

Discussion of a Guide to Developing Safety Protocols for International Craniofacial Outreach Programs During the COVID-19 Era

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We read with great interest the recently published article by Salehi et al¹ proposing suggestions to safely resume international craniofacial outreach programs during the current COVID-19 pandemic. In this article, the authors provided recommendations to ensure patient and medical team safety before, during, and after international service trips. We commend the authors for providing numerous suggestions and discussing the roles of the patients, physicians, and local communities in promoting safety during the COVID-19 crisis. Since the crisis is constantly evolving, and relevant factors have changed since the Salehi et al¹ publication, we would like to propose additional recommendations to resume international outreach programs and update those suggested by the authors.

At least 10 COVID-19 vaccines are currently in circulation (either approved or undergoing phase 3 clinical trials)² in the United States and other countries. Current data demonstrates that vaccination significantly reduces the risk and severity of COVID-19 infections and may also reduce the risk of COVID-19 transmission within the vaccinated population.^{2,3} Given this knowledge, we recommend that any healthcare professional participating in international outreach programs be fully vaccinated against COVID-19 before travel and continue to be tested prior, during and after their visits. Both doses of the currently approved vaccines should be administered, with the second dose administered at least 14 days before travel to ensure that those who are vaccinated reach peak immunity before departure.³ Getting vaccinated, in addition to the use of personal

protection equipment, hand hygiene, and social distancing, can significantly reduce the transmission risk for volunteers and patients.⁴ Access to vaccines is a new milestone in the pandemic response, and it holds great promise regarding the resumption of international plastic surgery outreach opportunities.

The authors were justified in their recommendation of giving COVID-19 tests to patients before procedures when tests are available, but they did not provide specific suggestions for situations where tests are not available. In an ideal environment, we would suggest implementing a preprocedural quarantine for all patients of at least 10 days before the date of surgery, in concordance with the Center for Disease Control guidelines.⁵ However, it is unlikely that the families of most cleft patients, who come from impoverished areas and travel long distances in order to reach the medical center, would be able to comply with quarantine requirements. In addition, the high volume of patients operated on during such trips further complicates the institution of a full quarantine period. A more realistic suggestion could be a shorter quarantine period (3–5 days), which could be facilitated if the visiting organization provides the families with financial assistance for short-term housing, food, and childcare.

In most cases, it will be necessary to proceed with surgery without knowing the patients' disease status and assume that all patients may potentially carry COVID-19. Thus, we would encourage that Operating Room (OR) personnel wear appropriate personal protective equipment (eye protection, N-95 respirator masks) for all cases, and that additional measures are taken to prevent respiratory droplet transmission. For example, as highlighted on the COVID-19 Surgical Patient Checklist, only essential personnel should be in the OR when intubation and extubation takes place.⁵ We would additionally recommend that a 20-minute pause be taken after both procedures to allow respiratory droplets to settle, which has become a standard protocol at the senior author's institution for COVID-positive or COVID-suspected pediatric patients. Innovative suggestions have also been made to create make-shift negative-pressure operating rooms and smoke evacuators in low-resource settings, which warrant further exploration.⁶ Comprehensive predeparture planning and collaboration between the local and visiting teams will allow for optimized safety protocols based on the resources and needs of the community.

The authors suggested numerous excellent recommendations to protect patients and the medical team from contracting COVID-19 in order to resume international craniofacial outreach programs amidst the current pandemic. We commend the authors for their timely work and advise that the list of suggestions be continuously updated as the pandemic situation evolves, especially as effective vaccines and accurate, affordable COVID-19 tests become broadly available worldwide.

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