Letter to the Editor

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As the COVID-19 outbreak spreads all over the world causing more than 1.6 M infections and the death toll arises, health workers continue to be at the front line and as such are exposed to hazards that put them at risk of infection. Precise and detailed guidelines for infection prevention and control during health care have been published by the WHO, but what about surgical procedures? Both elective and emergency surgical procedures can represent an important exposure for COVID-19 infection and given that, main surgical societies are publishing their recommendations. The entire surgical community agrees on the necessity of review all scheduled elective procedures giving priority to all patients with imminently life-threatening needs. Patients with malignancy that could easily progress or with active and urgent symptoms are included. This strict selection is done with the aim of minimize utilization of infrastructure and reduce risk for both patients and health care team [1].

Use of protection equipment is fundamental in the everyday practice, even because patients are usually not tested for COVID-19 especially when asymptomatic. It is well known that the aerosolization of blood-borne viruses for laparoscopy or smoke from electrosurgery can expose the surgical team to an increased risk of infection. Although it is not clear if the virus can be found in laparoscopy CO₂ or smoke [2, 3], it is safer to treat COVID-19 as a virus with possible aerosolization properties. N95 masks and face shields should be highly recommended and a device for smoke evacuation and cleansing should be used during surgery.

Considering the well-known benefits of mini-invasive surgery of reduced hospital stay and complications, laparoscopic surgery should be performed in both elective and

emergency patients even for the reduced exposure to smoke compared with open surgery.

Our surgical oncology team has a long experience in peritoneal malignancy treatment both with HIPEC and PIPAC. In a complete agreement with recent recommendations from WHO and main surgical societies, we reviewed all scheduled procedures and selected those which could not be postponed.

We usually perform laparoscopy using a single-port platform, and we adapted smoke evacuation as we do for PIPACs, smoke is exsufflated through two sequential micro-particle filters into the air-waste system of the hospital. The first filter is connected to a trocar: we use a “Lapview CO₂ smoke filter LESS7008” by Fairmont—Essex-UK. An extension line (PRAA609401 by Phoenix—Modena-Italy) is then used to connect the first filter to the second one which is an adult–pediatric electrostatic filter. (VT150 small ref 352S19024 by

filters, tubing and smoke evacuation system

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Fig. 1 Filters, tubing and smoke evacuation system

Covidien) The smoke is so exsufflated into the air-waste system (Fig. 1). This system is very cheap (not more than 20 Euros), very easy to find, completely desposable and very effective!

Moreover, we adapted open surgery. During open surgery, as we do, we use RapidVac smoke sponge Guard Tubing (2.2 cm × 3 mm) connected to Covidien smoke evacuator.

Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical approval This article does not contain any studies with human participants or animals performed by any of the authors.

Informed consent None.

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