**Reflections from BOFAS Webinar on Foot and Ankle Services in the Era of COVID 19**

Thursday 4th June. Transcribed by **James Davis, BOFAS President**
**Rick Brown, Chairman Ed Committee**

This useful collection comprises the thoughts and experiences of the individual invited speakers and does not represent official BOFAS guidance.

**F&A Trauma during the COVID Lockdown**

20:05 F&A Trauma experience in the Liverpool Trauma Centre
*Andy Molloy, University Hospital Aintree*

20.15 New F&A Procedures out of necessity
*Bob Handley, John Radcliffe Hospital, BOA Vice President*

20.20 Will there be an aftermath of neglected trauma?
*James Davis, Torbay Hospital, BOFAS President*

**New Practices in F&A Services during COVID**

20.35 The Oxford Experience of Telemedicine for F&A Patients
*Rick Brown, Nuffield Orthopaedic Centre, Oxford*

20.40 Video Technology for Consultation and Networking
*Paul Halliwell, Royal Surrey Hospital*

20.45 Are steroid blocks safe in F&A Surgery?
*Professor James Teh, Nuffield Orthopaedic Centre, Oxford*

**Re-starting Elective F&A Surgery**

20.55 Restarting Foot & Ankle Services - The BOA's view
*Don McBride, University Hospital North Midlands, BOA President*

21.00 The CD's view of the Challenges for a DGH
*Callum Clark, Wexham Park Hospital, Clinical Director*

21.05 How can Foot & Ankle operations be prioritised using the RCS System?
*Chris Blundell, Northern General Hospital, BOFAS Past President*

21.10 Conundrums of Safe F&A Surgery eg which procedures need Level 2 PPE.
*Robert Clayton, Fife NHS Trust*

21.15 Rationing theatres between Arthroplasty & F&A Surgery?
*Prof Robert Middleton, CD Poole Hospital NHS Foundation Trust*

***F&A Trauma Experience in the Liverpool Trauma Centre***
***Andy Molloy, University Hospital Aintree***
Team working from the start
All news in fracture clinic seen by Consultant
with mini c-arm available for early effective decision making
Virtual fracture clinics worked hard and effective.
NEW trauma database established and avoided lost patients.

New local trauma management guidelines (similar to BOASTs)
Agreement of >3 Cons to go to theatre.

- Ankle Fracture: if reduced then managed non=op.
- Foot Fracture : Only mangled feet to theatre.

7% of all trauma developed COVID, of which 20% died. (2% death overall).
Massive drop off of in presentation of all trauma including F&A,
Leaving only pilons and unstable ankles to go to theatre.

Audit database 31% of fractures treated differently

***New F&A Procedures out of necessity***
***Bob Handley, John Radcliffe Hospital, BOA Vice President***
Had to work within precious resources
To do work of 1 former op list (100%) requires:

- 180% theatre time
- 180% surgeon time
- 210% anaesthetist time
- 267% nurses time.

Need early effective decision is vital

***Will there be an aftermath of neglected trauma?***
***James Davis, Torbay Hospital, BOFAS President***
Still too early to decide.
Did not expect to see the increase in patient driven neglect.
T&O Cons in ED able to pick up earlier potential errors and thus reduce harm.
Reduced fracture clinic by 70%
Use of cutting edge technology allowed early/instant MDT.

60% reduction in theatre efficiency needed to
make decision on whether to operate with a risk assessment,
Based these on new developing data for risk factors from Wuhan, Italy & UK.
Covid Surg Collaboration (mostly gen surg emergencies; T&O safer)

- 30d mortality 24%

- Pulmonary compl in covid + 51%
- RF: male, >70yrs, asa 3 or 4 ( resp or cardiac)

Overall: Predicts that harm from delay < benefit of T&O Cons in ED

**The Oxford Experience of Telemedicine for F&A**

**Rick Brown, Nuffield Orthopaedic Centre Oxford**

Telephone consultation and then follow up satisfaction survey

265 consultations at defined time communicated to patient

Effective clinical decisions in 89% for F/U's and only 69% for New

Discharged 20% on phone and 10% F2F

WL 10% from phone 20% F2F

Patient view of usefulness survey Median score>9/10

Patients still want a F2F for a future consult

- 4.3% would want only telephone consultation
- 37.5% either
- 58.5% rather have F2F
- Increased to 72% if Consultant recommend Tel Consult

Effective way of providing service but should be part of the pathway to F2F consults.

**Video Technology for Consultation and Networking**

**Paul Halliwell**

Software:

- Multiple platforms available some have better encryption than others
- Zoom not recommended for patient sensitive data
- MS Teams adopted by many but account holders on other teams can crash so must logout then back in when changing teams

Video Networking its efficient and works well in line with GIRFT can use for MDT discussions

Video consult is no substitute for F2F consultation, but can be used as part of the patient pathway

Suggest Video Consultations should be performed by consultants only

Care should be taken not to allow it to be dominant in patient assessment

**Are Steroids safe in F&A?**

***Professor James Teh, Oxford***

Decisions on the use influenced by:

The system we work in
Scientific evidence available and its interpretation
Guidelines from societies and government

Scientific evidence is relatively non specific, based on 3 main papers

- Suppression of adrenal axis, which last a varying times depending on steroid
- Systemic effects of steroids after epidural injection
- Incidence of Influenza infection with the use of intra-articular steroids.
  Large study, Increased risk appears to be 1:1000

Current Guidelines from societies vary, most conclude use with caution and only when alternative therapies failed.

New experience that maybe steroids suppress the cytokine storm causing the more severe symptoms of COVID.

Recent paper of oncological patients, taking steroids shows higher risk groups for more sever course of COVID .

- Age >70
- Ethnicity
- Co-morbidities

World Evidence: Australian societies have not stopped steroid intra-articular administration

Conclusion: Informed consent and shared decision making, use other treatments first but don't exclude steroids from patient management.

**Restarting F&A Services the BOA's view**

**Don McBride *University Hospital North Midlands, BOA President***

Waiting lists started large now increasing significantly
Theatre capacity reduced
Our activity will be affected by other specialties with some taking priority
When starting need to think of patient and staff factors
Need to be cautious with patient selection and require informed consent for COVID
Caution driven to some degree by medicolegal factors

- Keyworker death action
- Delayed treatment action
- Class action for impaired function

Last month Parvezi et al (International consensus group) recommends don't start elective during lockdown!!!

***<u>The CD's view of the challenges for a DGH</u>***
**Callum Clark, *Wexham Park Hospital, Clinical Director***

No early significant guidance available
BODS been excellent with CD forums and discussion helping make local decisions.
RCS guidance produced for classification of urgency

Elective W/L

- Category 2: 1%
- Category 3: 2-5%
- Category 4: 95%

20% patients offered operation turned it down

29/4/2020 Simon Stevens letter to trusts to start Elective.
Anaesthetic colleges produced decent guidelines.
Local guidelines produced by trusts not in line with Govt guides

Have to try to develop safe green sites, according to helpful BOA document
classing as gold, silver and bronze helpful .
but gold really difficult to achieve and brings in staff challenges of isolation and testing

Complex problems to solve include

- Competing local and national guidance
- Clean pathway design difficult
- Training and rotas equally problematical
- Elective prioritisation- Orthopaedics low on list
- Outpatients brings another set of challenges

More committees required!!!!!!

***<u>How Can Foot and Ankle operations be prioritised using the RCS system</u>***
***Chris Blundell Northern General Hospital, BOFAS Past President***
Capacity is limited and not near normal
RCS published a classification of urgency system 11/4/20
Some minimal orthopaedic specificity

Cat 2:

- Osteochondral lesions
- Achilles ruptures
- Some failing joint replacements
- On going significant nerve damage.

Cat 3:

- Loose bodies.
- Rapidly deteriorating deformity that harm will come in <3/12.

In Sheffield waiting list has been prioritised

Cat 2: <1%. Cat 3: 4% Cat 4: 95%

Other societies have produced guidelines broadly referring to RCS guidance
BASK introduced a 2* rating for those that need to be done after 72 hours but not 4 weeks
"We need to be honest about where we stand in order of importance. We provide life improvement surgery in the majority and need to allow the life saving surgery priority".

***Conundrums in Safe F&A surgery***

**Robert Clayton Fife NHS**

Have to think of safety for both operating team and patient
Guidance different in Scotland from the rest of UK!!
Aerosol generating procedures require level 3 PPE

Aerosols < 10 micrometres stay airborne significantly longer than droplets.

5 mins fallow period for laminar flow theatre to clear air, 20 mins if non laminar flow

Any procedure using drills or saws classed as AGP in all of UK, except for Scotland where level 2 PPE adequate unless surgery close to airway.

Local classification of risk for patients based on age, sex, co-morbidities helpful
Reduction in risk by following national guidance

14 days preop shielding
48 hr pre op patient testing
Telephone consent
Separate red/blue/green pathways.

***Rationing theatres between arthroplasty and F&A***

***Prof Robert Middleton, CD Poole Hospital NHS Foundation***

Challenging times with Orthopaedics taking a back seat to the life saving specialties.
Time for orthopaedic subspecialties to work together and base the decision on individual cases and not the operation required.
Enhanced recovery (ERAS) for all patients is absolute
GIRFT expects all hospitals to deliver service to a the top 5% of hospitals assessed pre COVID
Accept that we may not be back to normal for months or years.