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.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.
Correspondence and Communications

Cosmetic tourism amidst the Covid-19 global pandemic

Dear Sir,

Amidst the current global pandemic, when healthcare resources worldwide have been restructured to save the lives of the critically ill and all non-essential surgery has ceased, we want to highlight a case of cosmetic tourism complications putting an increased burden on these already overstretched resources.

We previously published a case series of patients returning to Northern Ireland requiring treatment of complications following cosmetic procedures abroad, including prolonged aftercare and average costs to the NHS of over £4000 per person.1 We were surprised to discover that cosmetic tourism is still ongoing despite the global restrictions on travel and the statement from the European Association of Societies of Aesthetic Plastic Surgery (EASAPS) to immediately stop cosmetic tourism after the World Health Organisation declared a global pandemic on the 11th March 2020. In a statement also that also highlighted the concerns of post-operative care and follow-up and the risk of complications subsequently putting added pressure on health care systems.2

The patient in question is a 43-year-old female who travelled from the United Kingdom (UK) to Poland for a circumferential abdominoplasty with ‘fleur-de-lis’ extension at the start of June 2020. On returning home, she required admission to an NHS hospital 3 weeks post-operatively due to wound necrosis, dehiscence and cellulitis. This necessitated an inpatient stay for intravenous antibiotics, surgical debridement, washout of haematoma and application of negative pressure wound therapy (NPWT), with ongoing outpatient management to date. She had a past medical history of depression and previous gastric band surgery 2 years previously, with a pre-operative BMI of 24.

A recent paper by Kaye et al. has led to proposed guidelines from the leading aesthetic associations around the world, including the British Association of Aesthetic Plastic Surgeons (BAAPS), International Society of Aesthetic Plastic Surgeons (ISAPS) and the American Society of Aesthetic Plastic Surgeons (ASAPS), on how to safely reintroduce aesthetic surgery in the wake of the Covid-19 pandemic. Specifically, in relation to these recommended guidelines, the patient was asked what advice she was given with regards to Covid-19 risk. Interestingly, she was required to have a negative Covid-19 antigen swab, however this was performed 1 week pre-operatively and in the interim period she was not required to self isolate or get re-tested, nor was she advised to self isolate or take precautions while travelling from the UK to Poland. In addition, she was not consented regarding the associated risks of contracting Covid-19 in the perioperative period.2

At the time this procedure took place, Poland was treating towards their peak number of active cases with the highest daily number of new cases in Poland since this global pandemic began (n = 599) recorded the day before our patients’ surgery.3

Cosmetic tourism is already known to put patients at higher risk of multiple complications which is discussed in more detail in our previous article. However, the additional concerns surrounding this case are numerous, including: air travel for non-essential purposes, the lack of self isolation pre-operatively and a covid-19 test far in advance of surgery with disregard for any viral incubation period, particularly with this patient’s travel related risk. There was complete disregard for EASAPS guidance banning aesthetic surgery in this global pandemic, exacerbated by the fact this particular week was the peak of Covid-19 cases in Poland.

It must be highlighted that guidance is in place to assist surgeons in these decision making processes. An article endorsed by the Royal College of Surgeons of England aims to minimise Covid-19 risk to both patients and staff during elective surgery. Guidance involves self-isolation for 14 days and a negative antigen test 1-3 days prior to surgery.4 Guidelines for aesthetic surgery in particular have also been released, focusing on how to safely restart aesthetic surgery in the wake of this global pandemic. Recommendations include; operating on low risk patients, ASA 1 or 2 and procedures lasting less than 3 h. Patients should be screened for Covid-19 symptoms and have a negative Covid-19 test pre-operatively. The addition of a specific Covid-19 consent form will ensure informed consent in the new era of living with Covid-19.2 The risks to patients undergoing surgery who develop a perioperative Covid-19 infection are significant and have been highlighted in a recent publication in the Lancet, including: a 51% risk of post-operative pulmonary complications and a 30-day mortality rate of 38%.5

As we recover from this global pandemic and the world begins to normalise, we urge all surgeons undertaking aesthetic procedures to ensure they follow the relative aesthetic association guidelines to ensure both patient and staff safety. Our healthcare systems are currently at breaking point and the future remains unknown, for the greater

This letter has not been presented anywhere else.
good of mankind, we as surgeons must ensure our decisions are well informed and evidence based as we will be held accountable for our actions.

Funding

None.

Ethical approval

N/A.

Declaration of Competing Interest

None.

References

1. Martin S, Long R, Hill C, Sinclair S. Cosmetic tourism in Northern Ireland. *Ann Plast Surg* 2019;83(6):618-21.
2. Kaye K, Paprottka F, Escudero R, et al. Elective, non-urgent procedures and aesthetic surgery in the wake of SARS-COV-19: considerations regarding safety, feasibility and impact on clinical management. *Aesth Plast Surg* 2020;44:1014-21.
3. World Health Organisation health emergency dashboard; WHO COVID-19 Homepage. Poland. Available at: https://covid19.who.int/region/euro/country/pl [accessed 03 July 2020].
4. Cook, T., Ferguson, K., Johannsson, H., Harrop-Griffiths, G. (2020). Managing theatre processes for planned surgery between COVID-19 surges. [online]. Intensive care medicine anaesthesia covid-19. Available at: https://icmanaesthesiacovid-19.org/managing-theatre-processes-for-planned-surgery-between-covid-19-surges [accessed 01 July 2020].
5. Nepogodiev Dmitri, Glasbey James C, Li Elizabeth, et al. COVID-Surg Collaborative, Mortality and pulmonary complications in patients undergoing surgery with perioperative SARS-CoV-2 infection: an international cohort study. [published online ahead of print, 2020 May 29] [published correction appears in Lancet. 2020 Jun 9;:]. *Lancet* 2020;S0140-6736(20)31182-X. doi:10.1016/S0140-6736(20)31182-X.

Rebekah Long
E-mail address: beckylong88@googlemail.com

Serena Martin
Chris Hill
*Plastic Surgery Department, Ulster Hospital, Dundonald, BT16 1RH, United Kingdom*

Correspondence to: ward 18, Plastic Surgery, Ulster Hospital, Dundonald, BT16 1RH, UK.

© 2020 British Association of Plastic, Reconstructive and Aesthetic Surgeons. Published by Elsevier Ltd. All rights reserved.

https://doi.org/10.1016/j.bjps.2020.08.128