Journal of
Surgical Orthopaedic Advances

EDITORIALS

How Do We Restart Elective Orthopaedic Services Responsibly?

Enough is enough! We do not have a cure for COVID-19, and it is possible that this virus will remain in existence and be a recurrent threat to humanity. One day therapeutic anti-viral medications, a vaccine and herd immunity will offer protection to some or most of the community. These steps may be 12 to 18 months away, but the services of orthopaedic surgeons for primary and revision knee and hip replacement, knee ligament reconstruction, herniated lumbar disc and stenosis, and carpal tunnel releases, among other procedures, cannot wait a year or longer. Patients are in pain, cannot walk outdoors and have difficulty with activities of normal daily living. We are also concerned about the diminished dexterity and possible deconditioning of orthopaedic surgeons after the long layoff of 8 to 12 weeks. Professional basketball players have stated that they will require a month of practice to get back to game-ready status. What type of "spring training" will be available for orthopaedic surgeons? There are rumors that hospital administrators and other leaders desire a rapid ramp-up of patient visits and operative procedures shortly after an all-clear declaration in their geographic area. However, would that decision be in the best interest of both the patients and the orthopaedic surgeons?

The answer of how to resume routine patient visits and elective orthopaedic procedures seems logical to the two of us. Take *baby steps*. Test the water. When you want to go swimming in a lake and cannot see the bottom or unsure if a wetsuit is needed, what do responsible swimmers do? *Put a toe in the water* first. Check the temperature before jumping in. Don't jump in headfirst. Be prepared to pull back a little when necessary. Our recommendations should definitely be customized for your geographic location and type of practice.

At the Veteran's Administration hospital where the two of us presently work, many of our patients have numerous co-morbidities and are prone to COVID's most destructive effects. However, the veteran with severe pain due to an arthritic hip or knee, loosened components, or numbness and weakness in the hand or foot may develop habituation to pain medication, depression or even suicide. A primary or revision total knee or hip replacement is considered elective surgery, as is a lumbar decompression, carpal tunnel release, or shoulder arthroscopy. There is always risk of complications after elective procedures in patients with multiple co-morbid medical conditions, and now there are risks to hospital workers as well. In our opinion, despite these risks, these procedures should be resumed soon, but with a gradual approach. Until there is a "cure" or everyone can be reliably antibody tested (so we know who is potentially immune to COVID-19), we recommend the following "toe in the water" approach.

First, we should resume clinic visits for other than emergency essential problems. After appropriate telephone screening by mid-level providers, new patients with orthopaedic problems, preoperative evaluations and important postoperative checkups should be scheduled for an elective clinic visit. We should discourage or even prohibit routine return visits for cortisone or viscosupplement injections during this restart phase of clinic activity. Ideally, a rapid viral screening test would be performed on every patient entering the facility but, with the present limitation of this option, a verbal *COVID-19* questionnaire should be administered and, possibly, a temperature screening. Initially, clinic appointments should be limited to three per hour in order to decrease traffic and permit social distancing. The waiting room chairs should be separated by 6 feet, and the area should be monitored. Both patients and health care providers should wear masks at all times. The size of the examination room may not permit a family member to be present in addition to a resident or mid-level provider and attending surgeon. Hospital personnel should be assigned to wiping doorknobs and frequently touched railings and surfaces in the clinic on a regular schedule. In getting around the facility for x-rays and scans, perhaps no more than three people should be allowed at one time in an elevator, and a paper towel should be used to touch the floor buttons. The cafeteria seating spaces should be reorganized and perhaps limited to employees only. We should encourage patients to get in and out of the facility quickly.

Obviously elective surgical procedures should be based on the availability of beds and hospital staff. Preferably, there should be no patients with symptomatic COVID-19 in the hospital, or they should be strictly isolated. What type of cases should be permitted? It has been suggested that only the simplest procedures and only primary joint replacements should be allowed. However, this should be left to the discretion of the attending surgeon, as some complex procedures would actually relieve more pain and disability than the simpler procedures. We would suggest allowing half of the operating rooms to be used for elective surgery at the restart. The specific surgical service allotted to these rooms would be rotated or determined by the department chief in consultation with the division chiefs. Only two cases per day or less would be allowed in each elective room depending on the length of case. Minimal operating room personnel should be involved to permit appropriate separation and satisfactory time to sanitize areas between cases. This would be a start, with baby steps. The results and complications of these elective cases, both procedure and surgeon specific, should be carefully monitored for quality control after the long lay-off. We, as surgeons, should be prepared to decrease or even discontinue elective surgery if the results or complications warrant or if a secondary outbreak of the virus occurs.

These opinions are the authors' alone and are not endorsed by any hospital or university.

Robert A. Schultz, MD and **Paul F. Lachiewicz, MD**