APPROACH FOR THORACIC ANESTHESIA IN COVID SUSPECT AND POSITIVE PATIENTS

Based on current information, we recommend that **ALL** staff follow Enhanced Droplet and Contact precautions with a N95 mask (gown, N95 mask, Face Shield and gloves). Ideally, these procedures should be done in an Airborne Infection Isolation Room (AIIR) or Negative Pressure room. This will apply to all thoracic procedures listed below

- Intubation and Extubation
- Bronchoscopy
- Gastroscopy
- Rigid esophagoscopy
- Esophageal submucosal dissection
- All procedures requiring lung isolation
- Testing for lung leaks or bronchial staple line leaks
- Any thoracoscopy or thoracotomy without lung isolation
- Poor lung isolation with a DLT

SPECIFIC GUIDELINES

- Preoperative huddle with the surgical and nursing teams
- The 30 minute wait is not required post induction as all staff will be using EDCP + N95 mask. However, the OR doors must remain closed for 30 minutes post AGMP.
- Ensure adequate neuromuscular blockade at all times when manipulating the double lumen or endotracheal tube and no positive pressure ventilation should occur unless the tracheal cuff is inflated.
- Choose an appropriately sized double lumen tube (DLT) and attach a N100 filter to the lumen of the operative side (see attached picture). Any aerosol generated from lung manipulation will then be vented through this filter.
- A second N100 filter should be utilized on the anesthesia circuit to ventilate the patient (see attached picture) as per current practice.
- Confirm DLT placement utilizing the **Tower Video Bronchoscope**. Please confirm correct placement with your colleague or the surgeon
- Reconfirm the positioning of the DLT in the lateral position
- Please **pause ventilation** whenever the DLT or endotracheal tube is being manipulated utilizing the bronchoscope (Filter needs to be disconnected for this)
- In Line suction as per protocol on the ventilated lumen of the DLT and intermittent on the operative side with the N100 filter disconnected.
- Minimize testing for lung leaks or bronchial staple line leaks. Encourage visual inspection by the surgical team.
- Ensure slow, low pressure gradual expansion of the lung at the end of the procedure to avoid aerosol generation.
- With a large air leak, there is a potential to aerosolize through the chest tube system suction port. Consider a filter on the chest tube suction port.
- Ensure the 30 minute wait in the OR following extubation to allow for appropriate air exchange.
- GOOD COMMUNICATION BETWEEN SURGERY AND ANESTHESIA IS ESSENTIAL TO MINIMIZE AEROSOL GENERATION DURING THE PROCEDURE

DLT WITH N100 FILTER ON LUMEN OF OPERATIVE LUNG