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EDITORIAL

The world has been in the pandemic mode for a year and a half. Coronavirus disease-2019 (COVID-19) continues to spread at a slow burn and intermittent lockdowns done in past are now near normal. Till now estimated 275 million people have been infected worldwide, and 2.25 million are dead. The pandemic's course in 2021 will depend greatly on the arrival of a vaccine, and on how long the immune system stays protective after vaccination or recovery from infection. There is so much we still do not know about this virus, but we may hope that after a world-sweeping outbreak, the virus could burn itself out and disappear by 2021.

This virus is going to stay with us for quite some time and we will have to learn to live in harmony with it. As a minimal access surgeon, we must continue our services to the needy in this pandemic. Anesthetists and laparoscopic surgeons are at risk in the operation theater. Although we did not find any scientific evidence to support it and we hope that more data come to light in near future. If clear data come, we can have streamlined decision-making to reduce the risk to the surgeon. Despite the reduction in the number of elective laparoscopic surgeries conducted, many emergency and semi-emergency laparoscopic surgeries will need to be done. Although still there is no documented evidence, laparoscopic procedures have a theoretical risk of generating aerosols during the creation of pneumoperitoneum, and while using energy devices due to the generation of fume.

In this challenging time, minimal access surgical societies felt the need to take immediate action to define ways to protect surgeons who are caring for suspected or confirmed COVID-19 patients. The World Association of Laparoscopic Surgeons (WALS), Society of American Gastrointestinal and Endoscopic Surgeons (SAGES), and The European Association for Endoscopic Surgeons (EAES), in their joint recommendations, have advised that RT-PCR test should be done in every patient before surgery. Most of the operation theaters have positive pressure ventilation which prevents nonsterile air to enter in OR but there is the risk of the spread of aerosols faster. Therefore, negative pressure ventilation is required to prevent this from happening.

Port incisions should be optimum to just allow the port to pass and there should not be any unnecessary gap for pneumoperitoneum leak. The pre-set pressure of the CO_2 insufflator should be kept at 12 mm Hg. We recommend that a smoke evacuation system should be used in laparoscopic surgery and we should be minimum use of energy devices and cold hemostasis should be used whenever possible. We should also use appropriate filters for suction devices as they can be a potential source of virus dissemination. These strategies increase the cost of the surgery but could improve safety. Between two cases, a minimum of 1 hour gap should be there to disinfect the OR, and 1% hypochlorite solution should be used for cleaning OT tables and anesthesia instruments.

We advise that all of you, after finishing surgery, should remove scrub clothes and consider having a shower before changing into home clothes to prevent infection to your loved one. We should wash hands frequently and maintain safe social distancing. This pandemic has given a major challenge to surgeons who practice minimally invasive surgery, but we hope that some solution will come soon, and we will operate normally in the coming year 2021.

At last, I wish all of you a happy, healthy, and prosperous new year 2021.

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