Revised Algorithms have been developed for handling surgical cases in operating rooms during the COVID-19 pandemic.

These recognize the high risk of upper aerodigestive cases and will help better define the COVID-19 status of each patient whenever possible. This will enable us to optimally protect each patient and best define the level of personal protective equipment (PPE) required to protect health care providers.

A flow diagram has also been finalized to detail suggested operating room procedures for the handling of COVID-19 suspected (high risk) patients when operating on non-aerodigestive tract.

This protocol should be used when dealing with acute care and trauma cases for which a reliable history of travel, contacts and potential exposure cannot be established.

It is understood that Regional Health Authorities in rural and northern Manitoba may need to modify these algorithms to reflect region-specific logistics. Modifications should be determined through consultation between the regional Chief Medical Officers and Provincial Clinical Leadership in Shared Health.

Explanations
- The rational for separating Upper Aerodigestive Tract surgery from other surgery is due to significantly increased viral load in the posterior nasopharynx. Treating procedures that operate on this area of the body with enhanced precautions will enable us to optimally protect our staff.

Defining the COVID-19 status of the patient allows two things:
1. Optimal protection of the operating room staff; and
2. Optimal utilization of our supply of PPE.

The safest scenario is to isolate patients for 14 days, allowing a high chance of observing symptoms during this period. If patient is symptom-free after 14 days, there is a very low chance they will have the disease.
The next best option is to wait five (5) days, as it is estimated that upwards of 75% of infected patients will show symptoms within this timeframe. At least 25% of patients will not show symptoms even if infected with COVID-19. Viral testing and CT chest scans are used as adjunctive diagnostic tests for urgent operative patients.

While it is understood that early testing and symptoms are not completely accurate, the combination of a five (5) day isolation, immediate viral testing and CT scans of the chest are the most accurate current practice.

Use of diagnostic CT scans of the chest for asymptomatic patients not having aerodigestive tract procedures requires case by case discussion with radiology.