VASCULAR SOCIETY
The Vascular Society for Great Britain and Ireland

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Professionals

COVID-19 virus and vascular surgery

20 March 2020

Dear members

COVID-19 virus and vascular surgery

Background

The rapidly evolving situation regarding the COVID-19 (CV-19) virus is impacting on our patients and there are particular additional challenges for healthc workers. These guidelines take into account current recommendations, but the situation is highly likely to change.

The Vascular Society (along with GIRFT and the Specialist Commissioners) have contributed to NHS England to help give advice on the management of vascular patients in the current circumstances and these will be published shortly. The aims of this document are to give general principles rather than absolute advice, and local decision making is key.

Vascular patients and CV-19

The virus is a single-stranded RNA encapsulated corona virus which is highly contagious, and spread is predominantly by either droplets (larger particles) direct contact with patients (or fomites) rather than 'airborne spread' of smaller particles.

The elderly, the immunocompromised, those with IHD, men and smokers appear to be at greater risk of infection and these demographics are highly pertinent to our vascular patients.

We need to continue to focus on prioritisation according to patient's individual need, but also accept the hospital circumstances have changed and this r impact on clinical decision making. Principles include reducing unnecessary exposure to hospitals, deferring less urgent cases and reducing LOS or dependency on ITU.

If the spread of the virus follows that in other countries, some very difficult decisions will need to be made.

Vascular surgery: Elective surgery and outpatients

Most arterial surgery is either urgent or emergency in nature and should continue at present where possible.

Outpatients:

Where possible, only urgent outpatients should be seen, and virtual clinics should be considered.

On discharge, many vascular patients will either need no outpatient follow (but be given a telephone number to ring if in trouble) or can be reviewed in remote outpatient clinics.

Elective surgery:

Elective arterial surgery and venous surgery should be deferred. Asymptomatic carotid surgery and surgery for claudication should be deferred. The size threshold for AAA surgery needs to weigh up risk of rupture in the next few months with risk of intervention and resource limitation. >7cm or imminent rupture AAA currently is recommended.

Urgent/emergency vascular surgery

On call arrangements:

A second on-call consultant is advisable to help with both the emergency workload (and also if self-isolation becomes common). A vascular consultant surgeon should be on call and available to see all referrals. Trusts should consider having another vascular surgeon on call for delivering the surgery.

Investigations

Emergencies are likely to need a CT angiogram and proceed to surgery as appropriate.

AAA:

Ruptured aneurysms should ideally be treated by EVAR whenever possible to reduce dependence on the High Dependency Unit and reduce length of sta Open surgery should only be considered when EVAR is inappropriate or unavailable and in cases where there is a good chance of success. ITU capacity w need to be considered prior to intervention.

Critical leg ischemia / diabetic foot

Those legs immediately threatened require urgent intervention. Others may be diverted to a hot foot clinic for further assessment. Interventional radiolo approaches may allow more appropriate utilisation of scarce high dependency beds. There may be situations where primary amputation may be more appropriate than complex revascularisations, multiple debridements and potential prolonged hospital stay.

Carotids

Crescendo TIAs would normally need urgent surgery. If there are severe resource limitations, aggressive best medical therapy more appropriate for recen symptomatic carotids.

Spoke hospitals

Spoke hospitals allow patients to be cared for outside the hub. Currently, vascular surgical input is in the form of ward referrals, venous work, outpatient clinics, and angioplasties. These activities will need to be reviewed. There will need to be local flexibility, the but inpatient ward reviews, possibly in a virtua fashion may be appropriate.

Trainees

Surgeons in training will have keys roles to play in this crisis but the underlying principles of appropriate supervision, working practices, rest and pastoral remain.

Other specialities

Supporting other vascular staff, other specialities, colleagues and health professionals is crucial in these difficult times and VS members will have key role play. Emergency departments, ITU, anaesthetics, respiratory and general medicine will be under enormous stress and local discussions as to how our vascular teams are best deployed will need to be constructively discussed without jeopardizing our patients.

Appropriate use of scarce resources

In a worst-case scenario, resources may be severely limited and careful discussions and dialogue with other specialities may be required in order to appropriately prioritise care. Local solutions will need to found and all potential providers may be appropriate.

Decisions to intervene on patients who will require ICU input post-surgery will need to be in line any national ventilation guidelines.

Documentation

Brief documentation in the patient notes of the circumstances surrounding a perceived deviation from best therapy will help support these decisions at a later date.

Personal safety

Appropriate staff protection, planning and preparation for procedures, and team dynamics have been identified as being key to patient and staff safety a again local guidelines should be adhered to. Following local/national guidelines on self-isolation should also be followed.

Mental health well-being and burnout

This is likely to be the most challenging few months any of us have faced. Looking after colleagues, friends and co-workers over a sustained period of tim vital. Spending time with family and also talking, reflecting, eating, sleeping and exercising are key.

Research

NIHR is supporting COVID 19 research but all research is to be stopped unless patient safety is impacted.

Clinical training / education

This is likely to heavily impacted. Remote or virtual meetings will become important. The next sitting of the final Fellowship has been cancelled

Audit

Continued completion of the NVR remains critical.

Vascular Society and support

Local solutions are likely to most important, but the Vascular Society will try to offer support and can be contacted by email.

There is a helpful document from NHS England about supporting doctors in the event of a COVID19 epidemic
https://www.england.nhs.uk/coronavirus/wpcontent/uploads/sites/52/2020/03/supporting-doctors-covid-19-letter-11-march-2020.pdf
(https://www.england.nhs.uk/coronavirus/wpcontent/uploads/sites/52/2020/03/supporting-doctors-covid-19-letter-11-march-2020.pdf)

Colleagues at all levels will need to consider how they can contribute within their competencies and current GMC guidance
https://www.rcseng.ac.uk/standards-andresearch/gsp/duties-of-a-doctor-registered-with-the-general-medical-council/ (https://www.rcseng.ac.uk/standar
andresearch/gsp/duties-of-a-doctor-registered-with-the-general-medical-council/)

Yours sincerely

Professor Chris Imray

President of the Vascular Society of Great Britain and Ireland

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