ACTA ORTHOPAEDICA et TRAUMATOLOGICA TURCICA
www.aott.org.tr

Editorial

Orthopaedic surgeons and orthopaedic surgery in the era of COVID-19

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ARTICLE INFO

Article history:
Submitted 05 May 2020
Accepted 29 May 2020

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Hong Kong's COVID-19 outbreak preceded the eve of the global pandemic. A publicly funded healthcare system looking after an ageing population in one of the most densely populated regions in the world spells unique challenges. Territory-wide hospital emergency response in January two days after the region's first confirmed case involved sharp cuts in elective clinical services to preserve personal protective equipment, critical care capacities, and manpower deployment (1, 2).

To say Orthopaedic and Trauma services were affected is a gross understatement. We observed over 40% reduction in surgical volume. Priority was given to maintenance of emergency or "urgent-elective" services, such as fractures, life-threatening orthopaedic infections, and malignancies. Patients who had been waiting for over three years for their knee replacements could only be told it would be delayed *sine die*, as were professional athletes waiting to have their cruciate ligaments reconstructed to get back to the top of their game during their prime years – not conversations of life and death (thankfully), but with gravitas nonetheless. General anaesthesia was avoided to reduce N95 respirator expenditure over aerosol generating procedures, with regional anaesthetic techniques preferred. Early in-patient transfers to convalescent institutions freed up acute hospitable beds whenever feasible. Beds were converted to negative pressure cubicles for surveillance and isolation. Body temperature checks and travel history declaration forms were in place. Stable patients scheduled for yearly outpatient appointments were telephoned and advised not to return for follow up if their conditions allowed. Surgical training and research were also affected in terms of reduced caseload.

These measures amounted to almost 60% reduction in elective hospital admissions and almost 30% reduction in outpatient clinic (3). Personal protective equipment reserves remained stable (4). At the time of writing, no healthcare worker has died as a result of COVID-19 in Hong Kong.

Orthopaedic doctors and nurses were deployed to treat confirmed or suspected COVID-19 patients. Orthopaedic surgeons interpreting electrocardiograms, once vividly portrayed as "double-blind" studies, are now welcomed in open (sanitised) arms at COVID-19 isolation wards. Spine surgeons inserted intravenous drips instead of pedicle screws, while joint replacements surgeons operated ventilators instead of surgical robots. At the same time, let us not forget colleagues sustaining our own emergency trauma services as the demand remains. After all, one considers it less risky for orthopaedic surgeons to treat pneumonia, than for our learned physician friends to fix hip fractures.

The worst of times brought out the best in people. Friendships were brokered and alliances forged across medical disciplines. We have become ever more appreciative of intensive care expertise brought to the table - within and beyond operating theatres - from our anaesthetic colleagues. We owe our thanks to nurses, physiotherapists, phlebotomists, radiographers, clerical staff, cleaners, porters, and yes - even hospital administrators.

Cite this article as: *Wong JSH, Cheung KMC. Orthopaedic surgeons and orthopaedic surgery in the era of COVID-19. Acta Orthop Traumatol Turc 2020; 54(3): 221-2. DOI: 10.5152/j.aott.2020.20150*

Lofty visions and "call-to-arms" boiled down to harsh realities and vicissitudes necessitating daily compromises. There were missteps and false starts – forecasts to be amended, guidelines to be revised as new evidence emerges. The measures of triumph were not of Instagram or Facebook posts of postoperative x-rays, but empty wards from discharged patients, "unremarkable" chest radiographs clinically correlated with patients in recovery. The work does not end then, however; for the passing of COVID-19 pandemic heralds joints and ligaments to reconstruct, tendons to repair, fractures to fix, spines to decompress.

So let us fight on, not in the certainty of victory, but out of resilience and solidarity. For there is a difference between "being dragged into the arena to face a battle to the death, and walking into the arena with your head held high" (5). Because we owe it to our teachers and forebearers, whose shoulders not only allowed us to see further, but to contribute further. Because our patients deserve us.

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