A Summary of Recommendations for Plastic Surgeons during the Coronavirus Disease 2019 Outbreak

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Background: The coronavirus disease 2019 outbreak presents unique challenges to the healthcare system. The lack of unified guidelines on what constitutes elective surgery left plastic surgeons without a clear framework to guide their practices. More urgently, the ambiguity in defining elective surgery leaves plastic surgeons without clear guidance as states begin to phase in these procedures.

Methods: Recommendations issued by state governing bodies as of April 28, 2020, were reviewed. National society and federal guidelines pertaining to postponement and resumption of elective surgeries affected by the coronavirus disease 2019 outbreak were also reviewed. Recommendations based on the above are collated for plastic surgeons.

Results: Thirty-six states and the District of Columbia provide recommendations regarding elective surgery. Cosmetic surgery is considered an elective surgery and should be postponed; this may be among the first elective surgeries to safely resume. Societal guidelines provide disease-specific recommendations for cancer-related surgery and breast reconstruction. Trauma, other cancer-related reconstruction, and hand surgeries are considered nonelective if postponement threatens life or limb or if a patient is highly symptomatic. Postponement and resumption of oncology, trauma, and hand surgery cases depend on disease stage and complexity of reconstruction. Pediatric craniofacial surgery presents unique challenges due to the time-sensitive nature of the interventions.

Conclusions: Guidance on elective surgery is vague for plastic surgeons. Government recommendations and societal guidelines provide a framework for plastic surgeons to assess the elective nature of a surgical intervention and safety of resumption; however, a nuanced assessment must be made on local disease transmission, supply availability, and hospital capacity. (Plast Reconstr Surg Glob Open 2020;8:e3039; doi: 10.1097/GOX.0000000000003039; Published online 17 July 2020.)

INTRODUCTION

The coronavirus disease 2019 (COVID-19) outbreak caused by the SARS-CoV-2 virus was declared a pandemic by the World Health Organization on March 11, 2020. Following this announcement, the American College of Surgeons (ACS) issued guidance for triaging nonemergent cases based on an Elective Surgery Acuity Scale.¹ The ACS announcement was closely followed by the announcement by Centers for Medicare and Medicaid Services (CMS) recommending that “all elective, nonessential medical, surgical, and dental procedures be delayed” during the COVID-19 outbreak to minimize spread of the virus and preserve personal protective equipment (PPE).² Similar statements by The American Society of Plastic Surgeons (ASPS)³ and individual states soon followed. Despite the plethora of guidelines, the criteria of what constitutes an elective procedure remain elusive. As states begin to control local outbreaks of the novel coronavirus, public health officials and societies have issued guidance on the resumption of elective procedures.³⁻⁵

Surgical interventions that were considered elective were suspended, but it was unclear which should be rescheduled. Surgeons (ACS) issued guidance for triaging nonemergent cases based on an Elective Surgery Acuity Scale.¹ The ACS announcement was closely followed by the announcement by Centers for Medicare and Medicaid Services (CMS) recommending that “all elective, nonessential medical, surgical, and dental procedures be delayed” during the COVID-19 outbreak to minimize spread of the virus and preserve personal protective equipment (PPE).² Similar statements by The American Society of Plastic Surgeons (ASPS)³ and individual states soon followed. Despite the plethora of guidelines, the criteria of what constitutes an elective procedure remain elusive. As states begin to control local outbreaks of the novel coronavirus, public health officials and societies have issued guidance on the resumption of elective procedures.³⁻⁵

The lack of clearly defined criteria regarding what constitutes an elective procedure has resulted in haphazard...
implementation within practices and between providers. More urgently, this lack of clearly defined criteria portends a disordered resumption to normalcy. Plastic surgeons must be apprised of the most current state and society guidelines on the status of elective procedures and be amenable to adapt in the event of a second COVID-19 surge.9

In this report, we present recommendations issued by federal and state governing bodies concerning the cessation and resumption of elective surgeries. These recommendations, in conjunction with national society guidelines, are collated to provide guidance regarding elective surgery practices to plastic surgeons during the COVID-19 outbreak.

METHODS

Recommendations issued by state governing bodies pertaining to elective surgery are reviewed as of April 28, 2020. We also reviewed national society and federal guidelines pertaining to elective surgeries affected by the COVID-19 outbreak. Due to the variability in enforceability and terminology used by different states, the term recommendations will be used in this article when discussing state communications about elective surgery practices during the COVID-19 outbreak.

RESULTS

Thirty-six states and the District of Columbia provide recommendations or orders regarding the postponement of elective procedures.7–10 Twelve states provide specific recommendations, using examples.8,10,18–20,24,26–28,30,35 Readers are encouraged to reference their individual state’s government resources and medical boards for further information on specific recommendations and enforceability. An overview of the CMS Tier-based system for designation of elective surgeries is outlined in Table 1.

As many states have effectively “flattened the curve” by preventing an uncontrolled surge of COVID-19 cases, they have begun issuing guidance on the resumption of elective surgeries.44,45 To date, 24 states have issued guidance on plans to resume elective surgeries.10 Several national societies, including ACS and ASPS, have also issued guidance to their members.3,46 Factors to consider before resuming elective surgeries include local COVID-19 surge and prevalence statistics, hospital capacity, PPE and disinfectant supply availability, testing capabilities, and COVID-19-specific informed consent. (See document, Supplemental Digital Content 1, which displays the COVID-19 consent form, http://links.lww.com/PRSGO/B445.) Plastic surgeons should familiarize themselves with the specifics of their respective government guidelines and society recommendations.

Cosmetic Surgery

Plastic surgeons performed a total of 17.7 million cosmetic procedures in 2018; 1.8 million of these were surgeries.37 Five states specifically address cosmetic surgery in their recommendations.10,19,24,30,35 The ASPS guidance on elective surgery “recommends that all of our members provide only urgent or emergent care” for office-, ambulatory surgery center-, and hospital-based procedures.3 It should be noted that although the ACS guidelines suggest that Tier 1a to 2b procedures (low-to-intermediate acuity in healthy to unhealthy patients) may be performed in ambulatory surgery centers,1 both CMS and ASPS guidelines recommend against performing all elective surgeries, if able.2,3

Recommendation for Cessation and Resumption

Cosmetic surgeries were recommended to be suspended apart from complications requiring operative intervention. As states begin to allow resumption of elective surgeries, cosmetic surgeries may be safely resumed, as such cases are typically performed in ambulatory surgery centers without an overnight stay (Table 2).41

Oncologic Reconstruction

Numerous guidelines, ranging from state recommendations to societal guidelines, have deemed oncology procedures to be nonelective. CMS guidelines divide cancers into Tier 2a (low-risk cancer) and Tier 3a (most cancers); the guidelines recommend postponing Tier 2a procedures and recommend against postponing Tier 3a procedures.2 Surgeons, however, are required to define low risk versus most cancers on their own. State recommendations provide less-nuanced information regarding cancer care, with only 12 of the 50 states and the District of Columbia providing information regarding oncologic surgery; none provide guidance on breast reconstruction.45–51

The Society of Surgical Oncology provides resources for breast cancer treatment by type and stage during the COVID-19 outbreak, with recommendations to temporize patients with endocrine therapy or neoadjuvant chemotherapy when appropriate.48 Further, a recent National Comprehensive Cancer Network article on cancer care during the COVID-19 pandemic suggests that patients with early-stage breast cancer can be appropriately treated and temporized with endocrine therapy until they can undergo surgery. The American Academy of Otolaryngology-Head and Neck Surgery provides guidelines on time-sensitive head and neck oncologic procedures and guidelines for safe resumption of elective cases.49,50 The authors suggest that, in light of resource limitations, providers must focus their efforts on treatments that are “most likely to be successful, symptom-relieving, or lifesaving, and consider those patients likely to get the greatest benefit from treatments.”51 Plastic surgeons must work collaboratively with medical and surgical oncologists to provide the most appropriate treatment options to their cancer patients in light of the COVID-19 outbreak.

ASPS issued a statement regarding breast reconstruction during the COVID-19 outbreak. The statement defines delayed and revision breast reconstruction as “elective and thus should be postponed until which time the system in your area can accommodate elective surgery as deemed safe for patients.”52 The recommendations provide more nuanced guidance concerning immediate breast reconstruction, advising surgeons to weigh the risk of exposure, PPE use, staff availability, and
hospital capacity. Immediate autologous breast reconstruction is defined as elective (excluding chest wall reconstruction) and should be delayed. The guidelines also suggest an individualized approach to oncoplastic reconstruction and contralateral balancing procedures. The guidelines also suggest that plastic surgeons evaluate implant-based breast reconstruction on a case-by-case basis. Surgeons should also evaluate patient comorbidities and risks of additional anesthetic exposure from staged oncologic reconstruction, such as is required for delayed breast reconstruction. The ASPS statement on breast reconstruction suggests that “in general, plastic surgeons should err on the side of caution and delay reconstruction” during the COVID-19 outbreak. As states begin to phase in elective surgeries, these guidelines will undoubtedly change.

Recommendation for Cessation and Resumption

Oncologic reconstruction amenable to outpatient care should be prioritized. Oncologic reconstruction requiring inpatient stay should be performed with careful consideration to the risk of SARS-CoV-2 infection, given the immunocompromised state of oncology patients, inpatient capacity, and PPE availability (Table 2).

| Tiers | Definition | Example | Action |
|-------|------------|---------|--------|
| Tier 1a | Low-acuity surgery, Healthy patient | Outpatient surgery/non–life-threatening illness | Postpone surgery |
| Tier 1b | Low-acuity surgery, Unhealthy patient | Non life-threatening but potential for morbidity and mortality if surgery delayed. Surgery requires inpatient stay | Consider postponing surgery |
| Tier 2a | Intermediate-acuity surgery. Healthy patient | Postpone surgery if possible |
| Tier 2b | Intermediate-acuity surgery. Unhealthy patient | Do not postpone |
| Tier 3a | High-acuity surgery. Healthy patient | Inpatient |
| Tier 3b | High-acuity surgery | Inpatient |

Table 2. Summary of Recommendations Based on State, National, and Society Recommendations for Initial Delay and Resumption of Elective Surgeries

| 2a. Cosmetic | Initial Recommendations for Delay | Recommendations for Resumption |
|--------------|---------------------------------|-------------------------------|
| Cleft Lip Repair | Postpone | Prioritize ambulatory intervention |
| Cleft Palate Repair | Ideally postpone, while taking into consideration age of patient >12 months | Those requiring inpatient hospitalization should prioritize time-sensitive procedures |
| Alveolar Bone Grafting | Ideally postpone, while taking into consideration timing of eruption of permanent canines | |
Trauma Reconstruction

Trauma reconstruction represents a wide range of procedures that vary in the acuity level. Only Florida provides specific recommendations on trauma-related surgery, designating such procedures as nonelective and "permissible." However, states such as Ohio provide more generic recommendations, stating that nonelective procedures include those that, if not performed, would be a "threat to the patient’s life" or would cause "permanent dysfunction of an extremity or organ system." For plastic surgeons, such guidelines pertain to reconstructive procedures that, if not performed, may compromise the life or limb of a patient. CMS guidelines recommend that trauma Tier 3b procedures that should not be postponed; however, this recommendation applies to high acuity, unhealthy patients based on CMS criteria. Plastic surgeons must assess the acuity of trauma patient’s reconstructive needs to determine if their intervention is life- or limb-saving.

Facial trauma represents a range of clinical presentations and interventions. Based on CMS criteria, facial fractures in highly symptomatic patients are classified as Tier 3a and, therefore, procedures to correct the same should not be postponed. Operative facial fractures for cosmetic purposes are classified as Tier 1a and, therefore, the relevant treatment for the same should be postponed. Facial nerve repair for acute facial nerve injury after trauma is classified as Tier 3b and should not be postponed. The only state to mention facial trauma is Minnesota. Their recommendations specifically state that if there is "threat of permanent dysfunction of an extremity or organ system, including teeth and jaws," then such an intervention is considered nonelective. The guidelines recently developed by AO CMF International Task Force for facial trauma that suggest performing fracture fixation to restore function and, when possible, performing closed reduction, using scalpel over cautery, and minimizing suctioning and power-assisted drilling.

Recommendation for Cessation and Resumption

Plastic surgeons should work closely with their trauma, orthopedic, and neurosurgery colleagues to determine the acuity of the injury and the need for timely reconstruction. Facial fractures requiring operative intervention for highly symptomatic patients should proceed. Priority should be given to ambulatory interventions after assessment of each hospital’s inpatient capabilities and PPE supply (Table 2).

Pediatric Craniofacial Surgery

The pediatric population is largely unaffected by the SARS-CoV-2 virus, with <1% of children younger than 10 years old affected and <2% of children younger than 19 years old affected. Pediatric craniofacial surgery is unique due to the time-sensitive nature of many pediatric procedures. This nuance is neither captured by national or state guidelines, nor by craniofacial society guidelines. The only state to mention the importance of age when considering the elective nature of an intervention is Arizona, which recommends that surgeons “consider the health and age of the patient.” Of note, craniofacial surgeons face a high risk of COVID-19 exposure, as procedures involving the oral cavity are aerosolizing procedures and increase transmission risk of the virus.

Cleft lip repair is a low-acuity procedure typically performed in healthy patients, making this a Tier 1a procedure based on CMS guidelines; cleft lip repair can be delayed without functional consequences, and therefore should be postponed. Cleft palate repair is likewise a low-acuity procedure and is typically performed on healthy patients, making this a Tier 1a procedure. However, significant evidence exists indicating that cleft palate repair performed after the age of 12 months is associated with worse speech outcomes; for this reason, cleft palate repair is typically performed before the age of 12 months. Similarly, alveolar bone grafting is classified as a Tier 1a procedure; however, this procedure must be timed with eruption of the permanent canines. Craniofacial surgeons should take this timing into account when considering alveolar bone grafting. Orthognathic surgery is generally a low-acuity procedure performed in healthy patients timed based on orthodontic intervention. Though orthognathic surgery is timed with orthodontic treatment, delaying orthognathic surgery will not interfere with the orthodontic treatment plan.

Mandibular distraction osteogenesis and tongue lip adhesion are typically performed for patients with airway obstruction due to retrognathia and glossophtosis seen in Pierre Robin sequence. When mandibular distraction osteogenesis or tongue lip adhesion is performed to avoid intubation or tracheostomy, the procedure is classified as Tier 3a and should not be postponed. When the procedure is performed in healthy patients in an outpatient setting, the procedure is classified as Tier 1a; even in such a circumstance, the age of the patient must be taken into account to determine the optimal timing of the procedure.

Craniosynostosis presents a unique challenge for craniofacial surgeons, as patient age and severity of symptoms play a key role in the timing of the procedure. For patients who present early, minimally invasive interventions may be preferred. Minimally invasive options are typically favored before the age of 4 months due to higher risk of complications after the age of 4 months. Patients who are not candidates for minimally invasive options, open cranial vault remodeling is favored before the age of 12 months as re-ossification potential decreases after the age of 1 year and complication rates increase. Patients presenting with symptoms of elevated intracranial pressure are classified as Tier 3a; intervention should not be postponed.

Recommendation for Cessation and Resumption

Craniofacial surgeons should assess the time-sensitive nature of the planned procedures to determine if a procedure can be postponed. As states begin to resume elective surgeries, craniofacial surgeons should prioritize ambulatory procedures. Those cases requiring inpatient hospitalization should prioritize time-sensitive procedures, with attention paid to inpatient capabilities and PPE supply (Table 2).
Hand Surgery

Hand surgery encompasses a wide range of procedures, ranging from trauma to infections to arthroplasty. CMS guidelines categorize carpal tunnel release and similar procedures as Tier 1a, recommending such interventions be postponed. They list nonurgent orthopedic cases as Tier 2a, recommending consideration of postponement. Any highly symptomatic patients or limb-threatening disease processes or injuries would be classified as Tiers 3a and 3b, respectively; such cases should not be postponed. No state recommendations specifically address hand surgery, though several, such as Ohio, consider interventions to prevent “permanent dysfunction of an extremity” non-elective. To date, no national society guidelines provide guidance on elective hand surgery.

Recommendation for Cessation and Resumption

Based on existing national and state guidelines, hand surgery interventions for traumatic injuries requiring operative fixation or repair, infections, and amputations amenable to replantation would be considered non-elective. As states allow elective surgeries to resume, hand surgeons should prioritize cases for symptomatic patients that are amenable to ambulatory intervention. Hand surgeons should assess inpatient capabilities and PPE supply before proceeding with complex interventions requiring inpatient stay (Table 2).

General Recommendations for the Safe Resumption of Elective Cases

Safe resumption of elective cases requires a thoughtful plan for a phased reopening. The Ohio Department of Public Health provides such an example with a 2-phased approach. Phase 1 allows for resumption of ambulatory, outpatient procedures, while phase 2 allows for all elective procedures to resume. Standards for progressing between the phases is based on a statewide assessment of testing availability, PPE inventory, equipment, and supplies, as well as monitoring for unexpected disease resurgence. Our institution’s guidelines provide additional guidance for COVID-19 testing—requiring all inpatients and outpatients scheduled for surgery to undergo COVID-19 polymerase chain reaction testing either at the time of admission or within 5 days of their surgery date, with self-quarantine in between to minimize interval exposure. In line with ASPS recommendations, our institution also requires a COVID-specific informed consent detailing the risks of contracting SARS-CoV-2 and the potential risks for postoperative recovery. Though the Centers for Disease Control and Prevention currently does not recommend testing of asymptomatic healthcare workers, the National Health Service and British Association of Plastic Reconstructive and Aesthetic Surgeons recommend routine testing of asymptomatic healthcare workers.

DISCUSSION

Plastic surgery represents a broad field of practice, encompassing a range of acuities and patient ages. As such, recommendations on elective plastic surgery must be nuanced to encompass the diverse nature of the specialty. National and state guidelines provide a framework for plastic surgeons to reorganize their practices based on exposure risk and resource limitations. The enforceability of current CMS and state-level guidelines remains unclear. Readers are directed to their respective state’s resources for further information.

National society guidelines, particularly ASPS, ACS, and Society of Surgical Oncology, provide more nuanced guidance for certain procedures. Plastic surgeons must critically examine their practices to determine the level of acuity of their patients and interventions. When questions arise regarding the appropriateness of a surgical intervention, surgeons may turn to institutional bioethicists for guidance or refer to published ethical considerations during the COVID-19 outbreak. Those procedures that qualify as elective should be postponed in an effort to minimize exposure risk and aid in the collective effort to preserve limited PPE supply (Fig 1).

As states begin to resume elective surgeries, plastic surgeons must remain apprised of guidelines issued by states and societies, as local COVID-19 outbreaks will impact transmission risk, hospital capacity, and PPE supply. Local surgeons also may reimpose restrictions on elective procedures. Of special note, ASPS recommends...
that members obtain additional informed consent due to risk of SARS-CoV-2 infection by proceeding with elective surgery (see Appendix, Supplemental Digital Content 2, which shows the statement of informed consent, http://links.lww.com/PRSGO/B456). Plastic surgeons must partner with local and state public health departments, hospital and clinic administrations, and patients to ensure a safe resumption of elective surgeries.

**SUMMARY**

Plastic surgeons must familiarize themselves with national, state, and societal guidelines pertaining to their field of practice to assess the elective nature of an intervention. Elective interventions must be postponed in an effort to preserve limited resources and minimize exposure risk until states allow the resumption of elective surgeries. The COVID-19 outbreak presents unique and novel challenges for our healthcare system—as plastic surgeons, we must weigh our individual responsibilities to our patients against our collective responsibility to preserve limited resources and increase healthcare capacity during the acute phase of the COVID-19 outbreak.

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