

# AOA and subspecialty COVID-19 position statements and advisory documents pack

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This document contains the range of position statements and advisory documents in relation to the COVID-19 pandemic issued by the Australian Orthopaedic Association (AOA) and orthopaedic subspecialty societies as at 28 April 2020.

The AOA website ([aoa.org.au](http://aoa.org.au)) should be consulted for up-to-date versions of these documents and additional updates and advice. Queries can be directed to [aoa@aoa.org.au](mailto:aoa@aoa.org.au)

It also contains a directive from the SA Government on management of emergency surgery as an example of a government position on the matter. The document is also [available online here](#).

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*2020*

# Position statement: Orthopaedic surgery during the COVID-19 pandemic

Australian Orthopaedic Association

March 2020

## Background

Orthopaedic surgery involves operating on bones, joints and the musculoskeletal system for the treatment of injuries, arthritis and other conditions.

These conditions range from acute emergencies and trauma needing rapid treatment to those requiring reconstructive procedures that may be performed in a less time-critical way in months to years after their onset.

## AOA's position

1. Care for the emergency (urgent and essential) orthopaedic surgery needs of Australians must be preserved at its present level during the period of the COVID-19 pandemic to prevent future physical disability in the population.
2. Non-urgent and lower-priority surgery must be suspended in all hospitals until such time as the effects of the COVID-19 pandemic on the Australian health system are fully known.
3. Arrangements in line with these recommendations should be put in place immediately.

The actions outlined above have regard for the health and wellbeing of staff and our patients. They will help to preserve the resources of the Australian health system and the orthopaedic, anaesthetic and nursing workforce to manage the urgent and emergency needs of the community.

Orthopaedic surgery frequently involves the use of drills and saws that can aerosolize tissue and present a risk to health workers in the current COVID-19 environment. Often orthopaedic patients are older Australians with cardiovascular and respiratory conditions; some are immune-compromised individuals. Orthopaedic procedures involve admission to hospitals and the consumption of health resources including personal protective equipment (PPE). Frequently they involve a form of rehabilitation that involves regular postoperative visits and in which "social isolation" as a preventative measure against COVID-19 transmission is challenged.

Urgent and essential surgery is time-critical surgery in which a known or expected significant deterioration in life or limb function will occur within hours, days or weeks. Examples of urgent and essential surgery include acute fracture and dislocation surgery, major trauma surgery, urgent spinal surgery and surgery required for intractable, severe pain. Reconstructive surgery and elective joint replacement surgery that may be performed at a later and safer time are not examples of urgent and essential surgery.

Orthopaedic surgeons are the key decision makers – in conjunction with their patients – in this process. A process should exist in every local area and hospital, by which senior peers or heads of orthopaedic departments provide expert guidance in decision-making. This is particularly the case where ambiguity exists in non-emergency cases. It is recognised at this time that there is some regional variation, and in rare circumstances capacity exists for minor modification of this recommendation – in the very short term.

Andrew M Ellis OAM

President

The Australian Orthopaedic Association

# Position statement on the staged and safe approach to the return of orthopaedic surgery during COVID-19

Australian Orthopaedic Association

24 April 2020

## **The Commonwealth announces a staged return to some elective surgery from 27<sup>th</sup> April 2020.**

The Australian Orthopaedic Association (AOA) welcomes a staged and safe approach to the return of orthopaedic surgery. This would apply to treatment of conditions of bones and joints across the spectrum of orthopaedic surgical management, recognising that safety of patients and the health workforce is paramount. It is further recognised that this will occur in a system that is resource-constrained and surgeons and hospitals will need to “choose wisely”, until such time a “business as usual” is reinstated.

The surgical management of patients is not an isolated activity but must be viewed in the context of overall health effect on the nation, the use and supply of PPE, the resources likely to be consumed and the stability and security of the logistic supply chain (which often has an off-shore basis).

Therefore, AOA supports the restriction of service at this time to be made on a fractionated or rationed system (“the allocation”), based on a percentage by time of previous operating time sessional use. This is best used as a moderator because it is equitable and even in its effect and can be based on readily available data. It is probably best applied at a hospital level, as some surgeries can be safely left for restoration of normal activity. An example of this is surgery carried out for cosmetic reasons or where a superior clinical benefit has not been demonstrated through surgical intervention.

It is expected that surgeons will work with hospitals to prioritise their patients’ needs for surgery, accounting for risk factors and co-morbidities, while having regard also for the safety and availability of health care workers and hospital facilities.

Double theatres should be avoided, surgery should be consultant-performed as much as practicable and all efforts should be made to use the theatre resource wisely and in a time-efficient manner.

AOA has advocated that the category system for elective (planned) surgery has not been ideal for orthopaedic surgery but accepts that Category 1 and 2 surgeries will continue, within surgical time-based restrictions, at this time. This should include most types of time critical orthopaedic surgery in most parts of the body. These are time-dependent operations that would include many reconstructions and joint stabilisation procedures, and not just arthroplasty surgery.

**“Category 3 – Needing treatment at some point in the next year. Their condition causes pain, dysfunction or disability. Unlikely to deteriorate quickly.”**

Category 3 encompasses many conditions of the musculoskeletal system, which can cause significant pain and disability and reduce quality of life. Further, they can restrict function, impose significantly on activities of daily living, and reduce participation in the workforce and social functioning.



Orthopaedic surgeons of all disciplines are used to assessing, prioritising and planning surgical treatment for these patients. Their professional judgement can be relied upon to balance risk and to prioritise these patients within an 'allocation' towards high-value and low-risk procedures.

The production of long lists of what could or should be performed at this time of limited resources is thought to be unhelpful. Many decisions are also contributed to by individual patient circumstances and functional loss, within the broader category of a particular operative treatment. Various scoring systems, adequacy of non-operative treatments, individual circumstance and pain reports all underpin the expert judgement of the surgeon in decision making at this time. Other factors assessed include the relative risk of surgery, guided by the ASA, the requirements of an ICU bed and individual risks of operative surgery (such as obesity). The treating orthopaedic surgeon should consider all these factors, as low risk and high value procedures should be the only ones booked at this time.

Therefore, AOA supports the judgement of orthopaedic surgeons to prioritise their patients within "the allocation" of operative surgery, which each surgeon will receive.

Certain procedures that are of lower value to the wider health system or equivocal benefit to patients should be avoided at this time. These include those that could be safely and reasonably deferred, or those likely to require longer periods of recovery or greater risk, such as operations in patients with high co-morbidities (ASA 3 or above). Surgery for cosmetic conditions or deformity correction and conditions that remain well controlled with non-operative treatment should not be performed until "business as usual" is reinstated with respect to operating room resources.

# SESA position statement on surgery during the COVID-19 pandemic

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Shoulder and Elbow Society of Australia



26 March 2020

We support the Australian Government and the Australian Orthopaedic Association positions of limiting elective surgery to reduce the burden on the national health system so as to prevent harm to patients, health care workers and ancillary staff during a pandemic. This will help preserve limited resources and free up drugs, equipment and staff that will be needed for patient treatment in the upcoming weeks and months, and enable time to prepare for capacity stress on the health system.

The principles of this position are to massively reduce the number of cases performed as well as to avoid long-term harm for the small number of patients who would suffer a significant adverse outcome by a delay in their surgery of weeks to months.

**While the definition of a Category 2 case is broad, we support the spirit of the category which is to limit surgery to truly urgent cases only.**

The impact of a potential COVID-19 infection in those patients undergoing surgery needs to take into account the co-morbidities of the patient. If we operate on patients during this pandemic, we are imposing greater than normal potentially harmful interactions with our stressed health system.

Clearly Category 1 cases and expedient management of trauma should continue, but even in this setting consideration for non-operative treatment should take place for those patients with significant co-morbidities and where there is no clear superiority of surgery over non-operative treatment.

Before any surgery does take place, surgeons should have a plan in place as to how to deal with a complication if it arises, given the limited resources which are likely to be available in the very near future. Avoid surgery in older or more compromised patients where possible.

Acceptable truly urgent Category 2 cases would include:

- Fractures
- Infections including Arthroplasty Sepsis
- Unreduced acute dislocations
- Acute major tendon disruptions / tears / avulsions such as Triceps, Distal Biceps, Pectoralis Major.

The following cases will almost never reach a Category 2 classification:

- Elective arthroplasty
- Revision arthroplasty (except for periprosthetic fracture).
- Instability surgery
- Capsular release surgery
- Rotator Cuff Repair
  - (An example of a possible exception to this may be a young patient with an acute traumatic injury and a pseudoparalytic shoulder with large multi-tendon tear).

This position statement will be reviewed on a daily basis and further updates will be provided as more information becomes available.

**Jeff Hughes**  
SESA President

# ASA position statement on surgery during the COVID-19 pandemic

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Arthroplasty Society of Australia

27 March 2020



The Arthroplasty Society of Australia strongly supports the position taken by the Australian Orthopaedic Association and the Royal Australasian College of Surgeons with regard to the performance of all non-essential surgery.

Delaying lower-limb arthroplasty surgery will result in a prolongation of disability; however, this must be balanced against the risk of surgery at this particular time. Exposing patients, medical staff, and other ancillary hospital staff to the risk of serious illness and the possibility of quarantine at a crucial time is a real concern. Medical manpower must be preserved to prepare for the increasing workload of the pandemic. PPE, drugs and devices used to manage COVID-19 must be preserved.

Non-operative treatment should be considered where possible and wherever possible managed in the ambulatory setting or the emergency department, without admission to hospital.

Arthroplasty surgery should only be considered after appropriate peer review for these urgent conditions:

1. Acute deep infections
2. Periprosthetic fracture requiring surgery
3. Acute prosthetic dislocation, which should be managed in a closed fashion wherever possible
4. Fractured neck of femur
5. Chronic periprosthetic infection creating a threat to life or limb
6. Implant failure by breakage
7. Collapsed femoral head (AVN) resulting in severe intractable pain

Elective primary and revision hip and knee arthroplasty surgery should otherwise be cancelled or delayed during the COVID-19 crisis.

In all cases where surgery is to be performed according to the above guidelines, the specific risks of the case to staff and patients as well as the post-operative care in the specific hospital environment must be considered. Documented peer review of each proposed case is to be performed prior to surgery.

As this is an evolving situation this position statement will be reviewed and updated as required.

ASA Executive Committee

**Bill Donnelly**, President

**Michael Solomon**

**Neil Bergman**

**Jonathan Mulford**

**Stephen McMahon**



28<sup>th</sup> March, 2020

The Spine Society of Australia supports the Australian Government's decision to temporarily suspend elective surgery, except for urgent Category 2 procedures. Category 1 surgery will continue.

Appropriately, the Prime Minister has left the categorisation of the proposed surgery (Category 1 or urgent Category 2) to the treating surgeon. We cannot stress too greatly the weight of this discretion on our craft group in the current health and economic crisis that Australians are experiencing.

While we exercise restraint, we need to communicate our decisions to our patients with empathy and understanding, combined with a steadfast collective adherence to what our CMO and PM are asking of us. What we do now matters.

***Category 1 – Needing treatment within 30 days. Has the potential to deteriorate quickly to the point where the patient's situation may become an emergency:***

- Unstable cervical, thoracic, lumbar fractures.
- Tumors involving neurological impairment or instability.
- Infections, unresolved by medical means with neurological or potential instability.
- Acute neurological deficit eg cauda equina syndrome.

***Urgent Category 2 – Needing treatment within 90 days. Their condition causes pain, dysfunction or disability. Unlikely to deteriorate quickly and unlikely to become an emergency:***

- Surgical treatment of postoperative complications, other than planned revision surgeries.
- Chronic and severe incapacitating pain:
  1. Must include neurological deficiency with unambiguous findings on clinical examination; AND
  2. Patient ability to function severely impacts ADLs to the extent that the patient could not manage their symptoms for a further 3-6 months.

**The above criteria are to be read in conjunction with the 2020 SSA Category 1 & 2 Table that follows.**

**The distinction between Urgent and non-urgent Category 2 will not always be straightforward. In situations of uncertainty surgeons must review the patient details with a colleague or the hospital**

**administration. If there continues to be uncertainty after discussion, the surgery should not proceed.**

**At risk patients, in all but the most urgent cases, are to be deferred (including but not limited to - age, complexity of surgery, need for an ICU bed, obesity, diabetes, cardiovascular disease, immunocompromised, respiratory illnesses, smokers, addiction).**

**Any patient who is otherwise unwell must be postponed.**

The risk of proceeding in both categories in relation to the patient contracting COVID-19 during the admission must be discussed and documented as part of the risk benefit analysis in the consent process.

The formation of **temporary hospital based surgical determination committees** is anticipated to ensure transparency and to manage local resources. Surgeons need to work with their hospitals to ensure Category 1 cases are not delayed and only Urgent Category 2 cases, capable of withstanding peer scrutiny, are presented for approval. In areas where no committee has been established, consultation with a colleague and the anesthetist should be routine and documented.

Working in close consultation with your hospital, anesthetist, and operating staff is also essential to ensure safety of the medical team and the efficient use of resources, especially stocks of PPE.

**The restrictions to elective surgery are to take effect as from midnight, Wednesday, 1 April 2020.**

Spine Society of Australia Executive Committee

Michael Johnson, President

Matthew Scott-Young, Vice President

Bill Sears, Past President

Brian Freeman, Editorial Secretary

Kevin Seex, Treasurer

John Costi

Rob Kuru

Ralph Stanford, Educational Secretary



**2020 SSA Category 1 & 2 Table**

| Pathology    | Presentation                    | Qualifier   | Category |
|--------------|---------------------------------|---|----------|
| Degenerative | Radiculopathy                   | <ol style="list-style-type: none"> <li>1. &gt;8 weeks duration; AND</li> <li>2. failed epidural steroid injection; AND</li> <li>3. severe unremitting leg or arm pain resistant to medical management.</li> </ol> | 2        |
|              | Radiculopathy                   | Functionally relevant weakness  | 1        |
|              | Radiculopathy                   | Necessitating admission to hospital, unlikely prospect for discharge due to pain  | 1        |
|              | Cauda equina syndrome           |   | 1        |
|              | Myelopathy                      |   | 1        |
|              | Spinal stenosis                 | Functionally relevant neurological deficit  | 1        |
|              | Spinal stenosis                 | Severe unremitting symptoms resistant to medical management and significantly interfering significantly with activities of daily living (ADLs) and self care  | 2        |
|              | Spinal stenosis                 | Claudicant leg pain , but able to continue with ADLs and self care  | 3        |
| Deformity    | Paediatric/adolescent scoliosis | Skeletally immature, Curve $\geq 90^\circ$  | 2        |
|              | Paediatric/adolescent scoliosis | Skeletally immature, Curve $< 90^\circ$   | 3        |
|              | Adolescent                      | Skeletally mature   | 3        |
|              | Adult spinal deformity          |   | 3        |
| Infection    | Spinal epidural abscess         | Failed medical management, systemic sepsis, progressive neurological deficit  | 1        |
|              | Vertebral osteomyelitis         | Without pathological fracture   | 3        |
|              | Vertebral osteomyelitis         | With pathological fracture and instability or systemic sepsis   | 1        |

|                             |   |   |   |
|-----------------------------|---|---|---|
| Trauma                      | Unstable cervical, thoracic, lumbar spine | SLIC/TLICS $\geq 5$   | 1 |
|                             | Other spinal fracture                     | Assessed under normal criteria, following discussion with colleague |   |
|                             | Spinal cord injury                        |   | 1 |
| Tumour                      | Metastatic cord compression               |   | 1 |
|                             | Pathological fracture                     | With instability  | 1 |
|                             | Contained vertebral body metastasis       | Single metastasis   | 1 |
|                             | Contained vertebral body metastasis       | Multiple metastases   | 3 |
| Postoperative complications | Wound infection                           |   | 1 |
|                             | CSF leak                                  |   | 1 |
|                             | Instrumentation failure                   |   | 2 |
|                             | Adjacent segment degeneration             |   | 3 |



27<sup>th</sup> March 2020

In light of the Covid-19 pandemic and the unprecedented forthcoming strain on health resources the Australian Knee Society has listed knee surgical procedures below to assist with decision making. The society encourages surgeons to obtain a documented independent peer opinion before scheduling surgery for Urgent Category 2 and should not perform surgery on non-urgent category 2 or category 3 patients.

#### Category One

- Acutely infected Total Knee Replacement
- Acute septic arthritis or other knee or bony sepsis requiring surgical drainage or debridement
- Open fractures of femur, patella or tibia
- Significantly displaced fractures with likely a clearly suboptimal outcome with non-surgical management
- Knee dislocations that are irreducible, unable to be stabilized in a splint or associated with vascular injury
- Infected pre-patella bursa not resolving with non-operative management
- Malignant tumours around the knee
- Quadriceps or patellar tendon rupture
- Peri prosthetic fracture and/or broken implants

#### Urgent Category Two

- Painful acutely locked knee due to loose body, detached OCD or obstructive meniscal tear
- ACL Reconstruction with locked knee secondary to obstructive repairable meniscal tear
- Chronically infected painful Total Knee Replacement threatening to progress to systemic sepsis

#### Non-Urgent Category Two and Category Three

- Primary Knee arthroplasty
- Revision Knee arthroplasty, except as above
- ACL Reconstruction with intact meniscus or undisplaced meniscus tears
- Arthroscopy, except as above
- Proximal Tibial or Distal Femoral Osteotomy
- Patellofemoral stabilization

This list is not exhaustive and in the situation where there is doubt, the AKS executive advises surgeons to obtain the opinion of a peer before scheduling surgery.

The situation is changing rapidly and these recommendations will be updated as required.

**President**

Christopher Vertullo

**Secretary**

Myles Coolican

## **Position statement from the AOFAS about Elective Surgery and Covid-19**

We support the Australian Government and the Australian Orthopaedic Association positions of limiting elective surgery to reduce the burden on the national health system so as to prevent harm to patients, health care workers and ancillary staff during a pandemic. This will help preserve limited resources and free up drugs, equipment and staff that will be needed for patient treatment in the upcoming weeks and months, and enable time to prepare for capacity stress on the health system.

The principles of this position are to massively reduce the number of cases performed as well as to avoid long-term harm for the small number of patients who would suffer a significant adverse outcome by a delay in their surgery of weeks to months.

While the definition of a Category 2 case is broad, we support the spirit of the category, which is to limit surgery to truly urgent cases only.

The impact of a potential COVID-19 infection in those patients undergoing surgery needs to take into account the co-morbidities of the patient. If we operate on patients during this pandemic, we are imposing greater than normal potentially harmful interactions with our stressed health system.

Clearly Category 1 cases and expedient management of trauma should continue, but even in this setting consideration for non-operative treatment should take place for those patients with significant co-morbidities and where there is no clear superiority of surgery over non-operative treatment.

Before any surgery does take place, surgeons should have a plan in place as to how to deal with a complication if it arises, given the limited resources, which are likely to be available in the very near future. Avoid surgery in older or more compromised patients where possible. Consider a hospital-based committee to review cases deemed necessary to be managed operatively.

Acceptable truly urgent Category 2 cases would include:

- Fractures that cannot be managed non-operatively
- Open injuries of bone and soft tissues
- Infections including diabetic foot sepsis
- Tumours (there won't be many.)
- Tendon ruptures eg. Tibialis Anterior (Only those Achilles ruptures not suitable for non-operative management )
- Achilles avulsions off bone

The following cases will almost never reach a Category 2 classification:

- Ankle arthroscopy (except when used as part of fracture management)
- Ankle instability surgery
- Elective arthroplasty
- Revision arthroplasty (except for periprosthetic fracture).
- Fusions
- Flat foot and Cavus foot surgery
- Bunions
- Claw toes/hammer toes
- Neuromas
- Ganglions

This position statement will be reviewed regularly and further updates will be provided as more information becomes available.

David Lunz  
AOFAS President

## AOTS Guidelines for Emergency Orthopaedic Surgery during the COVID-19 pandemic

A sound, ethical and principle-based approach will be required during the COVID-19 pandemic. During the time of COVID-19 surgical care will be challenged. There will be a risk for healthcare workers acquiring COVID-19 from infected patients by aerosolization, which will mean strict attention to the use of PPE and appropriate anaesthetic measures. Timely treatment and discharge will also be a priority in order to ensure the resources are used in the most efficient means possible. Timely treatment and appropriate decision making may mean orthopaedic surgeon utilise abbreviated treatment protocols will be preferred, in order to ensure a maintenance of access to hospital inpatient resources and beds. Non operative treatment treatments will confer advantage over operative treatments if similar outcomes, or even slightly downgraded outcomes are expected. These are the principles of operating in the austere environment, and of husbanding resources. As surgery may take twice as long in full PPE, hospital resources may, and will, be deployed elsewhere and health care workers infections there will be a reduced capability and operating room resources will be rationed. Choose operation wisely. Consider alternative treatments. Consider whether reconstructive work should be delayed until after the effect of the COVID-19 pandemic peaks and/or resolves. Protect the patients, your staff and yourself.

### Emergency

Requires immediate action; life threatening or permanent limb injury.

#### Priority 1 – requires care in 1-4 hours

- Patients in haemorrhagic shock
- Patients septic shock
- Joint Dislocations
- Open or Closed Fractures with neurovascular compromise
- Open Joint fractures
- Cauda Equina Syndrome

**Life and Limb Threatening Injuries:** patients with multi-trauma and pelvic and acetabular fractures, with major haemorrhage, open fractures, compartment syndrome and the threat of exsanguination require emergency resuscitation and management.

**Amputations:** Early amputation in patients where limb salvage has an uncertain outcome may be more appropriately treated with early amputation

**Debridements:** Consider early local flaps and accepting deformity in order to minimise the number of returns to theatre.

**State Trauma Guidelines:** Adherence to trauma guidelines will continue to ensure patients with multi-trauma are managed in the most efficient and effective facilities.

**Priority 2 – requires care 4-12 hours (all can be Priority 1 if patient septic or in shock)**

- Open Fractures with no neurovascular compromise
- Deep and extensively contaminated lacerations
- Patients with septic native or prosthetic joints
- Paediatric and Adult displaced articular Fractures including supracondylar fractures.
- Infected Fractures
- Paediatric septic arthritis and osteomyelitis with subperiosteal collection.

**Priority 3(a) – requires care 12-24 hours**

- Open fractures with no neurovascular compromise
- Ongoing post-operative wound haemorrhage
- Significant soft tissue deficit
- Unstable Spinal Fractures
- Paediatric Joint Dislocations
- Paediatric Fractures with neurological compromise
- Paediatric Spica for Extra articular Femoral Fractures
- Paediatric and Adult Femoral and Tibial Fractures

**Fragility Fractures:** Fragility fractures of the hip, femur and tibia remains a surgical priority over the first 48 hours. Ensure patients may be able to fully weightbear at the end of surgery to facilitate early discharge.

**Priority 3(b) – requires care 24 hours-1 week**

- **Complex Fractures:** Early Planning and surgical treatment to facilitate early discharge
- **Simple Periarticular Fractures:** Consider day-case treatment for simple fractures
- **Upper Limb Fractures:** Consider day-case treatment

### **Trauma Management Principles**

- Dislocations of native and replaced joints should be reduced in the Emergency Department whenever possible. Should the reductions be stable, then patients should be discharged with follow-up.
- Upper Limb Injuries may be managed non-operatively, with the recognition that delayed reconstructions may be required.
- Acute Ligamentous injuries of the knee may be managed in a brace non-operatively rather than early reconstruction.
- Non contaminated penetrating injuries of the limbs with no underlying neurological or vascular injury may be debrided and sutured in the Emergency Department with appropriate follow-up.
- Abscesses in patients without systemic sepsis may be incised and drained in the Emergency Department with appropriate follow-up

### **Trauma Volume**

- Low energy/fragility fractures will continue to occur at a similar incidence. There may be an increase depending on the effect of COVID-19 on the level of supervision.

- Higher energy trauma is likely to decrease in incidence however will continue to occur as bottle shops will remain open, random breath tests had ceased and people having more recreational time.
- Cases related to interpersonal/domestic violence is also likely to remain at a similar incidence, or even increase during social isolation
- Major trauma in-hospital mortality and elderly hip fracture 30-day mortality are both higher than COVID-19 in even worst-case scenario countries. Not securing these essential services will result serious adverse outcomes during the pandemic due to otherwise preventable mortalities.

## **Emergent (Semi-elective)**

Requires care over the next three months

### **Category 1**

- Fracture non-union treatment
- Nerve Decompression for entrapment neuropathy

### **Category 2**

- Avascular Necrosis

### **Category 3 Elective Surgery (delayed until the end of the Pandemic)**

- Total Joint Replacement Surgery for reasons other than trauma
- Revision Arthroplasty except for Periprosthetic Fractures
- Anterior or Posterior Cruciate Ligament Reconstructions
- Osteotomies
- Arthroscopic or open surgery to joints for reasons other than infection or locked joint
- Bunions
- Hammer/Claw/Mallet Toes
- Joint Stabilisation surgery for recurrent instability
- Dupuytren's Contracture Release

The list of Category 3 is not exhaustive. It provides an indication of the types of procedures which should be delayed. Please choose wisely

The guidelines may be updated as more information become available.

## **References**

Australia Health Ministers; Advisory Council: National Elective Surgery Urgency Categorisation Guideline April 2015.

British Orthopaedic Association. Management of patients with urgent orthopaedic conditions and trauma during coronavirus pandemic

Australian Commission on Safety and Quality in Health Care. Clinical Care Standards. Hip Fracture Care Clinical Care Standard September 2016 Joint Stabilisation surgery for recurrent instability

Potential Impact of COVID-19 in Injury Patterns Presenting to Health Services in Australia.

**Marinis Pirpiris**

**AOTS President**



# APOS statement on paediatric orthopaedics during the COVID-19 pandemic

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Australian Paediatric Orthopaedic Society

30 March 2020



COVID-19 is a target that is moving too fast and every patient, surgeon and hospital will soon find themselves in an individual situation that won't allow generalisations. We trust our paediatric orthopaedic colleagues to make sound decisions and to ask for help when required.

Given the rapidly developing nature of this situation, APOS will not at this point be releasing an advisory list regarding elective surgery categorisation. We trust that each surgeon will continue to be guided by the best interests of patients, team members and the public.

At the moment, every patient and family member that comes to hospital is potentially at risk and places hospital staff at risk. The degree of risk is constantly changing as the pandemic evolves. The risk is different for every individual patient and for different orthopaedic units. Every hospital encounter uses resources, whether staff, beds or equipment. The available resources will differ between orthopaedic units. The paediatric orthopaedic specialty and patient population involves hospitals with adults and children, surgeons in higher risk age groups, and patients in higher risk groups and from higher risk regions.

We trust each surgeon to consider whether the benefits of any pre-COVID-19 standard of care outweigh the current risks with every patient that you treat in your current situation and that you will constantly re-evaluate. We trust that if a surgeon decides to bring a patient to hospital or operate on a patient and there is an exposure, infection or subsequent resource shortage, they will be satisfied with their decision making and satisfied that the risk was justified.

APOS members are encouraged to contact the APOS executive for guidance and support if needed while we all try to do our best at a very challenging time.

## APOS Executive Committee

**Nicole Williams**, President

**Samya Lakis**, Treasurer

**Lynette Reece**, Treasurer

# ANZSA position statement on orthopaedic oncology surgery during the COVID-19 pandemic

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**March 31 2020**

The Australia and New Zealand Sarcoma Association strongly supports the position taken by the Australian Orthopaedic Association and the Royal Australasian College of Surgeons with regard to the performance of all nonessential surgery.

Delaying oncology surgery may result in significant mortality risks; however, this must be balanced against the risk of surgery and mortality in COVID-19-positive patients or those with malignancy or on immunosuppressive care and with less aggressive lesions.

Exposing patients, medical staff, and other ancillary hospital staff to the risk of serious illness and the possibility of quarantine at a crucial time is a real concern. Medical manpower must be preserved to prepare for the increasing workload of the pandemic. PPE, drugs and devices used to manage COVID-19 must be preserved.

Non-operative treatment of bone and soft tissue tumours should wherever possible be managed in the ambulatory setting or the emergency department, without admission to hospital. This should be in consultation with an orthopaedic oncologist initially to determine urgency of care, imaging and biopsy technique and ambulatory needs to maximize opportunity to avoid an adverse oncological outcome. The orthopaedic oncologist will work with the multidisciplinary team to determine the safest way forward.

Consultation regarding oncological conditions prior to definitive histological diagnosis will require consultation with a network of local or national orthopaedic oncology experts.

**Orthopaedic oncology surgery should only be considered for these urgent conditions:**

1. Primary bone or soft tissue malignancy of any sort – diagnosis by biopsy preferably; preferably closed biopsy, but open as required to determine treatment requirements.
2. Staged bone or soft tissue resection surgery part way through treatment or commencing care during the COVID-19 period may require surgery as decided by the MDT group e.g. Osteosarcoma Ewing's, soft tissue sarcoma.
3. Secondary bone malignancy diagnosed or undiagnosed with impending risk of fracture or acute limb complications
4. Acute orthopaedic oncology prosthetic complications including infection or breakage or dislocation requiring acute operative care.
5. Benign aggressive lesions with impending fracture or risk of acute neurovascular complications or at risk of significant functional compromise.
6. Complex Multiteam orthopaedic oncology surgery to be reviewed on a "case by case" basis to determine whether it can safely be delayed and the timeframe (e.g. pelvic and complex spine resections with complex surgical teams)

As this is an evolving situation this position statement will be reviewed and updated as this COVID-19 crisis progresses.

**Peter Steadman**

**Chair of Orthopaedic Committee**

**Australian and New Zealand Sarcoma Association**



# The Australian Hand Surgery Society

ABN: 64 388 980 516

7 April 2020

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## Updated Guidelines for Emergency and Elective Surgery Covid-19

There continues to be concern about what surgery can and cannot be done in the face of the Covid-19 pandemic.

The categories and timelines are difficult to interpret and apply. If the patient is going to be adversely impacted if treatment is not performed in a timely manner and they will have a permanent disability at 12 months which could have been avoided surgery should be considered.

If an adverse outcome can be easily corrected as a secondary procedure with a reasonable probability of success this may be the best option.

Currently the public and private sectors are under-utilised in readiness for the impact of Covid-19. Hand surgery is nearly always done as a day case. If patients are prepared to accept the risk of contracting the infection if they have treatment and they are not at risk of requiring an intensive care unit bed it makes sense to perform surgery if it will prevent a permanent disability and impairment.

Our focus should be on reducing the footprint in the hospital to preserve resources and maximise the flexibility of the hospital to deal with the impact of the Covid-19 epidemic.

If you are uncertain about whether or not it is reasonable to operate on a patient please ask the medical advisory committee in your hospital for approval. Each hospital will have its own requirements and will be under the direction of individual state health authorities.

Sincerely

Jeff Ecker  
President of the Australian Hand Surgery Society

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## COVID-19 PANDEMIC and the MEDICO-LEGAL CONSULTANT

By Drew Dixon

President – AOA Medico-Legal Society

COVID-19 has direct implications to those specialists doing musculo-skeletal assessments of claimants after workers compensation injuries, motor vehicle accidents, occupational liability claims as well as Comcare and Military Compensation.

The “at risk” demographic is:

1. Persons over 70 years of age;
2. Co-morbidities such as diabetes, cardio-pulmonary disease or;
3. Immunosuppressed individuals eg on chemotherapy.

Most musculo-skeletal Assessors are Senior Consultants and face-to-face interviews and examinations put them and the claimants, themselves, at risk.

### What is the Corona Virus?

Corona Virus is common in animals such as bats, camels and civets and it is rare for Corona virus to infect humans. Corona virus has also caused MERS (Middle East Respiratory Syndrome). Under the microscope, the viruses look like they are covered with pointed structures that surround them like a Corona or crown.

The source of COVID-19 is likely to have been linked to a wet market in Wuhan, China with symptoms usually seen within 14 days such as a cough, fever, shortness of breath and ultimately respiratory failure, kidney failure or death.

### Why is COVID-19 so contagious?

This virus is more readily transferrable than the SARS epidemic of 2003. A carrier may be asymptomatic but pass it onto close contacts, therefore the need for social distancing eg. domestic isolation is mandatory after overseas travel for 14 days. Severe cases show increased levels of plasma cytokine levels eg, interleukin (IL 1 & 10), TNF-alpha: tumour necrosis factor alpha, compared with carriers or less symptomatic patients. It was noted that the virus is highly contagious and spreads quickly in aged care facilities and low level care facilities like rehab centres and centres for children with multiple disabilities.

All patients and claimants should thus be screened before assessment:

1. Certificate from GP showing no current URTI;

2. At risk to be tested:
  - a. if they have been overseas in the last 14 days prior to symptoms; or
  - b. if they've had close contact with a confirmed case; or
  - c. if they have a fever more than 38 degrees or a history of acute respiratory infection (cough, sore throat, short of breath); or
  - d. In NSW if they live in a community with a local transmission or live in remote Aboriginal communities; or
  - e. If referred by GP or PHU.
3. Temperature screening at the rooms;
4. Masks, gloves and hand sanitisers for both claimants and Assessors;
5. Wiping surfaces such as desk tops, counters, chairs, arm rests and pens before and after each patient;
6. Antiseptic wiping of repetitively used instruments such as goniometers, tape measures, dynamometers and tendon hammers between all patients.

#### In patient assessment

Occasionally, WPI assessments have to be done in nursing homes and retirement villages. Such settings require extra PPE (personal protection equipment) such as gloves, goggles, surgical gowns as well as N95/P2 masks.

Droplet precautions include standard mask, gloves, goggles and gown for suspected low risk contact (short time).

Airborne precautions include N95 mask, gloves, goggles and gown, if there is productive cough or confirmed case.

#### Assessments

While some can be done "on the papers" based on a consensus of clinical notes and relevant investigations, most require one on one interaction, for example, psychological assessments, ENT, most GIT (that have had gastroscopy, endoscopic biopsy and colonoscopy) can be achieved by teleconference. Others, such as scarring, could be assessed by Skype.

#### Skype/ZOOM

While asymmetry, eg, spinal motion, shoulder elevation, wasting and active range of motion of joints can be assessed visually on Skype, both parties (Insurer and Plaintiff's solicitors) would have to be in agreement where there are claims that require expedition and avoidance of undue prolongation of the medicolegal process, for example, claimants that need their claim resolved due to increased post-traumatic stress disorder and advancing co-morbidities, pleomorphic dyscrasias or malignancy.

Unduly prolonged older assessments since the date of injury produce very anxious claimants and deteriorating depressive disorders, particularly with the probability of loss of wages and unemployment, difficulty with sleeping associated with fatigue the following day and with interpersonal relationships and prolonged impact of the injuries on their ADLs, for example, household chores, home maintenance and recreations is distressing to claimants and may require expeditious review.

Current SIRA Guidelines (23 March 2020) notes that Skype/ZOOM assessments can proceed if all the parties are informed of the option and both parties consent as well as the claimant.

Medical Assessors cannot proceed to Skype or video conferencing without contacting the Case Manager or DRO and without consent of the parties.

Preliminary assessment by Statutory Bodies such as SIRA can be facilitated by doing preliminary screening and the Assessor can obtain relevant history before the date of consultation.

For paper assessments to proceed, the parties must be informed of the option and must consent. This option cannot proceed without these options without consulting the Case Manager or DRO nor without the consent of the parties.

Telephone assessments are not acceptable as it is not possible to confirm the identity, privacy and confidentiality of the claimant over the phone.

Review Panel Assessments by teleconference for WCC or SIRA (MAA) are still currently proceeding. If further assessment is required, it can proceed if both Medical Assessors are available and elect to proceed. If both Medical Assessors are not available, the appointment will be deferred for later Panel Review.

The AOA (Australian Orthopaedic Association), in their document regarding non-urgent elective surgeries, published on [AOA COVID-19 Information Hub](#), advised all non-urgent elective surgery in public and private hospitals has been ceased and that only Level 1 surgery, for example, emergency trauma or life threatening conditions such as a malignant condition, are permissible.

It noted that 10% of deaths in Italy are health workers and that four health workers in a Melbourne Private Hospital tested positive overnight (25 March 2020) , forcing co-workers into isolation.

In summary, critical surgery, which is essentially life and limb saving surgery, can proceed.

#### Nosocomial Spread

For those musculo-skeletal specialists still in hospital practice, who also do WPI assessments, care has to be taken to seek if there has been URTI, pre-op, recent travel history from overseas or immunocompromised patients that may necessitate the need for full PPE. It may mean social distancing at work, de-segregation in OPC (outpatient clinic) and the use of alternatives in claimant assessment.

These are:

1. Telehealth;
2. E-health Exchange with GPs and physios;
3. Home visits by video conference (Skype or remote monitoring eg, wound care), range of motion of joint replacement, follow up x-rays and scans;
4. Avoiding unnecessary OPD visits;
5. On-line educational programs, eg exercise programs at home, avoidance of gym work and crowded exercises classes;
6. Assistive devices for use at home such as lumbar rolls, therabands, pulleys, light weights exercises, hamstring stretching, quads drill etc;
7. Teaching/continuing IME training/peer review, teaching at bio-skills labs and bio-simulation techniques and Cadava workshops will require extra protective gear. Continuing IME training will probably require WEBINARS, currently available for the AMLC (Australian Medicolegal College) rather than large group tutorials. Peer review is done by submitting IME reports to colleagues for review, giving 5 CPD points for 3-4 reviews and 3 points for the Reviewer for each IME report. Because of cancellation of annual meetings, such as RACS, AOA, AOA-RACS-AMLC Combined Medico-legal conferences, CPD modification will be required.

#### Workers Compensation Commission

AMS e-Bulletin No. 101 March 2020, from Judge Gerard Phillips, expresses concern about workers having to travel distances to AMS assessments and then travel home, particularly by public transport. Current directives are for travel by private transport, eg, family car, Uber and taxi, to avoid contact with the general public.

At present, AMS face to face medical assessments have been suspended. This could partially be alleviated by claimants travelling by private transport, for eg family car, Uber and taxi to minimise contact with the general public. Facilitation by Insurer or the Statutory Bodies, eg WCC, could help address these concerns.

In the meantime, briefs allocated should be retained until they can be re-listed. A refresher fee for reviewing the file at that time may be considered.

#### Cruise ships

A public health study of COVID-19 outbreaks on the Diamond Princess Ship in Japan and the Grand Prince Ship in California showed Corona Virus can survive on surfaces for up to 17 days. The virus was identified on a variety of surfaces in cabins of both symptomatic and asymptomatic passengers up to 17 days after cabins were vacated, but before disinfection procedures had been conducted. Some studies have shown COVID can usually last up to 3 days on plastic and stainless steel, with the amount of virus left on these surfaces decreasing over time. It is noted that over 45% of infections were asymptomatic when tested, partially explaining



the “high attack rate” of the virus among passengers and crew. Between the two ships, there were more than 800 total COVID-19 cases including 10 deaths.

Closer to home, Ruby Princess passengers who had disembarked in Sydney have been followed up and some have tested positive to Corona virus. The sicker passengers were transferred immediately to hospital. It does seem the longer COVID-19 positive passengers and crew stay on board cruise liners, that endemic numbers rise, despite weeks of self-isolation in cabins and repetitive cleaning and hand washing/sanitiser. Travellers from overseas, particularly Asia, Europe and the USA, have the compulsory 14 day self-isolation at home before being able to travel for WPI assessment.

Screening on arrival from overseas would include temperature checks, swabbing for corona virus and droplet blood testing to determine who should be quarantined at a designated centre eg, hotel, or isolated at home.

The messages for Senior Medico-Legal Consultants is:

1. Avoid “conferences at sea”;
2. Avoid unscreened recently returned overseas travellers;
3. Frequent wiping of surfaces such as door knobs, desk tops, bathrooms, PCs, hand rails etc;
4. Avoid patient crowding in the waiting room (1.5 metres distancing);
5. Current WCC advice is only one IME consultant and one claimant in the consulting room.
6. The Interpreter should be linked by telephone for the IME review;
7. Clean equipment after each patient;
8. Practice face-to-face distancing during interviewing;
9. Provide sanitiser in the reception area, consulting room and antiseptic wash in WC.

The Federal government has emphasised social distancing, self-quarantine and frequent hand washing which has started to flatten the curve of viral virulence in the community and avoid the exponential rise in infection rates that is seen in Northern Italy and Spain.

At present, logistics for obtaining adequate protective gear has been gradually overcome as is early screening.

A successful anti-viral treatment is not yet available although trials have been done with anti-malarials such as Plaquenil and there may be a place for a SARS type vaccine in the future. It has been urged by the Federal Government that older Australians have the recently made available flu vaccine.

In summary, the majority of disputes lodged with the WCC will require an AMS either in person or via video/ZOOM. Where the worker has passed away, assessment can be made “on the papers”.

The current procedure is:

1. Matter referred to Arbitrator:
  - a. Resolved
  - b. Determined
  - c. AMS Assessment
  - d. Remit to Registrar to be held on pending list
2. Attempt to narrow the evidence to the issues between the parties.
3. Refer for AMS Assessment by video or in person.
4. In person assessment with claimant alone as noted above, interpreter attending by telephone.
5. Minimal time period with sanitising precautions as noted above.

At present, video/ZOOM conferencing is being utilised for IME assessments, provided the parties are in agreement. If these arrangements are satisfactory, WPI assessments can be made. If there is subsequent need for face to face determination, such reviews can be postponed until the COVID PANDEMIC “is over”, with the above precautions still in place.

It is suggested that at the end of the ZOOM reports, a note is made that the report and assessment was made possible by video conferencing as a result of the COVID PANDEMIC.

South Australia

## Emergency Management (Appropriate Surgery During COVID-19 Pandemic No 3) Direction 2020

under section 25 of the *Emergency Management Act 2004*

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### Preamble

- 1 On 22 March 2020 I, Grantley Stevens, Commissioner of Police, being State Co-ordinator for the State of South Australia pursuant to section 14 of the *Emergency Management Act 2004* (the *Act*), declared pursuant to section 23 of the Act that a Major Emergency is occurring in respect of the outbreak of the Human Disease named COVID-19 within South Australia.
- 2 Now I, Grantley Stevens, being of the opinion that this is necessary to achieve the purposes of the Act, give the following direction pursuant to section 25 of the Act.

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### 1—Short title

This direction may be cited as the *Emergency Management (Appropriate Surgery During COVID-19 Pandemic No 3) Direction 2020*.

### 2—Revocation of previous direction

- (1) This direction replaces the *Emergency Management (Appropriate Surgery During COVID-19 Pandemic No 2) Direction 2020*.
- (2) The *Emergency Management (Appropriate Surgery During COVID-19 Pandemic No 2) Direction 2020* is revoked.

### 3—Appropriate Surgery Direction

- (1) Subject to subclause (2), the only surgical treatment that may be performed in the State of South Australia is—
  - (a) emergency surgery and procedures performed for conditions where failure to do so expediently and safely will lead to the following outcomes:
    - (i) loss of life; or
    - (ii) loss of limb; or
    - (iii) permanent disability;
  - (b) non-emergency but urgent surgery and procedures performed for conditions where failure to do so in a clinically appropriate timeframe will lead to a predictable and evidence based outcome as follows:
    - (i) loss of life where surgery or a procedure would otherwise have prevented this;

- (ii) permanent disability where surgery or a procedure would otherwise have prevented this;
- (iii) where clinical evidence supports an increased risk of a type referred to in subparagraph (i) or (ii) should surgery or a procedure be significantly delayed,

provided that no alternative, non-surgical or procedural intervention exists.

**Note—**

Procedures may, for example, include endoscopy, bronchoscopy, interventional radiology and cardiology.

- (2) Subclause (1) does not prevent the performance of the following:
  - (a) procedures undertaken in a community setting utilising local anaesthetic by primary health and allied health practitioners within their scope of practice;
  - (b) procedures and surgical treatments undertaken by dentists in the management of—
    - (i) patients with acute dental pain (for example, endodontic treatment under rubber dam, or extraction); or
    - (ii) significantly damaged upper front teeth (for example, due to trauma, with restorative treatment provided under rubber dam or soft tissue pathology (e.g. ulcers)); or
    - (iii) complex medically compromised patients with dental concerns which may compromise their systemic disease; or
    - (iv) those at a higher risk of rapid progression of dental disease due to socioeconomic or cultural factors; or
    - (v) patients referred by a medical practitioner for medically necessary dental care;
  - (c) procedures to complete—
    - (i) any cycle of IVF treatment that a patient has commenced before the commencement of this direction; or
    - (ii) any procedure required for the preservation of eggs for future IVF where required health treatment will render eggs non-viable;
  - (d) surgical termination of pregnancy.
- (3) To avoid doubt, nothing in subclause (2) is to be taken to allow the performance of cosmetic surgery.

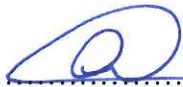
**4—Powers of authorised officers**

Nothing in this direction derogates from the powers of authorised officers to exercise powers pursuant to the Act.

**IMPORTANT— IT IS AN OFFENCE TO BREACH THIS DIRECTION**

This direction operates from the 3<sup>rd</sup> day of April 2020 at 0001 hours

SIGNED at ADELAIDE on this 2<sup>nd</sup> day of April 2020  
at 1845 hours

  
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**GRANTLEY STEVENS**  
STATE CO-ORDINATOR

