EXITING THE PANDEMIC
The Head and Neck Society

Priority
The following categorization provides illustrative examples and is not supposed to represent an exhaustive list.

- Level 1a – Airway emergencies and neck trauma
- Level 1b – Neck abscess
- Level 2 - Diagnostic procedures (endoscopy, lymph node biopsy) Confirmed cancer surgical treatment, thyroidectomy for refractory thyrotoxicosis, Skin cancer – melanoma and SCC, any case with limited but developing airway compromise
- Level 3 - Diagnostic thyroid lobectomy, parathyroidectomy, parotidectomy. Skin cancer - BCC
- Level 4 – Surgery for RRP, endoscopic dilatation, thyroglossal duct cyst, branchial cyst, branchial sinus/cleft.

MDT decisions need to be tailored to local needs, facilities and expertise. However, full consideration should be given to non-surgical treatment options wherever possible. This must be weighed against the potential benefits in terms of reduced travel and reduced hospital footfall from procedures for example, laser endoscopic resection for early laryngeal cancer as opposed to 5-6 weeks of daily radiotherapy. Wherever possible procedures should be done under local anaesthetic (eg lymph node biopsies). The use of haemostatic agents such as Floseal, Tisseal or Artiss should be considered where this might reduce the need for a drain and so reduce hospital length of stay. Careful consideration should be given to allowing patients home with drains in situ to return the following day for assessment of drainage and drain removal.

MeNTs
Outpatients – Face to face appointments should be reserved for those cases where there is a specific need to bring the patient for hospital for a specific examination, procedure or investigation. In most cases this should be following a telephone triage consultation (for 2 week wait referrals the use of the risk calculator accessed from the ENT UK website is to be
encouraged ADD LINK). If imaging is clearly needed this should be arranged prior to the appointment or on the same day.

Wherever possible arrangements should be made to ensure that a patient coming to hospital can get any investigations needed at the same visit as their OPA and preadmission if required in order to reduce footfall in the hospital from multiple visits. The aspiration should be to move to a ‘One stop’ model.

Head and neck patients in the first year of follow up should continue to be seen for face to face appointments at the discretion of their surgeon or oncologist, but those on 3 month or longer follow up regimes should be risk assessed via telephone (using the H&N follow up risk calculator- ADD LINK). Post chemoradiation patients could wait until after their post treatment MRI/PET scan.

Tertiary referrals should be seen once all their investigations have been completed at the referring hospital and the results have been received and reviewed at MDT, so that they are coming to discuss their treatment plan and sign consent for procedures/treatment.

Investigations which are AGPs should be reserved for patients for whom essential information will be gained, not available from other non AG investigations. For instance, a patient who has a suspicious neck mass will need cross sectional imaging and this is likely to identify a primary site in which case the FNE will not have added much to the diagnosis or treatment planning.

**Inpatients**

Where possible and local resources allow, Pre COVID standards of care should apply. However, there must be an acknowledgement of the increased risk of general anaesthesia to patients who are COVID +ve. There is also an increased risk with increasing length of procedure, length of hospital stay, increased patient frailty/comorbidity and rehabilitation needs. All of these should be factored into the treatment decision making at the MDT and during discussion with the patient. These are not new principles introduced just in the light of COVID but they should be applied with more rigour than in the Pre COVID era. Consideration should be given to the use of specific risk assessment scoring strategies such as those outlined in the MeNTs paper (ADD LINK).

Ideally each Trust should consider the division of work into clean (COVID –ve) and dirty (COVID +VE) areas. This may require the use of other premises such as private facilities or the conversion of existing real estate within the Trust.

**PRE OP COVID Testing**

All patients being admitted for elective H&N procedures should undergo some form of COVID testing according to Trust protocol. Ideally surgeons should be tested regularly to ensure they are also COVID free before operating. Most trusts will have a hierarchy of testing with the most rigorous testing reserved for patients undergoing the most high risk procedures. All patients undergoing free flap reconstruction should be considered in this category as well as pharyngolaryngectomies, laryngectomies, total thyroidectomy when combined with neck dissection, craniofacial resection and lateral temporal bone resection.
Patients should be given an information leaflet outlining as far as possible the changes to their treatment from what would have been considered as ‘standard of care’. The leaflet should also explain in general terms the increased risk from general anaesthesia for COVID positive patients which might result in their cancellation at short notice if they fail their pre-operative COVID screening. This should emphasise the importance of the period of self isolation prior to their admission. Patients should be contacted regularly during the self isolation period to support them and to ensure adherence to the isolation and preoperative testing.

Each Trust should have an ongoing local audit of COVID infection which can be used to inform patients of the risk involved.

**Procedures that can be removed from waiting list or only undertaken in exceptional circumstances.**

**Specific PPE requirements.**

All head and neck operations should be undertaken using full PPE. Where there are limits on the availability of PPE, non AGPs could be undertaken with normal surgical gowns, masks and visor in tested non COVID patients. For AGPs, full PPE with FFP3 masks and proper eye protection should be worn even in the COVID free patients.

For longer procedures standard PPE with FFP3 masks may well prove to be uncomfortable after an hour or two of operating and so consideration should be given to using Hazmat protective equipment so that there is as little compromise as possible to safe surgery.

**Training**

For the foreseeable future, H&N procedures should be Consultant performed in order to reduce operative time and complications. Trainees may be involved in assisting and may carry out some small parts of a procedure within their competence but this will be very much less than they would have been able to do in the Pre-COVID era and they should not be left on their own even for endoscopy or minor surgical procedures such as lymph node biopsies or skin cancer resections. There may be circumstances under which senior fellows or very experienced associate specialists may be able to operate at the discretion of their supervising Consultant.

As this period of a relative embargo on operative surgical training may extend for a considerable period, there should be active investment in the development of wet lab and cadaveric facilities for regular dissection training and the practice of surgical procedures within the confines of the Anatomy Act.

**Research**

It is particularly important for centres to record and audit, surgical outcomes, delays to treatment start dates, and deviation from previous ‘standard of care’. Participation in National audits and initiatives are to be encouraged for example recording data through COVIDSurg ([https://globalsurg.org/covidsurg](https://globalsurg.org/covidsurg))
KEY POINTS

1. H&N cancer surgery should continue according to best practice

2. Wherever possible H&N surgery should be in cold (COVID –ve) sites or cold sections within a hospital.

3. A robust screening protocol must be implemented for all H&N patients and staff involved in their care

4. There is an agreed prioritisation for H&N cases with emergency and (non-thyroid) cancer as the top priorities.

5. Modifications to practice restricted to: telephone/video consultations as much as possible; up front investigations (will mean more scanning); PPE for AGP’s; screens for endoscopy; separate rooms for endoscopy until other possible safety measures are understood; video-link MDTs especially for more extended members; probable avoidance of prolonged or extensive CO2 laser and trans oral electrosurgery if alternatives are suitable.