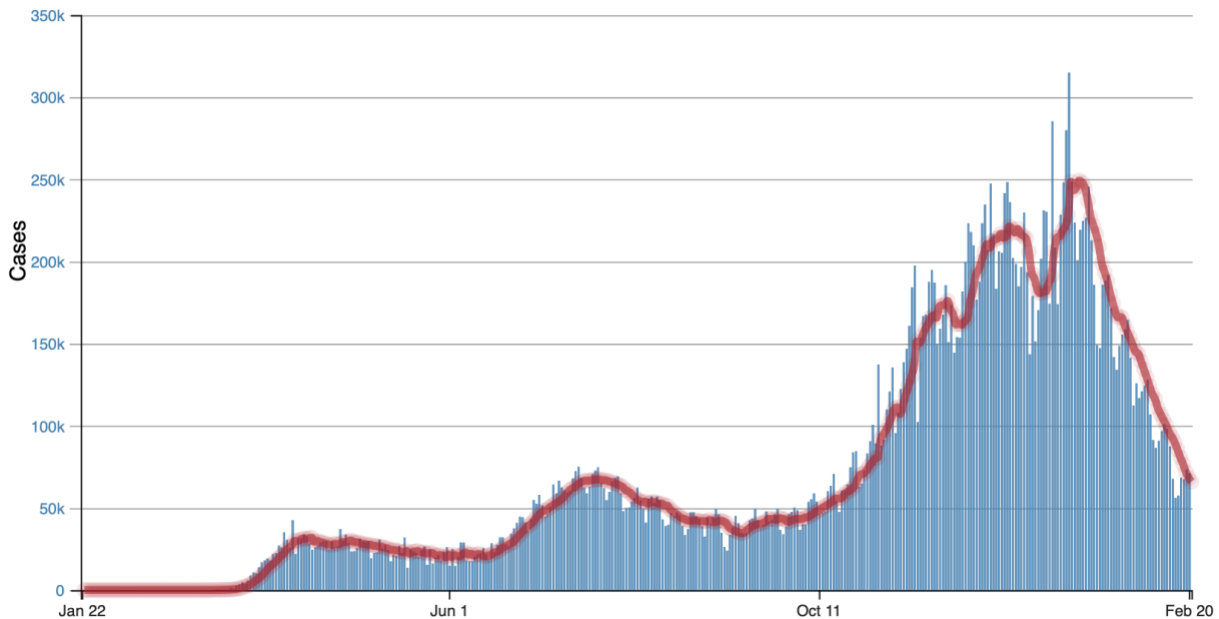


**SOCIETY FOR AMBULATORY ANESTHESIA (SAMBA)  
STATEMENT ON TIMING OF ELECTIVE AMBULATORY  
SURGERY DURING COVID-19 RESURGENCE IN THE U.S.  
February 23, 2021**

The Society for Ambulatory Anesthesia (SAMBA) is concerned about the resurgence of COVID-19 cases<sup>1</sup> throughout the country. Beginning in late fall 2020 viral spread and rates of infection dramatically increased (Figure 1).<sup>2</sup> However, just very recently the numbers have started to mitigate, though rates of infection are almost twice the peaks that we saw in summer 2020. In addition, testing capabilities have escalated, and vaccination is being offered to healthcare workers and senior citizens.

**Figure 1**

**Daily Trends in Number of COVID-19 Cases in the United States Reported to CDC**



Source: [https://covid.cdc.gov/covid-data-tracker/#trends\\_dailytrendscases](https://covid.cdc.gov/covid-data-tracker/#trends_dailytrendscases)<sup>2</sup>

The Centers for Disease Control (CDC) continues to monitor the surge of new variants of the SARS-CoV-2 virus<sup>3</sup>. These emerging variants have mutations in the virus genome that alter the virus in many ways. These new coronavirus variants cause more severe disease, spread more easily, require different treatments, may not respond to previously proven therapies and change the effectiveness of current vaccines.

In order to protect the public, and healthcare personnel, SAMBA continues to support our previous [recommendations](#) to test patients before elective surgery to prevent the transmission

of coronavirus.<sup>4,5</sup> Asymptomatic COVID-19 patients scheduled for urgent and emergency surgery arriving in the operating room may represent the greatest risk to anesthesia providers and operating room personnel.<sup>6,7</sup> SAMBA believes that patients and healthcare personnel can remain safe and fulfill our mission of improving the health of our population by continuing to offer needed services.

As we stated previously, the expectation of a COVID-FREE environment is likely not possible. A more realistic and achievable goal is to be **COVID-SAFE**. SAMBA reiterates the use of the SAMBA COVID-SAFE checklist to help ambulatory anesthesiologists create COVID-SAFE environments. This in turn will reassure the public and our patients that we are committed to appropriate measures designed to protect their safety as they receive anesthesia care for their procedures and surgeries. If a facility complies with all of the checklist items on an ongoing basis, it may display the sign (see below) indicating it follows the Society for Ambulatory Anesthesia (SAMBA) **COVID-SAFE Checklist** measures.<sup>8</sup>

**Figure 2 (PDF version available on the last page)**



Source: [https://samba.memberclicks.net/assets/docs/SAMBA\\_Statements/Figure\\_2.pdf](https://samba.memberclicks.net/assets/docs/SAMBA_Statements/Figure_2.pdf)<sup>9</sup>

On December 8, 2020, the American Society of Anesthesiologists (ASA) and the Anesthesia Patient Safety Foundation (APSF) published a joint statement on elective surgery and anesthesia for patients after COVID-19 infection.<sup>10</sup> This statement addresses many of the questions that anesthesiologists, allied healthcare providers, surgeons, and facilities may have about the timing of elective surgery in a patient who has tested positive for SARS-CoV-2 or been diagnosed with COVID-19. In this statement, the ASA and APSF recommend the timing of elective surgery after recovery from COVID-19 utilizes both symptom- and severity-based categories.

*“Suggested wait times from the date of COVID-19 diagnosis to surgery are as follows:*

- *Four weeks for an asymptomatic patient or recovery from only mild, non-respiratory symptoms.*
- *Six weeks for a symptomatic patient (e.g., cough, dyspnea) who did not require hospitalization.*
- *Eight to 10 weeks for a symptomatic patient who is diabetic, immunocompromised, or hospitalized.*
- *Twelve weeks for a patient who was admitted to an intensive care unit due to COVID-19 infection.*

*These timelines should not be considered definitive; each patient’s preoperative risk assessment should be individualized, factoring in surgical intensity, patient co-morbidities, and the benefit/risk ratio of further delaying surgery.”<sup>10</sup>*

SAMBA supports the ASA/PSF statement, as we learn more of the systemic and long-term effects of COVID-19. We want to point out that patients having low risk procedures, especially without general anesthesia who have had asymptomatic COVID-19 can almost certainly safely proceed after the period of infectivity has passed. Current CDC guidance for when it is OK to release someone from isolation is made on a case-by-case basis and includes meeting all of the following requirements:

- It has been at least 10 days since the onset of the patient’s illness *and*
- The patient is free from fever without the use of fever-reducing medications for at least 24 hours *and*
- Other symptoms of COVID-19 are improving. (Loss of taste or smell may persist for weeks or months after recovery and need not delay the end of isolation.)

The CDC also recommends that you do not need to repeat a test [for at least 3 months](#) in patients who have tested positive for SARS-CoV-2. However, duration of isolation for up to 20 days after symptom onset may be warranted in patients with severe illness or immunosuppression.

The decision to proceed with ambulatory procedures should consider postoperative recovery and rehabilitation required for a particular procedure as COVID-recovered patients may tolerate the intraoperative period but be unable to fully participate in or tolerate postoperative rehabilitation and recovery. Prehabilitation may help mitigate an increase in surgical morbidity and mortality since we know that patients can have clinical deterioration of functional capacity as a result of COVID-19 infection or inactivity simply due to quarantine.<sup>11, 12</sup> Prehabilitation has been shown to improve postoperative outcomes in a variety of patient populations undergoing major operations. Participation in a prehabilitation program has been associated with shorter length of stay and lower costs after operation.<sup>13,14</sup> The American College of Surgeons Post-COVID-19 Readiness Checklist for Resuming Surgery, includes prehabilitation discussions.<sup>15</sup>

In some areas, hospitals have chosen to halt elective surgeries to preserve personal protective equipment (PPE) and maintain capacity to manage COVID-19 patients. As a consequence, ambulatory surgical centers may be asked to perform procedures of higher complexity, or take care of higher-risk patients than is typical for any given facility. As patients continue to be apprehensive to engage with the healthcare system, outpatient care may offer a safer alternative to an in-patient setting.

The goal is to continue to provide necessary and safe elective care to patients in ambulatory surgery centers, while avoiding the transfer and admission of patients to a hospital due to poor patient selection, or preventable surgical complications. It is important to recognize, however, that in ambulatory surgery centers, the triad of patient selection, surgeon selection, and case selection has been shown to determine outcomes.<sup>16</sup>

- **Patient selection:** There are many medical conditions that may preclude a patient from having surgery in an outpatient setting. However, in general, high-risk patients may undergo low-risk procedures in ambulatory surgery settings, and lower-risk patients can undergo higher-risk procedures. Frail patients are particularly vulnerable to postoperative complications.<sup>17</sup> Surgeons, anesthesiologists and primary care providers should work together to determine the health status of patients and decide the timing and location of a surgical procedure.
- **Case selection:** Each facility should assess its ability to perform procedures according to their delineation of privileges and governing board approval. In addition, the facility must be able to provide a level of care comparable to the care provided in a hospital. Typically, most ambulatory surgery centers limit cases to levels 1 and 2 and some level 3 case complexity as determined by the governing board of the facility and the patient's health status.

### **Levels of Surgical Complexity<sup>18</sup>**

#### **Level 1**

- Minimal risk to the patient independent of anesthesia
- Minimally invasive procedures with little or no blood loss
- Often done in an office setting with the operating room principally for anesthesia and monitoring
- Includes: breast biopsy, removal of minor skin or subcutaneous lesions, myringotomy tubes, hysteroscopy, cystoscopy, fiberoptic bronchoscopy, cataracts

#### **Level 2**

- Minimal to moderately invasive procedure
- Blood loss less than 500 cc
- Mild risk to patient independent of anesthesia
- Includes: Diagnostic laparoscopy, dilatation, and curettage, fallopian tubal ligation, arthroscopy, inguinal hernia repair, laparoscopic lysis of adhesions, tonsillectomy, adenoidectomy, umbilical hernia repair, septoplasty, laparoscopic cholecystectomy, rhinoplasty, hysterectomy, myomectomy

#### **Level 3**

- Moderate to significantly invasive procedure
- Blood loss potential 500-1500 cc
- Moderate risk to patient independent of anesthesia
- Includes: laminectomy, hip/knee replacement, major laparoscopic procedures
- Excludes: Open thoracic or intracranial procedure

- **Surgeon selection:** During the performance of higher risk procedures, despite equal training and equivalent certification, there are surgeons who are recognized by their peers as being especially capable and whose patients tend to do best in terms of surgical outcome and lower morbidity and mortality.<sup>19, 20</sup>

In summary, during the ongoing COVID-19 pandemic and recent resurgence, ambulatory surgery facilities should continue following COVID-Safe procedures. Careful patient selection includes not only SARS-CoV-2 testing, but also a preoperative clinical evaluation to determine a patient's health status and functional capacity. Patients who have had symptomatic COVID-19 infections may have had a period of bed rest and convalescence even if they have not been hospitalized. Implementing a post-COVID-19 prehabilitation program, when indicated, may decrease perioperative complications. Other preventive measures include appropriate case selection, keeping in mind that local hospitals may lack bed capacity and intensive care unit resources to admit patients who may need to be transferred to a higher level of care.

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**Leopoldo Rodriguez, MD, MBA, FASA, SAMBA-F**  
SAMBA President

**BobbieJean Sweitzer, MD, FACP, SAMBA-F**  
SAMBA President-Elect

**Dawn Schell, MD**  
SAMBA Vice-President

The following facility:

is proud to declare that we follow the  
Society for Ambulatory Anesthesia  
(SAMBA)

**COVID-SAFE** Recommendations\*



Outpatient • Office Based • Non-Operating Room

[www.sambahq.org](http://www.sambahq.org)

\*See Society for Ambulatory Anesthesia (SAMBA) Checklist For COVID-SAFE  
Ambulatory Surgical Facilities (5/15/20).

SAMBA has not verified this facility's compliance with the SAMBA Checklist.

Compliance with the Checklist does not guarantee that the risk of transmission has been eliminated.