Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Web-Based Medically Necessary, Time-Sensitive (MeNTS) Procedure Scoring Worksheet

In Reply to Ing and Ing

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We want to thank Dr Ing and colleagues for their interest in our article¹ and for their generosity and willingness to share the Excel (Microsoft) spreadsheet that they have created for simplification of the calculation of medically necessary, time-sensitive (MeNTS) procedure scoring. Since the initial electronic publication of our article, there have been several individuals and centers that have inquired about the availability of such tools, and others have proceeded to create their own online MeNTS score calculators. In addition, based on a large number of requests from their clients, 2 major electronic health records systems (Epic Systems Corporation and Cerner Corporation) are in the process of developing electronic health records-based versions on their platforms.

Because of concerns about data security and confidentiality when using insecure spreadsheets, we have created and have been using an MeNTS scoring tool using the REDCap system for our internal institutional use. REDCap is a secure web platform for building and managing online databases and surveys, with an interface that is ergonomic on desktops, tablets, and mobile devices of most platforms (ie Apple, Windows, and Android). Given the interest we have received from so many physician and hospital leaders, we have also created a publicly available version available to interested parties at: <https://redcap.uchicago.edu/surveys/?s=RNDNEXFA7H>. In addition to efficiently capturing and calculating MeNTS scores, it provides the user with the option to print or email a pdf version of the completed worksheet. Additionally, although there is an option for inclusion of patient-specific information, this information is not required to use the MeNTS score calculating function. In doing so, we hope that surgeons will be able to use this tool in a way that is specific to the workflows that have been created at their institutions.

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Absence of Evidence Is Not the Evidence of Absence: Clinical Consideration when Interpreting Guidelines for the COVID-19 Pandemic

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As the global prevalence of novel coronavirus 2019 (COVID-19) increases, with a death toll exceeding that during wartime, scientists and clinicians alike are racing against time to provide clarity on pathogenesis, mode of transmission, and to research potential treatment and vaccines amid the pandemic. In the meantime, hospital guidance¹ is essential to protect healthcare providers (HCPs) and for disease containment. However, definitive guidelines are often elusive given the rapid emergence of new data and the time constraints for robust evidence.

The algorithm presented by Forrester and colleagues¹ suggested screening all preoperative patients whenever feasible for COVID-19 status. This is essential, rather than depending on unreliable screening protocols. To prevent false reassurance with potential serious implications of infecting multiple HCPs, highly sensitive screening for COVID-19 is necessary. Given increasing evidence of asymptomatic spread,² estimating the extent of asymptomatic carriers based on the prevalence of COVID-19 in the community may be underestimated, unless widespread screening occurs to identify the true negatives.³ Nonetheless, pitfalls with screening for atypical presentation, such as conjunctivitis in the absence of influenza-like symptoms and possible variation in screening sensitivity over the progression of COVID-19 from upper respiratory tract to pneumonia, are not well researched.

Guidance on some aspects of personal protective equipment (PPE), such as neck covering for aerosol-generating

medical procedures (AGMPs), remains uncertain. The anterior neck was found to be the most frequent zone for contamination after PPE doffing.⁴ However, neck covering was not mentioned in the algorithm.¹ Despite a lack of evidence of HCP infection from neck contamination, which is difficult to prove, it is a plausible concept, as neck cleaning is not normally performed. Furthermore, while the globally recommended practice of social distancing is unattainable in the hospital setting, universal masking should be a recommendation for both staff and patients to prevent droplet spread. This is particularly relevant when there is a paucity of evidence regarding droplet travel distance, asymptomatic or pre-symptomatic transmission,² and the significance of short-range aerosol spread.⁵

Amid the COVID-19 pandemic, one of the ways to obviate the need for AGMPs is the use of regional anesthesia and sedation, especially in extremity operations, which may become the “new normal.”⁶ Nonetheless, one must ensure that the sensory/motor block is appropriate for surgical anesthesia to prevent an urgent need to convert to general anesthesia. Furthermore, level II PPE is recommended, which means HCPs don surgical mask and barrier PPE, and the patient also wears a surgical mask to prevent droplet transmission, with or without oxygen underneath.

The aforementioned are only examples of uncertainty in many guidelines in which supporting evidence is scarce. An absence of evidence is not the evidence of absence. Given time, more data will emerge on COVID-19, but until then, physicians should consider clinical judgment and resources in decision-making to protect HCPs and patients.

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Revisiting the Volume-Outcome Association: It Is Time to Ask the Right Questions

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We applaud Dr Wasif and his colleagues at the Mayo Clinic for their work, “Correlation of proposed surgical volume standards for complex cancer surgery with hospital mortality.”¹ Hindsight bias occurs when a series of past events are perceived to be more predictable than they actually were. This phenomenon can arguably be applied to the promotion of regionalization of operative care over the span of the last 20 years in the US. The volume-outcome association came on the heels of other policy-producing quality improvement measures, championed by the Centers for Medicare and Medicaid Services.² In retrospect, the next step should have been a solicitation of research on surgeon practices and effectiveness of institutional perioperative services that affect outcomes similar to the Surgical Care Improvement Project. But unfortunately, the “Take the Volume Pledge” initiative capitalized on this new risk-adverse culture, locking in selective referrals for high-risk procedures and tasking the care of underserved and disadvantaged patients to low-volume centers that feel torn between the desire to do no harm and the ability to do no harm.

The finding that more high-risk operations are being performed at large referral centers—evidence of growing regionalization—has not been ubiquitous across all patients. The use of high-volume centers by minority patients and those within low socioeconomic brackets has been stagnant. The physical, financial, and social barriers preventing treatment at these centers further widen disparities of surgical care.³ These barriers may inform a patient's preference, but the truth is that many will accept a higher mortality rate in exchange for local care.⁴ Finally, the long-term impact of fractionation and discontinuity of care associated with procedural-based regionalization has not been elucidated.

The authors' conclusion that volume is only a part of the equation is corroborated by their earlier research, which showed an attenuation of the volume-to-outcomes relationship over time.^{5,6} Studies such as the one presented give the surgical community a second chance to ask the right questions. Can low-volume centers that duplicate the structural processes of high-volume centers have comparative mortality rates after surgery? Furthermore, is 30-day mortality after complex cancer surgery still the most appropriate outcome to study? Reporting overall morbidity and quality of life has become standard after oncologic treatments. Unfortunately, the lack of follow-up after surgery at large referral