UROLOGICAL SOCIETY OF AUSTRALIA AND NEW ZEALAND

# Guidelines

# Personal Protection Equipment (PPE) for Urologists During COVID-19 Pandemic

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| **Number:** | Pol 021 | **Version:** | | 1.0 | |
| **Subject:** | Patient Care | **Distribution:** | | Members Only | |
| **Authorised by:** | Board of Directors | **Approved Date:** | 30/03/20 | **Review Date:** | As needed |

## Purpose and Scope

These guidelines were developed by USANZ to provide advice to Urologists conducting invasive procedures on patients during the COVID–19 pandemic.

## Evolving Situation

We recognise that guidance may vary over time and undertake to update this advice as necessary to provide as much practical safety to our members as possible, whilst ensuring that patients are able to access safe appropriate care.

Evidence is limited and the advice provided is based on existing data as well as clinical opinion. Advice may well change over time and be impacted by supply issues in this rapidly changing and challenging situation. Advice will also depend on the transmission of COVID in your community, so you may have some local modifications as well.

Emerging guidelines and practice protocols will be issued by a variety of organisations and they should be considered as evidence emerges.

## Risks for Urologist

All non-urgent procedures should be postponed. USANZ's Guidelines for Urological Prioritisation During COVID-19 contains further information to assist urologists on making decisions on the prioritisation of procedures.

Where possible, it may be advisable test for COVID-19 of patients to reduce known risk to staff. However, the currently available PCR testing may provide a false negative result early in the course of the disease, so is of limited benefit to reassure staff regarding patient safety. The newer immunoglobulin tests that may be available in the next few weeks may well provide better early detection of disease, and provide greater reassurance, and further advice may follow once there is availability and clinical experience with the new tests.

Urologists generally do not perform significant aerosol generating procedures but are exposed to urine and blood in the course of their daily work. The risk of contamination from a urine splash is minimal, COVID-19 not having been identified in urine to date (although other coronaviruses have been found in urine). Faecal spread is possible, however considered a low risk. Aerosol risks to urologists may be more significant from patients coughing during intimate procedures e.g. catheterisation, LA cystoscopy, or following intubation/extubation.

Additionally, laparoscopic & robotic procedures have their inherent specific risks with surgical smoke understood to carry viral particles.[1] Pneumoperitoneum with insufflation/disinflation protocols and filter type/use need to be reviewed as aerosol concentration of viral particles are likely to be a risk to all staff.[2] The recommendations on laparoscopy are evolving, with a RACS policy due. Current recommendations are to continue using whichever method you would normally use, however take

additional care to minimal surgical plume, and release of pneumoperitoneum. This advice may change based on RACS advice in this area, which is being currently considered.

PPE rules are in place for invasive procedures where patients are either proven **COVID-19 positive, or symptomatic and at high-risk**. The surgical team is recommended to vacate the theatre during any intubation in theatre, to avoid exposure to aerosol during airway care. You should only enter the theatre after 10-20 minutes later when the airway is secured and fully connected and you have been informed that it is safe to do so (it can take 10-20 minutes for the aerosol to settle). At the end of the procedure, the patient should be moved to a bed with no airway disconnection. Everyone apart from the anaesthetic team may then leave the theatre, and only then should extubation occur. Consider regional or spinal anaesthetic as an alternative to GA.

## Ward/ED recommendations

**1. General**

Surgical mask to be worn when coming within 2m of any patients (regardless of symptoms) who have:

a. Arrived from overseas in the preceding 14 days

b. Have had casual or close contact with a suspected or confirmed case of COVID-19 within the preceding 14 days

Staff who are identified as vulnerable to COVID-19 through occupational health assessment (e.g. based on pregnancy, risk factors or an underlying medical condition) to wear a surgical mask when coming within 2 metres of any patients (regardless of patient symptoms).

**2. Patient with respiratory symptoms**

Surgical mask to be worn when coming within 2m of any patient with an acute respiratory illness.

**3. Suspected or confirmed COVID-19 patient**

Enhanced droplet and full contact precautions i.e.: surgical mask, gown, gloves and eye protection (safety glasses or face shield).

## Operating Theatre Recommendations

| LEVEL | COVID-19 RISK | PPE | EXTUBATION |
|---|---|---|---|
| **1.** | Low risk, asymptomatic | Gown<br>Gloves<br>Apron<br>Surgical mask Surgical cap<br>Visor/goggles/glasses Surgical scrubs | Minimise exposure time in theatre after extubation<br>Keep surgical mask/PPE on during transfer ± extubation, if helping |
| **2.** | COVID-19 +ve or high risk (symptoms + fever)<br>Low aerosol risk | Gown<br>Gloves<br>Apron<br>Surgical scrubs<br>Surgical mask Surgical cap<br>Visor/goggles/glasses | 20 min interval following intubation & extubation before entering (or re-entering) the room |

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| **3.** | COVID-19 +ve or high risk<br>Receiving aerosol generating treatment (e.g. ventilation, CPAP, high pressure nasal oxygen) in ICU / ITU / HDU | Gown<br>Gloves<br>Surgical scrubs<br>FFP (full face protection)3 mask (fitted) or ventilated hood<br>Surgical cap<br>Visor/goggles/glasses | Not applicable |

## General Advice

- We have to assume the majority of patients seen in the next 3 months will have been exposed to COVID-19.
- Only perform invasive procedures on non-deferrable urgent and acute cases.
- FFP3 masks must be fit-checked.
- Remember all PPE equipment is SINGLE USE.
- Reduce patient contact to a minimum, and minimise the number of staff involved.
- Avoid diathermy smoke, low diathermy settings: if possible use a smoke extractor.
- Careful & controlled de-sufflation must be performed before port removal in laparoscopy.
- If asked to perform a procedure on a ventilated patient, make sure that it has been at least 10-20 minutes since intubation or any disconnection, wear an FFP3 mask or ventilated hood, and assume that all surfaces are contaminated.
- For self-ventilating cases, as well as your own PPE, make sure the patient wears a standard surgical mask during the procedure.
- Always use a buddy to assist you with de-gowning to reduce contamination risk.
- Refer to RACS guidelines for the management of surgical patients during the COVID-19 pandemic for futher information

## References


1 Kwak, H. D., Kim, S. H., Seo, Y. S. & Song, K. J. Detecting hepatitis B virus in surgical smoke emitted during laparoscopic surgery. *Occup Environ Med* **73**, 857-863, doi:10.1136/oemed-2016-103724 (2016).

2 A, M., S, P. & E, M. *ERUS (EAU Robotic Urology Section) guidelines during COVID-19 emergency*, <https://uroweb.org/wp-content/uploads/ERUS-guidelines-for-COVID-def.pdf> (2020).


## Superseded documents

- None

## Revision history & Review date

These guidelines will be monitored and reviewed by the Board as the health crisis develops.

| Version | Date | Notes | By |
|---|---|---|---|
| 1.0 | 30/03/2020 | Approved | Board of Directors |

## Contact


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