 weeks.^{8,14} These examinations typically can be rescheduled after the peak of the crisis has passed.⁸ A fetal echocardiogram for high-risk patients typically will include an urgent clinical indication, or a moderate-to-high risk referral indication with a gestational age less than 24 weeks, or confirmed congenital heart disease with a gestational age more than 34 weeks.^{8,14} The examinations in this category should be scheduled as soon as possible. The details of this management process have been fully covered in the provided references and are beyond the scope of this editorial.^{8–12,14}

Transesophageal imaging is considered high risk because it is associated with viral aerosolization and consequent increased risk of transmission.^{15,16} Consequently, the threshold

for this imaging modality in pediatric practice should be high during the coronavirus crisis. These examinations have low priority in the setting of a weak indication, borderline clinical effect, or if an alternative imaging modality could be diagnostic, according to published consensus and guidelines.^{8–12}

Consider the Venue Selection for Imaging

Echocardiographic examinations may be possible at the point of care by the clinicians already taking care of these children with suspected or proven coronavirus infection.^{17–19} This approach is advantageous not only for patient convenience but also for infection control. The final location for an echocardiographic examination often will require thoughtful consideration of the following: risk of viral transmission, including pregnant women; monitoring capabilities; and staffing requirements.^{4–8} A complicating factor in pediatric practice is that children with this infection often may be asymptomatic.^{20,21} In certain circumstances, such as the peak of the coronavirus crisis, it may be reasonable to test new pediatric hospital admissions for this infection to guide the choice of appropriate measures, including infection control.^{2,3,8}

In the operating room environment, transesophageal echocardiography often is performed in the setting of a secure airway.⁸ This approach to airway management can minimize aerosolization of viral particles and contain viral spread.^{21,22} The conduct of transesophageal imaging in the setting of pediatric coronavirus infection should consider current recommendations indexed to institutional practice and the intensity of the coronavirus crisis.^{4–8} There may be dedicated probes and machines in this pediatric setting, depending on local factors.^{4–8}

Consider the Approaches to Imaging

The conduct of the echocardiographic examination in children with suspected or confirmed coronavirus infection should be tailored to address the clinical question.^{4–8} The cardiac manifestations of COVID-19, such as pericarditis and myocarditis, should be considered during this focused examination.²³ Prolonged echocardiographic examinations should be minimized to limit exposure, given that infectious risks likely are present in asymptomatic children during the crisis phase of COVID-19.^{21–24} Consequently, an experienced practitioner should complete the examination in a focused, time-efficient but comprehensive fashion.^{4–8} Even though this strategy may erode the educational environment, the safety of learners and trainees is more important, as outlined clearly by the Accreditation Council for Graduate Medical Education (full details available at www.acgme.org/covid-19).²⁴

Apart from the imaging protocol, the conduct of the pediatric echocardiographic examination should take place according to institutional standards for infection control during the crisis, including adequate barrier techniques.^{4–8} The degree of personal protective equipment will depend on level of infectious risk as defined by specific testing, institutional protocol, and the level of the pandemic at a given hospital.^{6–8} Clinical symptoms in infected children often may be absent, prompting

interim strategies such as testing all hospitalized children as needed or raising the index of suspicion for active infection.

Airborne precautions against viral droplet infection include N95 and N99 masks and powered air purifying respirators.^{15,16} Transesophageal imaging in suspected or confirmed coronavirus-infected patients carries a heightened risk of viral transmission because of the increased load from viral aerosolization.^{4–8} It may be reasonable during the height of the crisis to assume that all children who require transesophageal examinations are positive for the infection. In the setting of a protocol for disease testing, a documented negative test within 48- to 72 hours may be considered adequate at some institutions to conduct the examination with standard precautions such as eye protection, mask, and gloves rather than the enhanced standards with full personal protective equipment.⁸ In pediatric patients for whom testing results are unknown and who have an endotracheal tube before arrival in the operating room or interventional suite, the risk of viral transmission from aerosolization is considered low.^{4–8}

How should the risks of viral aerosolization be managed in asymptomatic untested children who have not undergone tracheal intubation and who require transesophageal imaging in the operating room or interventional suite? In this scenario, it is reasonable to expect that the infectious risk is high, assuming that these children may be positive for infection and that endotracheal intubation generates a high load of aerosolized viral particles.⁸ In this setting, airway management and probe placement likely should proceed with maximal barrier precautions, including personal protective equipment and consideration for air turnover in the given space.⁸ It also is reasonable that the transesophageal probe be placed and positioned by the airway team during aerosol precautions to minimize operator and infectious risks.^{4–8} In the setting of children with known positive infection, full isolation and aerosol precautions should apply not only for the conduct of the echocardiographic examination but also the overall care of those pediatric patients.^{4,8,15,16}

The intensity of the coronavirus crisis at a given institution challenges in many ways not only the imaging protocols but also the infectious control procedures for pediatric perioperative echocardiography. An additional consideration for infection control concerns the appropriate care of echocardiographic equipment (the “hardware”) to minimize the risks of viral transmission.^{4–8} The relevant probes and machine consoles may be covered with disposable plastic. Depending on institutional circumstances, certain hardware can be specifically designated for imaging of suspected or confirmed pediatric cases of coronavirus infection.^{4–8} Although most disinfectant solutions are virucidal, all echocardiographic equipment should be processed thoroughly for the goals of viral clearance and hardware functionality with maximal protection of patients and ultrasound providers.^{25–27} Despite the variations in sanitation protocols, these standards should comply with the recommendations from the American Institute for Ultrasound in Medicine to balance infectious risks with imaging performance.^{4,8,25–27}

Education and teaching in pediatric echocardiography are important.^{13,24} During the coronavirus crisis, however, learner

well-being has a higher priority.²⁴ In this stressful clinical learning environment, it is reasonable to cancel elective rotations and to restrict trainee exposure.²⁴ Furthermore, education in echocardiography can be transitioned to distance-based learning, including remote conferencing technology.²⁴ The protection of echocardiography personnel can be enhanced further by thoughtful assignments for staff with risk factors for severe infection such as advanced age, chronic conditions, immunosuppression, and pregnancy.

Conclusions

The coronavirus pandemic has significantly affected the conduct of pediatric echocardiography in the perioperative setting. Careful consideration of the indications, venues, and approaches for echocardiographic imaging will both optimize patient care and infection control during the crisis.

Conflict of Interest

None.

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