Point of view of the Dutch Society for Gynaecological Endoscopy (WGE) on surgery during the COVID-19 crisis

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To the editors: we are still in the middle of the SARS-CoV-2 virus pandemic with almost 2 million confirmed cases and 123 thousand deaths worldwide (1, 2). As a result, a second crisis becomes visible: a reservoir of delayed elective surgery and the consequences of postponed treatment of less urgent complaints. Currently, in the Netherlands elective gynecologic surgery has been put on hold, as anesthesiologists and operating room personnel is needed in intensive care units, limiting available resources. Since acute surgery is still performed debate about safe procedures and preventing unnecessary risks is hot topic. Despite numerous international safety statements and two Dutch guidelines (3, 4), discussion about the following two important questions, “how can we accurately screen for COVID-19 before surgery and is this even needed” and “what are the contamination agents during surgery and which precautions should be taken to protect health care providers (HCP)?” (3, 5-10), is ongoing.

Although based on limited evidence (11, 12) guidelines suggest performing PCR and CT-scan for asymptomatic patients, preferably 48 hours before surgery. We fear that suggested preference of CT-scan -testing with significantly higher sensitivity (11, 13, 14) might become the bottleneck of pre-operative screening due to limited capacity in the future (15, 16).

The second struggle is about the contaminating agents. These can be divided in three groups: proven contagious, possible presence of RNA, undefined but possibly not contagious. In the first group, production of droplets and aerosols, especially during in- and detubation (17-19), is taken care of by additional protective measurements. The second group, for example surgical smoke, blood and removed tissue (20, 21) is surrounded by multi-interpretable arguments and ambiguous considerations as excessive protection and threatening lack of resources or unnecessary costs. And finally, the unknown instances, CO2 from the pneumoperitoneum during laparoscopy.

The Dutch Society (WGE) supports the international and national statements and advices the following guidelines for surgery on a *COVID-19 positive tested patient*:

- Elective surgery should be delayed for a period of two weeks or when repeated testing is negative.
- Personal Protective Equipment (PPE) for the surgeon during (laparoscopic) surgery contains eye protection, waterproof gown and at least a IIR surgical mask
- There is no reason to perform a laparotomy, when laparoscopy is normally the procedure of first choice.

- There are no limitations to vaginal or hysteroscopic surgery, except for normal protective methods.
- To decrease the contamination risk of HCP in laparoscopy we advise low pressure ORs during in- and detubation if possible, balloon trocars that minimize gas leakage, active evacuation of surgical smoke and CO2 in a closed circuit, removal of tissue after desufflating the abdomen, allow the OR air the be sufficiently refreshed before attending new surgery (3).

With the availability of national guidelines and support from international societies, we sincerely hope that we can find the evidence to perform save surgery and protect patients and HCP.

On behalf of the Dutch Society of Gynaecological Surgery (WGE).

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