MALAYSIAN SOCIETY OF ANAESTHESIOLOGISTS
AND
COLLEGE OF ANAESTHESIOLOGISTS, AMM

UPDATE on GUIDELINES ON ELECTIVE SURGERY AND ANAESTHESIA FOR PATIENTS AFTER COVID-19 INFECTION (19th September 2022)

The main objective of this update is to assess whether there is a necessity to revise the timing for elective surgery after Covid-19 infection.

Queries were raised by our members following the release of the guideline on surgical patient safety for SARS-CoV-2 infection and vaccination on 4th August 2022 by the Australian and New Zealand College of Anaesthetists.[1] The recent update recommended that non-urgent elective major surgery should be delayed for a minimum of 7 weeks and non-urgent elective minor surgery for at least 4 weeks provided the patient has returned to baseline function and is symptom free.[2,3]

On 19th March 2022, the Malaysian Society of Anaesthesiologists (MSA) and the College of Anaesthesiologists (COA), Academy of Medicine of Malaysia released the "UPDATE on GUIDELINES ON ELECTIVE SURGERY AND ANAESTHESIA FOR PATIENTS AFTER COVID-19 INFECTION". This document was in response to two updated guidelines that were released by the Association of Anaesthetists of Great Britain and Ireland and the Anesthesia Patient Safety Foundation.[4,5] This update was appropriate as our country had embarked on a nationwide vaccination programme where more than 90% of the adult population successfully completed two doses of the Covid-19 vaccination.

Currently, neither the Association of Anaesthetists of Great Britain and Ireland nor the Anesthesia Patient Safety Foundation has made any revisions to their latest guidelines, which is to delay all types of elective surgeries (minor or major) until after 7 weeks of Covid-19 infection, with emphasis that the optimal duration of delay is a clinical decision after considering the patients' clinical urgency.

For patients who had Covid-19 infections, the MSA and the COA reiterates for an individualised pragmatic approach for the timing of elective surgeries or procedures. Decisions should be based on the urgency of surgery and the patients' disease process and progress. Furthermore, patients' conditions following the infection, their infectious state and their vaccination status should be factored into the decision.

As part of the informed consent, the MSA and the COA encourage discussion with the patients and their carers to increase their awareness of the risks of anaesthesia/surgery after Covid-19 infection. They should take an active role in the decision-making process regarding proceeding with surgery that may affect their own health and well-being. These discussions can be in the form of verbal or/and written communication containing information to assist them in understanding the risks associated with performing surgeries after Covid-19 infection, for example, a 'Patient Information Sheet' or a 'Fact Sheet' that contains a general and specific information tailored to your institution

Regarding the type of preoperative testing for COVID-19, either rapid antigen or PCR tests are acceptable.[6,7,8,9] Reverse Transcription polymerase chain reaction (RT-PCR) is the gold standard test for detection of Covid-19 infection. However, the capacity for this test may be overwhelmed and the availability of the results may be delayed. The sensitivity of a Rapid

Test Kit (RTK) antigen improves when the test is performed in areas where Covid-19 is highly transmissible or when patients are symptomatic. However, it is less sensitive when performed among asymptomatic patients or in low transmissible areas. It is the prerogative of the physicians involved to choose tests that are most appropriate and applicable to their patients' conditions and situations, including the urgency of the surgery and sensitivity of the test performed. The MSA and the COA re-emphasise that routine testing using PCR within 90 days of a first positive test, when a patient with a Covid-19 infection presents for surgery, is not recommended.

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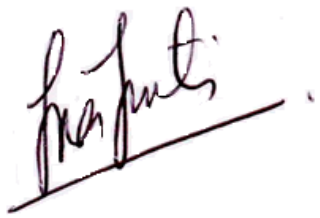

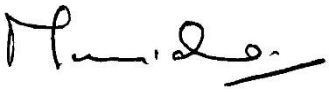

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