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Specialty guides for patient management during the coronavirus pandemic

Clinical guide for the management of non-coronavirus patients requiring ear, nose and throat treatment during the coronavirus pandemic

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"…….and there are no more surgeons, urologists, orthopedists, we are only doctors who suddenly become part of a single team to face this tsunami that has overwhelmed us".
Dr Daniele Macchine, Bergamo, Italy, 9 March 2020

As doctors we all have general responsibilities in relation to coronavirus and for these we should seek and act on national and local guidelines. These are constantly evolving and we should adhere to the latest advice available (which may change from the information in this document). Guidance from NHS England, NHS Improvement and Public Health England (PHE) is being frequently updated as the national caseload and required response evolves.

We have a responsibility to ensure that essential ENT care continues with the minimum burden on the NHS. We must engage with those planning our local response. Your trust will have an incident management team in place and plans on what activity continues in light of pressures on services and staffing. Please consult your local management team.

We may also need to work outside our specific areas of training and expertise and the General Medical Council has already indicated its support for this in the exceptional circumstances we may face: https://www.gmc-uk.org/news/news-archive/how-we-will-continue-to-regulate-in-light-of-novel-coronavirus

ENT may not be a speciality on the frontline with coronavirus but we do have a key role to play and this must be planned. In response to mounting pressure on the NHS, the elective

component of our work may be curtailed. However, non-elective patients will continue to need care. We should seek the best local solutions to continue the appropriate management of these patients while protecting resources for the response to coronavirus.

In addition, we will need to consider the possibility that facilities for emergency surgery may be compromised due to a combination of factors including staff sickness, supply chain shortages and possibly the use of theatres and anaesthetic staff to create additional ITU pods. This is an unlikely scenario but plans for it are needed.

In particular we need to consider patients who are vulnerable to the consequences of catching coronavirus, including those with a tracheostomy or respiratory compromise. As well as those with immune suppression, such as during or soon after treatment for head and neck cancer

It is also imperative we protect ourselves with the appropriate use of personal protective equipment (PPE).

Personal protective equipment

Any clinician assessing patients suspected or confirmed to be infected with coronavirus should wear appropriate PPE. Please check latest guidance from PHE: https://www.gov.uk/government/collections/wuhan-novel-coronavirus

Staff PPE is currently a fluid resistant surgical mask, single-use disposable apron and gloves, and eye protection if blood and or body fluid contamination to the eyes or face is anticipated, such as with flexible and rigid nasendoscopy examinations.

Currently filtering facepiece respirators FFP3 masks are being reserved for coronavirus-positive patients or suspected positive patients requiring aerosol generating procedures – these include intubation, NIV, optiflow, open suctioning, tracheostomy, bronchoscopy and high speed drilling. Please see guidance from PHE and consult your local infectious diseases team if in any doubt, and note that guidance on this may change.

Categories of patients to consider

ENT patients can be considered in the following categories:

- **Obligatory inpatient emergency admissions:** Continue to require admission and may require surgical management, eg for airway obstruction. We must expedite treatment to avoid delay in management, including any rehabilitation the patient may require.

- **Non-operative emergencies:** Patients who can reasonably be managed non-operatively, e.g. those with epistaxis. We must try and avoid admission unless this is really necessary.
- **Elective inpatients:** These must be prioritised in line with your trust's activity plans, with non-urgent cases postponed to minimise the use of inpatient beds. Urgent head and neck cancer and paediatric airway cases should continue where possible.
- **Day cases:** Most elective ENT surgery can be safely undertaken as a day case. Provision for day case surgery must be made as this is likely to continue until such time that theatres are unable to run due to the need for staff to be deployed elsewhere.
- **Outpatient clinics:** Elective outpatient attendances should be kept to the safe minimum. Increase the use of telephone clinics where possible. Clinic space may be needed to manage minor ENT emergencies to take pressure off the emergency department (ED).

When planning your local response, please consider the following:

Obligatory inpatient emergency admissions

- **As prevalence of coronavirus increases, a consultant must be designated as 'lead consultant'.** This duty can be for one day, a few days or even five days in small units. This is an essential role during crisis management. It cannot be performed by the consultant 'on-call' or the consultant in clinic or in theatre. They must be free of clinical duties and the role involves co-ordination of the whole service from ED to theatre scheduling and liaison with other specialties and managers.
- Support each other and share the workload. Do not expect the clinical director to do all the co-ordination!
- Use elective theatre capacity and surgeons to minimise preoperative delay.
- Use elective rehabilitation services to minimise postoperative stay.
- An anaesthetic guideline for patients who are coronavirus positive and require surgery will be required. Useful resources can be found on the Royal College of Anaesthetists' website: https://icmanaesthesiacovid-19.org/
- Make contingency plans for supply chain issues.

Non-operative management

- Clinical decisions during a serious incident must take into account the available facility for the current patient and also the impact this may have on the whole community.
- As the system comes under more pressure, there may be a shift towards **non-operative care** whenever possible.

- Non-operative care may reduce the inpatient and operative burden on the NHS.
- It may also protect the individual from more prolonged exposure in a hospital setting.
- It may free up beds for more urgent cases.

Elective inpatients

- Many elective ENT procedures requiring overnight care can be safely postponed.
- Prioritise urgent cases:
  - paediatric airway
  - head and neck cancer

Elective day cases

- Most elective ENT procedures are clinically suitable to be performed as a day case.
- During the coronavirus emergency, an increase in day case surgery will:
  - avoid unnecessary admission
  - reduce the exposure of the individual to a hospital environment
  - free up beds for more urgent cases
  - allow staff from elective theatres to continue working in a familiar environment.
- During an escalation in coronavirus, elective day case surgery is likely to be restricted to urgent cases. Careful prioritisation of day cases across both elective and non-elective patients will be needed, based on theatre/staff capacity. Further escalation will result in the cancellation of all elective surgery.
- Local plans may include stopping all elective surgery (including day case) to use space and staff for looking after critically ill patients.

Outpatient clinics

Most routine ENT outpatient appointments can safely be postponed if required. Consideration should be given to increased use of telephone clinics whenever possible, particularly for the vulnerable patient groups previously described. Where patients are clinically urgent and need to be seen face to face, direct contact should be kept to a minimum and PPE used where required.

EDs are likely to come under intense and sustained pressure. ENT surgeons can make an important contribution by agreeing to accept ENT patients direct from triage, without referral, therefore helping to reduce frontline ED workload.

As the prevalence of coronavirus increases, EDs will change their strategy using triage at the front door and streaming patients directly to ENT before examination or diagnostics. We are likely to be asked to take **all** patients presenting with ENT problems straight from triage. It is possible that this temporary service will need to be expanded to

provide a 12-hour service, seven days a week, by increasing your current ENT emergency clinic service. We may be asked to use alternative locations to see emergency patients where appropriate. For example, those who would normally be seen in minors could be seen in outpatients.

EDs will continue to take patients requiring resuscitation, etc.

Summary:

- We should avoid unproductive attendances at hospital where we can.
- Senior decision-making at the first point of contact can reduce or even prevent the need for further attendances.
- A decrease in elective work will allow greater senior clinician input at the front door.
- Clinicians may need to work in unfamiliar environments or outside their sub-specialist areas. They will be supported in doing so.
- No ENT patient should be scheduled for surgery without discussion with a consultant.
- Extend emergency clinics by making them open access between at least 09.00 and 17.00 and potentially later in the evening, depending on staffing levels.
- The longer hours will allow ED access and help reduce crowding in waiting rooms.
- The possibility of a seven-day service may need to be considered.
- Using telephone clinics will **not** reduce ED workload, although the patient information used will be very effective in reducing follow-up visits.
- Consider postponing long-term follow-up patients until the crisis has passed.

ENT escalation policy

This is intended as a guide. Each trust will have an individual escalation plan, which you should adhere to.

Prevalence	Low	Medium	High	Very high
Impact	Normal winter pressure Business as usual	Limited ITU Limited beds	No ITU Theatre ITU pods No beds Emergency discharges	Emergency surgery limited Isolation limited
Phase Response	Prepare to respond	Stop routines	Prioritise urgent	Major incident
Elective operating	Normal except no vulnerable patients, eg ASA 1 only	Urgent and cancer only	All elective surgery stops	
Elective clinic	Normal new patient Start reducing follow-up	Urgent and new cancer only No follow-up	Stop elective outpatients	