Considerations for Elective Facial Plastic Surgery in the Post-Coronavirus Disease 2019 Era

The Rhinoplasty Society of Europe recently convened a webinar regarding this topic on May 3, 2020, but this was not acknowledged within the EAFPS Task Force publication.1

We read your article with interest and wish to note the following:

(1) The authors state their aim is to make recommendations and guidance involving no one but surgeons. We would argue that collaboration should involve specialties outside of surgery, for example, infectious diseases, virology, and public health.

(2) The authors1 refer to “very well-documented cases of widespread infection of operating-room personnel” yet without reference to such cases. Please note that similar claims have been rejected in other studies.2

(3) There is an omission in the recommendations regarding consent. This may form the basis of a legal challenge similar to the UK Supreme Court, Montgomery v Lanarkshire Health Board case. Concern that surgery may accelerate and exacerbate disease progression of COVID-19 is evident in a small but important study3 that showed 20.6% of asymptomatic patients who unwittingly had elective surgery during the incubation period of COVID-19 died. This cohort, however, may not be comparable with those undergoing elective facial plastic surgery (eFPS) as simpler surgery had more favorable outcomes.3 Although an ongoing global collaboration (CovidSurg) is informing decision making with 12,000 patients in 600 hospitals in 70 countries, this may not be authentic to the needs eFPS.

(4) Telemedicine is not uniformly feasible and prone to failures as evident with the Attend Anywhere platform within the U.K.’s NHS. The use of local anesthetic and office-based procedures is controversial and may enhance risk of infection transmission by bioaerosol.

(5) There is a clear need to mitigate for false negative COVID-19 patients and care workers in a cold COVID-19 site. Yet the use of povidone iodine (PVP-I) disinfectant is problematic and concerns as to its use are expressed in the literature of neurotoxicity.4 It may, in fact, augment the olfactory effects of COVID-19. Furthermore, tranexamic acid as a potential repurposed drug has not been approved in this role by any regulatory authority.

(6) Quality of surgery is important. The challenge will be to reduce exposure risk while not diminishing surgical technique. We foresee the increased use of plume extractors or novel extraoral suction devices such as DuraMax.

(7) Multidisciplinary collaboration and accurate data dissemination are vital at the prerecommendation stage. Proper consensus and accountability protect against legal challenge and unintended consequence.

(8) eFPS will coexist with COVID-19 for the foreseeable future providing increased evidential opportunities to understand actual outcomes. Global multidisciplinary collaboration is paramount together with opportunities to scrutinize and comment transparently on these data.

Authors’ Contributions
D.E.J.W. proposed the publication, provided the literature search, and provided the initial draft; D.A.L. reviewed the draft, made recommendations for alterations, reviewed,
and approved the article before submission; R.E.W. co-authored the publication after review of initial drafting. He reviewed and approved the article before submission. All coauthors have reviewed and approved the article before submission.

**Author Disclosure Statement**

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**References**

1. Unadkat SN, Orl-hns F, Andrews PJ, Orl-hns F. Recovery of elective facial plastic surgery in the post-coronavirus disease 2019 era: recommendations from the European Academy of Facial Plastic Surgery Task Force. *Facial Plast Surg Aesthet Med*. 2020;2(4):233–237.
2. Zhu W, Huang X, Zhao H, Jiang X. A COVID-19 patient who underwent endonasal endoscopic pituitary adenoma resection: a case report. *Neurosurgery*. 2020;87(2):E140–E146.
3. Lei S, Jiang F, Su W, et al. Clinical characteristics and outcomes of patients undergoing surgeries during the incubation period of COVID-19 infection. *EClinicalMedicine*. 2020;21:100331.
4. Akcay E, Ersahin Y, Özer F, et al. Neurotoxic effect of povidone-iodine on the rat spine using a laminectomy-durotomy model. *Childs Nerv Syst*. 2012;28(12):2071–2075.

**Response to Whitehead et al. re: “Recovery of Elective Facial Plastic Surgery in the Post-Coronavirus Disease 2019 Era: Recommendations from the European Academy of Facial Plastic Surgery Task Force”**

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We thank Whitehead and colleagues for their interest in our document and welcome the opportunity to reply.

First, numerous webinars by various groups have been conducted on COVID-19 recovery in surgery worldwide. To cite every webinar, the contents of which have not otherwise been published, is not only impractical but as they are fluid discussions between colleagues, it is inappropriate to cite them. Second, the present document was never intended to be a strict set of clinical practice guidelines and should not be interpreted as such. It has been written as a guidance document utilizing available evidence, correct at the time of writing, and is subject to updates as new evidence emerges. It does not replace regular standards of care, nor individual surgeon clinical judgment. Multidisciplinary clinical practice guidelines will be achievable when more evidence is available.

With regard to “very well-documented cases of widespread infection of operating-room personnel,” we have read the case report by Zhu et al. Yet according to sources from the European Rhinologic Society, several other subsequent endoscopic cases have seen infection of operating personnel from COVID-19. Patel et al. also report a further case of transmission of COVID-19 from endoscopic transnasal pituitary surgery, despite the use of N95 personal protective equipment (PPE). The anesthesiologist in that case who was wearing a powered air-purifying respirator did not get infected. As physicians, our primary dictum is to first do no harm and until such a time when further evidence is available, best available PPE should be utilized. As our knowledge grows, these recommendations may well be downgraded but the importance of a caution statement without a reference cannot be overstated.

Where the infrastructure exists already, local/sedation anesthesia surgery such as for skin cancer work and other appropriate cases remains a valid option and is in line with the COVID-19 guidance from other specialty organizations such as the American Academy of Facial Plastic & Reconstructive Surgery (AAFPRS). Appropriate utilization of dedicated procedure rooms may help to aid the recovery process by improving the throughput of patients and reducing the backlog of patients waiting for surgery. Whitehead’s statement on increasing transmission by bioaerosol is unqualified.

Guidance on consent is beyond the remit of the present article and reference to Montgomery v Lanarkshire Health Board case is relevant to U.K. consent and differing rules apply to individual European nations. A variety of telemedicine platforms exist, not just limited to “Attend Anywhere,” as suggested by Whitehead et al. To practice safely in the current climate and to limit risk of transmission, aside from our article, many other similar publications recognize its applicability including those by the American Society of Plastic Surgeons, the American Academy of Otolaryngology-Head and Neck Surgery (AAO-HNS), the Brazilian Association of Otolaryngology and Cervicofacial Surgery, the British Association of Plastic Reconstructive & Aesthetic Surgeons, and the AAFPRS.