MEMORANDUM 3.27.20

SUBJECT:

"LSU Otolaryngology Strategic Surgical Resource Utilization Committee" (LOSSRUC)

Inaugurated 3.24.20 during COVID pandemic

COMMITTEE MEMBERS:

- Dr. Michael DiLeo
- Dr. Rohan Walvekar
- Dr. Moises Arriaga
- Dr. Andrew McWhorter
- Dr. Belinda Mantle
- Dr. Laura Pelaez
- Dr. Daniel Nuss
- *Ad Hoc:* Dr. Hernandez, Dr. Allen, Dr. Hetzler

PURPOSE: This is an advisory committee, assembled in the context of the COVID pandemic, whose purpose is to:

- Aid in decision-making with regard to patients whose conditions may require otolaryngology surgical care
- To make recommendations for preparation and management of surgical patients
- To recognize the COVID-related risks and limited hospital resources; and,
- To objectively address the need for prioritization of surgical care in otolaryngology for the duration of the pandemic.

NOTE*: This committee is focused on elective and urgent cases. True emergencies, in which action must be immediately taken (e.g., life-threatening airway obstruction, hemorrhage), are beyond the scope of this committee.*

COMPOSITION and ACTIONS:

- Primary members (as listed above)
- Additional ENT members may be also recruited *ad hoc*, for specific cases; they must be qualified otolaryngology physicians affiliated with LSU Otolaryngology Department and its clinical partners
- At least 3 members of the Committee will be required for each case brought for consideration
    - The Committee may invite consultants from other specialties to participate, as needed and appropriate to the patient's situation (e.g., Neurosurgery, General Surgery, Plastics, Pulmonology, etc.)
    - The attending surgeon can present her/his case to the committee but cannot serve as a voting member in determinations about her/his case
- ***NOTE***: Dr. Mantle is the representative for pediatric interests on this departmental committee, but she has suggested that a separate, focused Pediatric committee of similar nature might be the best solution for Children's Hospital of New Orleans, a suggestion which the committee supports.

- ***NOTE***: Decisions about cancer cases, which normally would be made in the customary fashion by the existing Tumor Board structure, will continue to be handled by Tumor Board, but during COVID pandemic cancer cases will also be addressed by this committee

ENGAGEMENT: This committee will review ALL non-emergency cases (i.e., Urgent and Elective cases) being proposed for operative management at all of the hospitals/surgery centers in which LSU Otolaryngology operates, until further notice. Any LSU Otolaryngology attending surgeon who wants to schedule a surgical case must notify a member of this committee, which will trigger the committee's review. The committee will meet every other day by virtual contact, but in the event that the committee cannot be convened timely, the Department Chairman will serve in the capacity of the committee.

Other than truly immediate emergencies as noted above, **no surgical otolaryngology case will be permitted to proceed in our institutions without the Committee's review, until further notice.**

This committee's review may also be triggered by request from other services in the hospital, or by request of patient's family or advocate. Recommendations of this committee, for or against surgery, will be binding; however, appeals can be considered in light of any new clinical information, or if patients, families or advocates desire additional review.

PROCESS AND CRITERIA: Each patient's case will be presented by the attending physician, and reviewed by the committee. Recommendations will be made, for or against surgical care. Where appropriate, recommendations may be made for deferment or delayed prioritization of such surgical care. Recommendations for optimal preparation and execution of the case, as well as special safety precautions, may also be made.

Decisions are to be rendered in good faith, using applicable clinical criteria and data; and on the basis of the patient's need, the surgeon's recommendation, and broader contextual considerations of risk to the healthcare workforce, the community at large, and the realistic availability of all necessary equipment, personnel and resources (e.g., ICU beds, blood products, PPE, etc.) to achieve the optimal result in each case.

GUIDELINES AND PRINCIPLES *for the Committee and Attending Surgeon to Consider**:***

1. COVID testing should be done on ALL patients who are being considered for surgery, until further notice.
2. If patients discussed by this committee are subsequently found to be COVID positive, they must be presented to the committee again
3. Options for the Surgeon to consider:
    a. Delay the case if delay will not result in harm
    b. Consider non-surgical care if it is a reasonable alternative
        i. E.g., radiation or chemo-radiation instead of surgery if appropriate
    c. Consider palliative approach if risks/co-morbidities are extreme or if prognosis is quite poor
    d. If the proposed surgery is for diagnostic purposes (e.g. Panendoscopy for histologic confirmation by biopsy, or for staging purposes), consider using noninvasive or

nonsurgical assessment tools including videos/photos of patient, along with imaging (CT, MR, PET, etc.), and FNA instead of surgery
    i. Also consider FNA of neck masses instead of mucosal biopsy in cases of suspected cancer when neck mass is present

e. If surgery is unavoidable, consider ways to limit mucosal disruption and viral aerosolization, including avoidance or minimal use of powered equipment, drills, debriders, & suctions
    i. Also avoid jet-ventilation, mask techniques etc.

f. If surgery is necessary, consider lesser surgery than one would do under normal circumstances.
   Examples:
    i. For trauma, perform MMF alone instead of definitive osseous reconstruction
    ii. For cancer, consider excision and simple closure, with staged reconstruction if free flap or other time-consuming techniques will be needed
    iii. For stenotic airways, consider dilation to temporize instead of doing definitive airway reconstruction (clearly on a case by case basis

g. In surgical planning, take into consideration the need for ICU care and Transfusion of blood products; take any available steps to reduce use of these resources

h. In surgical planning, take into consideration the risk to the operative team including Anesthesia, Surgeons, Nursing, and other support team members.

i. In every surgical case:
    i. Strict adherence to all applicable PPE requirements is mandatory
    ii. Wait 15-20 minutes post-intubation before entering room (unless patient has an airway challenge requiring surgeon to be present at induction)
        1. This waiting period may vary depending on specifics of the hospital's negative pressure ventilation systems
    iii. Limit number of persons in and out of room to minimize exposures and conserve PPE
        1. Eliminate "breaks" by support personnel in the midst of a case
    iv. Strict adherence to proper PPE doffing and disposal

All cases reviewed by this Committee will be documented.
COVID-specific notation will be included in surgical consent forms and documentation, to signify that the decisions were rendered in the context of this global pandemic.

<u>Standard COVID checklist to be recorded for all proposed surgical cases:</u>
Name of Physician presenting case
Institution/Campus
Patient Initials, age, gender
Clinical summary
COVID status: (negative – positive - pending)
Proposed surgery or procedure
Proposed timing
<u>Considerations:</u>

- Risk to patient if delayed, <u>*vs.*</u> risk to patient if hospitalized and taken to surgery
- Risk to surgical team

- Risk to institution
- Alternative treatment options
- Specific recommendations for surgery

COMMITTEE'S RECOMMENDATION FOR OR AGAINST

Respectfully submitted,
Daniel W. Nuss, MD, FACS
3.27.20