

Consent and Pre-operative Assessment for ENT surgery: A Graduated Return to Elective ENT within the COVID-19 Pandemic

Background information

The worldwide COVID-19 pandemic has had a huge impact on resources and the ability to provide healthcare across the UK. As the number of new cases starts to decline, plans are developing to resume elective activity.

Currently emergency surgery and time-critical surgery (e.g. cancer) continues to be provided within current resource availability. NHS England has recently [written to Trusts](#) to resume non-COVID-19 urgent elective services and to determine whether there is capacity to resume some non-urgent elective activity.

[Guidance has been developed by The Royal College of Surgeons England](#) and [ENT UK](#) to assist colleagues with preparing to resume services following the pandemic.

As departments prepare to resume activity the prioritisation of surgical waiting lists is vital, and [ENT UK guidance is available](#). The American College of Surgeons has recommended MeNTS¹ to allow prioritisation within the categories advised by ENT UK.

Informed consent

It remains unclear as to the risk of transmission of COVID-19 during surgery, hospitalisation and recovery at home. The impact of COVID-19 infection during recovery and subsequent outcome of surgery remains equally unclear.

The risks will vary depending on whether surgery is elective, urgent or emergency in nature.

In addition to the consent process prior to the COVID-19 pandemic relating to the procedure and risk of complications, additional points specific to COVID-19 need to be discussed during informed consent and prior to signing a consent form.

Possible COVID-19 virus carrier

Some patients could be asymptomatic or pre-symptomatic carriers of the virus, so occupational

factors (i.e. in roles that increase risk of exposure to COVID-19) and social factors (i.e. household or other close contacts with recent COVID-19) over the last 14 days are important questions to ask.

Once a decision has been made to proceed with surgery, the patient must self-isolate for a minimum of 14 days pre-operatively if the procedure is not time-critical. In paediatric patients, this must also include one or preferably both parents.

Risk of acquiring COVID-19

The journey to and from hospital and time spent in hospital may increase the chance of contracting COVID-19 due to the increased number of contacts encountered.

Asymptomatic carriers can develop COVID-19 within days of hospital admission.

Surgery may decrease or challenge natural immunity and increase risk of acquiring COVID-19 which could be more severe in these circumstances².

Associated risk factors

Risk factors for developing severe COVID-19 infection with serious consequences include the following conditions^{3,4}:

1. Increasing age, especially over 60 years old
2. Patients from care homes and nursing homes
3. Chronic lung disease or moderate to severe asthma
4. Ischaemic heart disease or cerebrovascular disease
5. Hypertension
6. Immunocompromised state - malignancy, smoking, transplant patients, immune deficiencies, HIV or AIDS, use of steroids, immunosuppressant therapy
7. Diabetes
8. Obesity
9. Frailty
10. Black and ethnic minority.

Surgery

The true outcomes of COVID-19 infection in surgical patients are not well known at present. Some countries report an increased rate of respiratory complications. If a patient contracts or develops COVID-19 while in hospital, recovery from surgery could be more difficult with an increased chance of serious illness or death².

If the patient requires emergency intensive care support or ventilation, this may not always be available within the hospital and transfer of care to another unit could become necessary.

Visitors may not be allowed during the stay in hospital depending on the status of the pandemic.

Consent process

Patients need to be informed regarding the extra risks potentially posed by COVID-19 (see Appendix 1) and discuss whether surgery is still the most appropriate treatment option or whether non-surgical treatment may be more appropriate. If surgery is required, then should this be undertaken now or would it be better deferred?

The elective waiting list should be prioritised as per local and subspecialty guidance. The general principle is that any procedure that can be delayed without a significant, adverse outcome should be delayed. The patient can be informed via letter that their procedure is postponed and of the rationale for postponement. If a patient's surgery is judged appropriate for procedure during the COVID-19 pandemic, clinical records should be reviewed to identify the newly recognised risk factors. If the risks to the patient outweigh the benefit of surgery during the COVID-19 pandemic, the patient can be informed via letter that their procedure is postponed and of the rationale for postponement. Patients who have no or few additional risk factors, or for whom the risk of postponing their procedure would be detrimental to their health, should be contacted (telephone/video/face-to-face) to discuss whether they wish to proceed with surgery after the additional risks associated with COVID-19 are discussed.

[The GMC](#) and RCS England guidelines suggest risks should be a combined assessment and discussion of the real risk of proceeding under current circumstances versus the real risk of delay.

All available alternative treatments must be discussed.

It is also important to discuss the treatment options and techniques if COVID-19 was not an issue.

The discussion should be clearly documented in the medical records, correspondence to patient and relevant clinicians. The timing and completion of a written consent form prior to surgery will be as per local policy, which may include a separate form with specific issues related to COVID-19 (see Appendix 2).

Pre-operative assessment for COVID-19

COVID-19 has an incubation period of 1-14 days (median 5 days). [Median time from onset of symptoms to clinical recovery is 2 weeks in mild cases and 3-6 weeks in severe or critical cases.](#)

Once a decision has been made to proceed with surgery, the patient must self-isolate for a minimum of 14 days pre-operatively, if not time-critical. In paediatric patients this may also include both parents.

All patients (for paediatric patients this will also include parents) should have 2 separate negative swab tests (taken at least 5 days apart) for COVID-19, the latest one within 48 hours of surgery. In view of a significant false negative rate, the results should be interpreted in alignment with potential COVID-19 symptoms. Lymphocyte count should be noted, as reduced % can be a prognostic indicator of COVID-19 severity.

Patients with a history of respiratory disease will be more difficult to evaluate. Anaesthetic and/or respiratory opinions may be necessary in addition to CT chest.

[Any patient undergoing high-risk surgery or requiring Level II/III critical care post-operatively may also require a pre-operative CT scan of the chest within 24 hours of surgery.](#)

Appendix 1

Checklist for COVID-19 discussion

- Alternative management and treatment
- Check for COVID-19 symptoms or possible contact with COVID-19
- Possibility of COVID-19 developing while in hospital or shortly afterwards
- Pre-operative investigations including swabs, FBC and CT scan
- Potential outcomes if develop COVID-19 during the recovery period
- Intensive care and possibility of death from severe infection
- Visitors to hospital
- Need to self-isolate

Appendix 2 - COVID-19 specific consent form

Addressograph

The following items have been explained and discussed:

- We have discussed the available alternative treatments.
- I have not experienced any COVID-19 symptoms during the last 14 days and have been self-isolating.
- No members of my household or any other contacts have been unwell with COVID-19 symptoms during the last 14 days.
- Coming into hospital may increase my chance of contracting COVID-19. This could be due to carrying or incubating the virus while symptom free, or acquiring infection within the hospital.
- We have discussed the need for pre-operative assessment that should include two recent swab tests, blood tests, and for some patients a CT scan of the chest. I understand that a negative swab result does not always mean a patient is disease free.
- The outcomes of COVID-19 infection during my recovery period have been discussed. If COVID-19 is contracted while in hospital, recovery from surgery could be more difficult with increased chance of respiratory (chest) complications, serious illness or death.
- If intensive care support is required, this could involve transfer to another hospital.
- Visitors may not be allowed during my stay in hospital, depending on the hospital policy at the time.

Signed:

Date:

Patient

Surgeon

Pre-operative checklist

- COVID-19 swab 1
- COVID-19 swab 2
- Blood test/lymphocyte count (where applicable)
- CT chest (where applicable)
- Anaesthetic opinion requested

References

Papers

1. Prachand, V. N. *et al.* Medically-Necessary, Time-Sensitive Procedures: A Scoring System to Ethically and Efficiently Manage Resource Scarcity and Provider Risk During the COVID-19 Pandemic. *J. Am. Coll. Surg.* (2020). doi:10.1016/j.jamcollsurg.2020.04.011
2. Lei, S. *et al.* Clinical characteristics and outcomes of patients undergoing surgeries during the incubation period of COVID-19 infection. *EClinicalMedicine* **21**, (2020).
3. Wang, B., Li, R., Lu, Z. & Huang, Y. Does comorbidity increase the risk of patients with COVID-19: evidence from meta-analysis. *Aging (Albany, NY)*. **12**, 6049–6057 (2020).
4. Pareek, M. *et al.* Ethnicity and COVID-19: an urgent public health research priority. *Lancet* **395**, 1421–1422 (2020).

Links

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<https://icmanaesthesiacovid-19.org/restarting-planned-surgery-in-the-context-of-the-covid-19-pandemic>

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