In Reply: Precautions for Endoscopic Transnasal Skull Base Surgery During the COVID-19 Pandemic

To the Editor:

To date more than 140 million cases of COVID-19 have been diagnosed worldwide, and 3 002 154 deaths have been reported as a direct consequence of the infection. This disease has put the different health-care systems under a terrible stress. Not only an overwhelming tsunami of patients has had to be taken care of, but also a considerable amount of health-care workers have been infected.

In that line, we read with most interest the letter published by Patel et al., in which they raised concerns of the high-risk profile of the endoscopic transnasal skull base surgery. They based the concerns on a narrative of personal communications of health-care workers infected in the context of endoscopic endonasal procedures. Since that first warning letter, many publications have recommended to minimize the endoscopic endonasal procedures, limit the personnel within the operating room (OR), minimize the use of drills or microdebriders, and the use of high standards of personal protective equipment (PPE).3-7

Now, a few days after our surgical team got completely vaccinated, we would like to share our experience. Our patients were screened for COVID-19 with a CRP swab test 72 to 24 h before the surgery. In case of an emergency, urgent swab test was ordered. The urgent swab test results were available between 2 and 6 h after the sample had been taken. PPE for the OR personnel was FFP2 mask, without any other different protecting gear from the usual gown and gloves, if the patient had been tested and was negative. The procedure was then carried out without any difference from our standard practice (ie, drilling as needed, and so on). If the patient was positive or unknown at the time of surgery, a dedicated OR is used. Only essential instruments and equipment are left in the OR. Level 3 protection gear is mandatory for all personnel (consisting of a waterproof scrub, double gloves, FFP3 mask covered with a surgical mask, and eye shielding with goggles or a plastic face shield). Later on in 2020, we incorporated powered air purifying respirators (PAPRs) as had been recommended6 for these surgeries.

During the first days of the pandemic, when every scheduled procedure was halted and no endoscopic surgeries were performed, 2 of our team members got infected. They thankfully suffered only mild symptoms. After that we managed, between periods of complete halt and periods of relative normality, to perform 24 endoscopic procedures, 8 for pituitary adenomas and 16 expanded endonasal surgeries for a variety of neoplasms. Only 1 of the procedures was performed as an emergency (pituitary apoplexy), and the rest were all scheduled. Two of the patients had an unknown COVID-19 status at the time of their surgeries, and the other 22 were negative (1 of them had suffered the infection 2 mo prior to the surgery). One of the negative patients turned positive 13 d after the surgery.

Fortunately, no health-care workers have been infected as a result of these surgeries. Now, with all personnel properly vaccinated, we hope that the chances are even lower, although the same protocol is being followed. The information presented here is not solid data, but only our experience. We felt that great concern had been raised around the endoscopic endonasal procedures,4,5 and more and more strict protocols were proposed afterwards.4-6 Now more experience has been gathered, and the test and PPE availability are not as scarce as at the beginning of the pandemic. The only intention of sharing our experience is to show that proper preoperative screening for COVID-19 and adequacy of the PPE to the patient’s COVID-19 status has resulted in safe surgery for both our patients and our health-care workers.

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