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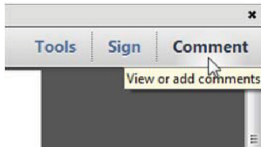
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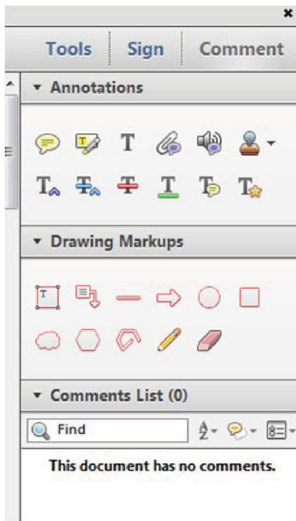
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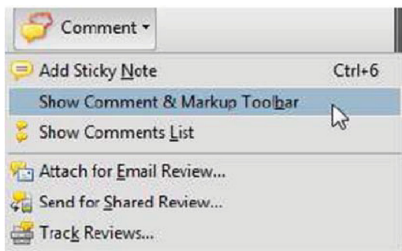


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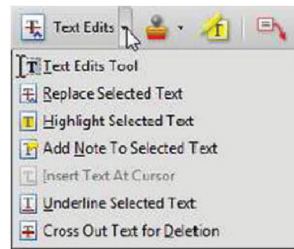
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In Reply: Precautions for Endoscopic Transnasal Skull Base Surgery During the COVID-19 Pandemic

To the Editor:

The COVID-19 pandemic crisis has been defying health professionals and managers at all levels. Due to the risk of health system overload, there is an unpaired need to infrastructure, human, and economic resource allocation management.

At a time when global attention is focused on the pandemic, we should not overlook that people continue to face other health problems. The incidents of trauma and accidental injury tend to decrease due to social distancing, quarantine, or locking. However, other diseases, such as stroke and neoplasms, inexorably follow their natural course.

The correspondence published by Patel et al¹ draws attention to the potential risks of endonasal endoscopic surgery in COVID-19 diagnosed or suspected patients and the need for surgical practice provisional update. Based on personal communication, it reports, in a narrative fashion, a series of cases of health worker contamination related to the care of patients undergoing endoscopic endonasal surgery despite the best efforts to perform a safe surgery. Similar incidents occurred in several reference services around the world. The authors emphasize the need for adequate use of personal protective equipment (PPE) in cases tested positive for COVID-19—although it questions the sensitivity and specificity of such tests—and recommend limiting the number of professionals during procedures only to the essential ones.

Since the pandemic breakthrough in Wuhan, China, in December 2019, thousands of health workers have been infected during the care of patients with COVID-19. The high viral load in the upper airways of infected patients poses a greater risk during endoscopic endonasal procedures, especially when high-speed drilling is needed, which increases the production of aerosols and the suspension of viral particles in the environment.²

It is very clear within the neurosurgical community that protocols should be planned to determine which neurosurgical cases must be prioritized. Such protocols should consider the urgency status and type of the procedure, the need and length of postoperative intensive care support, and the preoperative testing of patients when possible. Burke et al³ and Ramakrishna et al⁴ demonstrate in a pragmatic way how to implement such stratification initiatives. Moreover, given the potential shortage of intensive care unit (ICU) and ward beds, there is an opportunity to foster the ongoing phenomenon of adoption of quality

improvement programs such as the Enhanced Recovery After Surgery (ERAS). The ERAS implementation initiatives have shown improved patient outcomes while reducing length of stay and costs.⁵

Thus, the postponement of endoscopic endonasal neurosurgical procedures seems feasible and, in the current scenario, an appropriate solution.

Disclosures

The authors have no personal, financial, or institutional interest in any of the drugs, materials, or devices described in this article.

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