and need of filters) in accordance with others.⁵,⁶

As the father of asepsis Joseph Lister asked himself “if a man is not to take advantage of the opportunities that present themselves to him, what is he to do, or what is he good for?” It is not our intention to stop the process of human and professional growth that this pandemic has brought about. Nevertheless, after this simplified view of “war-time medicine” that required our availability in spoke hospitals to turn into COVID doctors, we feel that more planning is required to have the right specialists for COVID patients and to manage a second wave of the pandemic not as unprepared as we did. As far as we are concerned, we now need to rapidly move back to the professional competence we as surgeons were trained for, to be able to manage clinical complexity as it is, but with the thought that “being a doctor will never be the same after the COVID-19 pandemic.”

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The authors declare no conflicts of interest.

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Authors’ response:
Surgery in the coronavirus disease 2019 phase 2 Italian scenario: Lessons learned in northern Italy spoke hospitals

We thank Dr. Costanzi and colleagues for their appreciation and interesting insights about our work.† We perfectly agree with them that coronavirus disease 2019 pandemic dramatically changed the health system organization and surgeons’ duties. We would like anyway to make some points clear:

- We strongly believe that surgeons used to deal with critical patients and committed in the care of acute patients played a key role in facing this pandemic event, which seems to be a mass casualty event. The attitude of surgeons in managing scenarios involving people with different injuries and their ability to prioritize treatment and resources are crucial and effective in the field and in planning the correct hospital strategy. Previous experiences and training in these fields were of paramount importance and deserve attention for the future plans.
- Surgical critical care knowledge, one of the pillars of acute care surgery, revealed once more a mandatory background for surgeons.²
- The surgeons’ role is important in the “hub” hospitals and much more important in the “spoke” hospitals. In our opinion, their help is fundamental in the crisis unit too, of course together with hospital manager and directors, medical and emergency department, logistic, supply, and strategic staff.
- We continue, during this pandemic event, to face different surgical scenarios, emergent, urgent, and elective (particularly cancer related), and we continue to use laparoscopy (in coronavirus disease patients too) when the laparoscopic technique is recommended and widely recognized.³–⁵
- We fully agree in using adequate personal protective equipment and the precautions advised.
- Regarding patient positioning in severe acute respiratory syndrome coronavirus 2 patients, we never experienced any problem due to Trendelenburg position when required.

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Dear Editor,

We are grateful to Di Saverio et al.1 for their valuable contribution during the coronavirus disease 2019 (COVID-19) pandemic and for sharing their experience while providing a support for the current guidelines. However, we find ourselves in disagreement with some of their statements. The mentioned article takes for granted the risk of viral spread through the surgical smoke and pneumoperitoneum and suggests avoiding the laparoscopic approach as much as possible.

While agreeing on the concept of the potential risks of surgical smoke for the theater staff, which have been widely demonstrated, we feel that our clinical decisions during this pandemic must be evidence based to the greatest extent.

On this particular topic, there is no published proof of the presence of COVID-19 in the surgical smoke, and the suspect is only indirect.2 The available evidence of the presence of active hepatitis B virus (HBV), human immunodeficiency virus (HIV), and human papillomavirus (HPV) viral particles in the surgical smoke is low level and may not apply directly to the COVID-19. At our knowledge, up until now, only one article demonstrated the presence of HBV in the surgical smoke in 10 of 11 HBV-positive patients undergoing laparoscopic or robotic surgery.3 Several articles demonstrated the presence of HPV in the laser plume,4 whereas the results of studies on HIV yielded contrasting results.5 Although there is evidence of patient-surgeon transmission of HPV through the laser smoke, the particular kind of surgery for HPV-related warts, where the surgeon usually stays very close to the surgical field and easily inhales the smoke, makes HPV a biased experimental model for viral transmission during laparoscopic surgery. Despite HIV and HBV being blood-borne viruses, laparoscopic surgery is being performed in HIV and HBV patients for many years, and no clear demonstration is available of viral transmission through the pneumoperitoneum or surgical smoke. On the contrary, COVID-19 has a special tropism for the upper and lower respiratory tract. Viral RNA has been found in stools and blood, but no infective virus has ever been demonstrated in the gastrointestinal tract and in the blood. Furthermore, it must be emphasized that smoke production and evacuation may be even more difficult during laparotomy than laparoscopy, for the absence of a unique smoke escape channel.

For these reasons, we do not believe that results from the available literature can be extrapolated to the COVID-19 pandemic as to justify the current too restrictive guidelines on laparoscopic surgery against the evident and well-known and evidence-based advantages of laparoscopy with respect to the open approach in many fields of surgery. We feel that replacing a grade of recommendation A (known benefits of laparoscopic surgery) with a grade D (avoid laparoscopy on the basis of perceived dangerous laparoscopic smoke) is not consistent with a modern healthcare system.

Last but not the least, we feel that the restrictions placed on the practice of laparoscopic surgery during the pandemic may not be consistent with ethics and professionalism because they reduce the level of care and abdicate to the already world widely accepted criterion standards in surgical care. While this can be acceptable in war scenarios with limited resources, they may not be totally acceptable in the current juncture where, despite undoubtedly facing a challenging pandemic, resources and expertise are widely available and access to the highest standard of care must be granted to everyone.

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Authors’ response: Laparoscopy and COVID-19: An off-key song?

We thank Tebala et al. for their interest and comments on our article.1 At the end of their letter, the authors point out that “resources and expertise are widely available” during coronavirus disease 2019 (COVID-19) outbreak and a restrictive use of laparoscopy would have been acceptable only in a war scenario. Unfortunately, the current data resemble many features of this kind of scenario, with shortage of personnel, reduction of surgical services, operating rooms converted in intensive treatment unit (ITU) beds, and surgeons shifted to medical tasks as a global response to the pandemic.2 As of May 12, 2020, 163 doctors died after contracting COVID-19 in Italy,3 and health workers are heavily affected globally. In this setting, any additional source of contagion may produce catastrophic effects and threat the entire health system. A tailored strategy to protect health workers and patients, avoiding unnecessary risks, is a priority.4,5

A second worst pandemic wave, as in the Spanish flu, cannot be excluded, and a self-preserving strategy must be already in place to guarantee an adequate surgical response in the future outbreak peaks, despite the shortage of personnel, beds, and operating rooms.

Regarding the lack of evidence of SARS-CoV-2 presence in the peritoneal fluid, some anecdotal evidences are emerging. Viral RNA was detected in the peritoneal fluid of a COVID-19 patient who had undergone a laparotomy for a nonischemic small bowel volvulus6 and in the peritoneal waste of a patient treated with peritoneal dialysis.7 Thus, a prudential approach may be reasonable until

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