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Letter to the Editor

Implementing Emergency Gynecologic Surgery Guidelines during COVID-19

To the Editor:

New York City, the world's coronavirus disease epicenter, reached its peak of coronavirus disease 2019 (COVID-19) new cases and deaths in mid-April [1]. During the evolution of this crisis, New York City institutions collaborated to address the challenges facing their healthcare systems. The results of such informal and formal meetings to focus on the pandemic resulted in the establishment of universal testing protocols for patients who are pregnant, the suspension of all nonurgent surgeries, and the conversion of operative units to intensive care units (ICUs). In this letter, we share the protocol for the care of patients in need of emergent gynecologic surgery.

All patients are tested for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) when a decision for emergency surgery is made. Patients with pending SARS-CoV-2 results are considered as persons under investigation (PUIs) and are treated as COVID-19 positive. A PUI must wear a surgical mask, and all personnel in contact with the PUI require personal protective equipment (PPE). This PPE includes an N95 mask underneath a surgical mask, a face shield or eye goggles, a gown, double gloves, head covering, and shoe covers. There are designated PPE coordinators in each unit to ensure the proper distribution of supplies for the safety of the staff.

The patient is taken directly from the emergency department to the operating room (OR) because our preoperative hold areas are serving as ICUs. Our institution has 2 ORs assigned for PUI and patients who are COVID-19 positive; these rooms are large and well ventilated. Once the patient is in the OR, only the anesthesia team remains in the room for anesthesia induction. Intubations are performed with the assistance of a video laryngoscope while the patient is placed under a clear plastic sheet to reduce viral spread. After intubation, the surgical team returns to the room, which is then deemed a restricted zone to minimize all traffic in and out (Fig. 1).

During the surgery, we follow the gynecology surgical COVID-19 joint statement by the American Association of Gynecologic Laparoscopists, American Urogynecologic Society, International Gynecologic Cancer Society, Society of Gynecologic Oncology, Society of Gynecologic Surgeons, and the Canadian Society for the Advancement of Gynecologic Excellence, which recommends low carbon dioxide insufflation pressures between 10 and 12 mm Hg with the use of smoke evacuator systems and gentle release of pneumoperitoneum at the completion of the procedure during laparoscopy to reduce aerosolization of possible peritoneal SARS-CoV-2 [2]. This joint statement also addresses laparotomy and other gynecologic procedures.

Extubation is performed while the patient remains sedated to reduce his or her cough reflex. At the conclusion of the procedure, the nursing and anesthesia teams leave owing to staff shortage and redeployment to coronavirus disease units as also experienced by other institutions. Because our postanesthesia care units are also currently ICUs, the patient completes postoperative recovery in the OR while being monitored by the surgical team. On meeting milestones for discharge, he or she is escorted from the OR to the hospital exit by the surgical team to reduce patient exposure to the SARS-CoV-2 virus (Fig. 1).

The COVID-19 pandemic has been a unique time in which healthcare workers have come together nationally and internationally, sharing their experiences for patient care. As others continue to see an increase in the number of COVID-19 cases, we encourage everyone to look at national and international organizations and large institutional protocols in care of not just patients who have COVID-19 but all patients to ensure the safety of patients and staff.

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Fig. 1

Institutional protocol for patients presenting with non-COVID complaints and need for emergency surgery. COVID/COVID-19 = coronavirus disease/coronavirus disease 2019; ED = emergency department; OR = operating room; PPE = personal protective equipment; PCR = polymerase chain reaction; PUI = person under investigation; SARS-CoV-2 = severe acute respiratory syndrome coronavirus 2; Si/Sx = signs/symptoms.

References

1. Dong E, Du H, Gardner L. An interactive web-based dashboard to track COVID-19 in real time. *Lancet Infect Dis.* 2020;20:533–534.
2. AAGL. Joint society statement on minimally invasive gynecologic surgery during COVID-19 pandemic. Available at: <https://www.aagl.org/>

[news/covid-19-joint-statement-on-minimally-invasive-gynecologic-surgery/](#). Accessed March 25, 2020.

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