COVID-19: how to proceed with the practice of plastic surgery in Brazil. What do we know right now?

COVID-19: como proceder na prática da cirurgia plástica no Brasil. O que sabemos até agora?

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ABSTRACT

COVID-19 (coronavirus disease, described in 2019) is an infectious disease caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). Most confirmed cases are mild or asymptomatic, but the most severe cases can progress to severe pneumonia with respiratory failure and death. In Brazil, there is a scenario of an exponential increase in cases, making it challenging to identify the source of contagion. We cannot yet specify when the peak of the COVID-19 outbreak will occur in our country or when the numbers of new contaminants and deaths will begin to decrease. So, the most important thing is protection against a virus for which all the details about contagion, transmission, and treatment are not known. The pandemic impacted and modified medical care, especially for surgical specialties, where face-to-face care is essential and cannot be replaced entirely by telemedicine. Thus, this review aimed to compile theoretical and practical aspects regarding the pandemic COVID-19 and its impact on plastic surgery activity routine. Protocols are proposed for resuming our routines, analyzing countries’ experience at an advanced stage of the pandemic.

Keywords: Coronavirus infections; Surgery, Plastic; Patient safety; Elective surgical procedures; Protective devices; Pandemics.

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INTRODUCTION

COVID-19 (coronavirus diseases - 2019) is an infectious disease caused by the coronavirus of severe acute respiratory syndrome 2 (SARS-CoV-2). The most common symptoms are fever, cough and difficulty breathing, loss of taste or smell. Approximately 80% of confirmed cases are oligo/asymptomatic and most recover without sequelae. However, 15% of infections are severe, with extensive viral pneumonia cases, of which 40% progress to SARS, many of them requiring assisted ventilation in intensive care units, and 20% evolve to death. In the most severe cases, associated with pneumonia, we observed disseminated intravascular coagulation and multiple organ failure.

The disease is transmitted through droplets produced in the respiratory tract of infected people. When sneezing or coughing, these droplets can be inhaled or directly reach the mouth, nose, or eyes of close contact people. Alternatively, the hands can touch contaminated surfaces and carry the virus to the mucous membranes, infecting people. The time interval between exposure to the virus and the onset of symptoms is 2 to 14 days, with five days average. Among the risk factors for a worse prognosis are advanced age and comorbidities such as cardiovascular diseases, diabetes, obesity, and chronic obstructive pulmonary diseases. The diagnosis is suspected based on symptoms and risk factors and confirmed with real-time polymerase chain reaction assays to detect virus RNA in mucus or blood samples (RT-PCR). When the direct search for viral RNA is negative or cannot be made, the diagnosis can be confirmed by serology, or it can be presumptive, based on the clinical picture and characteristic chest computed tomography (CT) image.

Prevention measures include frequent handwashing, avoiding close contact with other people, and avoiding touching the mucous membranes with your hands. The use of surgical masks was initially recommended only for people suspected of being infected or for the caregivers of infected people, and, currently, the recommendation is for the general public. There is no specific vaccine or antiviral treatment for the disease. We still do not have any medication with proven effectiveness in this first phase of the infection, known as the viral phase. The most distressing and frightening of the disease is not accurately predicting and preventing the progression to its phase II of pneumonia and phase III of SARS. In this phase, ventilatory support with oxygen therapy is essential, and the treatment of immune dysregulation and the coagulation system, which become more harmful than the cytopathic effect of the virus.
The pandemic caused by the COVID-19 virus had its first cases identified in late 2019, starting in Wuhan, China. It spread across the world quickly and progressively, with an exponential increase in cases, making it challenging to identify the source of contagion. We cannot yet specify when the peak of the COVID-19 outbreak in Brazil will occur or when the numbers of new contaminants and deaths will begin to decrease. There are still many doubts about the virus’s behavior, both on an epidemiological scale and on an individual physiological issue. We know which risk groups are most affected, but we also see patients outside those groups succumb to it. Due to the lack of proven treatments, social distance is a real measure, but its duration and magnitude are heated debate objects.

The pandemic impacted and modified medical care, especially for surgical specialties, where face-to-face care is essential and cannot be replaced entirely by telemedicine. But we have countries that have already gone through the disease’s peak and are resuming their economic activities, including attending clinics to elective patients. This study aims to analyze theoretical and practical aspects related to the pandemic COVID-19 and its impact on the routine of plastic surgery activity, evaluating the experience of countries in an advanced stage of the pandemic and also to propose protocols for resuming our routines.

METHODS

Research carried out in PubMed in 2020, with the following terms related to the virus: “COVID”, “SARS-CoV-2”, “Coronavirus”; crossed with terms: “plastic surgery”, “elective surgery”, “surgical”. Websites of national and international agencies that disseminate epidemiological factors, guidelines, and guidance for COVID-19 were also researched.

RESULTS

Crossing the terms “COVID-19”, or “SARS-CoV-2” or “Coronavirus” with “plastic surgery”, “elective” and “surgical”, 15, 22 and 125 articles were identified, respectively, totaling 162 studies. Articles such as case reports, description of surgical techniques in infected patients, and medical education guidelines during a pandemic were excluded, resulting in 127 articles that were analyzed in more detail. The articles describe surgical routines adopted by different services in the different regions affected by the pandemic such as SubSahara, United States, Italy, Singapore, China, Turkey, England, Brazil, Spain, Pakistan, Argentina, among others. Descriptions of routines adapted to the pandemic COVID-19 were found in different medical specialties, such as gynecology and obstetrics, vascular surgery, cardiac surgery, bariatric surgery, ophthalmology, plastic surgery, and oncology. A survey carried out by Al-Benna and Gohritz, in 2020, showed that 22% of the websites of national plastic surgery societies have a specific section on COVID-19, with guidelines for their members or the general population. Our society proudly dedicates a chapter and a series of videos and web meetings on the topic (www2.cirurgiaplastica.org.br). In this analysis of the worldwide literature on guidelines, we unanimously observed the recommendation to test the presence of viruses (RT-PCR) or antibodies in patients (serology) in a comprehensive way, however, in our country, so far, we do not have government action in this regard, and we do not have enough tests available.

Plastic surgery comprises a range of services of a peculiar nature, ranging from wounds, trauma, burns, reconstruction, oncology to cosmetic surgery, and cosmiatry. According to a survey by the American Society of Plastic Surgery, in 2018, around 6 million reconstructive procedures, 2 million aesthetic procedures, and 16 million minimally invasive cosmetic procedures were performed. The pandemic does not affect the indication for emergency surgeries, but it does require well-established and rigorous adaptations of the hospital environment in terms of patient flow and personnel protection. The lower the circulation of people in any situation and, mainly, in hospital environments, the lower the risk of spreading the infection, and this premise directly affects elective surgeries, both essential and non-essential, and even more so any aesthetic procedure.

The concept of elective surgery, in this pandemic moment, becomes even more conflicting and depends on the judgment of the surgeon and the patient, taking into account the risk/benefit ratio and biopsychosocial aspects, especially in reconstructive surgery. The Federal Council of Medicine (CFM), in an ordinance, defines only urgent and emergency surgery, and no specific definition of elective surgery was found. According to the report of the Regional Council of Medicine of the State of Acre, Brazil (CRM-AC), the surgeries are established as follows:

ELECTIVE SURGERY: proposed surgical treatment, but the performance can wait for a favorable occasion, that is, it can be programmed.

URGENCY SURGERY: surgical treatment that requires prompt attention and must be performed within 24 to 48 hours.

EMERGENCY SURGERY: surgical treatment that requires immediate attention because it is a critical situation.

Stahel, in 2020, proposes an even more detailed classification of surgeries:
1. Emergency: must be performed within 1 hour;
2. Urgency: must be performed within 24 hours;
3. Elective urgency: must be performed within two weeks;
4. Essential elective: can be postponed for 1 to 3 months;
5. Non-essential elective: can be postponed for > 3 months.

In plastic surgery, we consider elective oncology surgeries essential and, even so, there is a recommendation to individualize these procedures:

- **Cutaneous oncology**: Gentileschi et al., in 2020\(^6\), define that only the cutaneous oncological cases below should be considered for surgery:
  1. Reoperation of melanoma cases for margin expansion and excision of sentinel lymph node;
  2. Skin tumors with bleeding and ulceration;
  3. Patients being followed up for solid tumors where resection can increase survival (breast tumors and melanoma);
  4. Aggressive fast-growing tumors (sarcoma and melanoma);
  5. Basal cell carcinoma should be evaluated for location (eyelids, for example).

- **Breast reconstruction**: Guidelines from the American Society of Breast Surgeons recommend that breast reconstructions be analyzed with caution. The procedure should be as less invasive as possible and, eventually, perform the definitive repair at the most appropriate time. Extensive procedures may require intensive care, which can increase the risk of contamination\(^8\).

There are reports in the literature of patients undergoing elective surgical procedures who, despite all negative screening for COVID-19, developed the disease in the postoperative severely, with death in most cases. The authors question the uncertainty of the NEGATIVE diagnosis before surgery and whether eventually, surgical trauma was not a factor in the worse prognosis of the disease. Besides, there was an exposure of all professionals and patients in the same environment at the time of surgery\(^5,9,31\). They recommend that elective surgeries be suspended. An increasing number of pieces of evidence show cardiorespiratory and microembolic or thrombotic complications in patients with the disease, but nothing is known about asymptomatic or pre-symptomatic patients\(^6,8\).

At the moment, the World Health Association and the official world bodies, recommend postponing elective surgeries\(^8,32,91\). The Brazilian Society of Plastic Surgery also recommends postponing elective surgeries:

> “**Considering the very personal characteristic of the development of the disease in each organism, which can range from asymptomatic to dramatically fatal evolution; it remains clear that taking a patient to surgical treatment (other than urgency and/or exceptionality as related to oncology), is to compete with recklessness and professional insecurity, especially patient safety. The postoperative evolution of a patient, primarily healthy, with COVID-19, can have dramatic consequences, which will certainly invoke the surgeon’s responsibility.”** (Report V - Brazilian Society of Plastic Surgery [SBCP in portuguese]).

And even referring to legal issues, the informed consent term must be increased by risks for COVID-19. However, also aware of these risks, the real danger to the patient during the perioperative period is not yet measurable.

**When and how to resume elective surgery?**

- Wait for favorable statistics to resume surgical activities: - Is the local number of confirmed cases decreasing?
- Are the local number of deaths and ICU admission falling?
- Informed consent, including information on signed COVID-19 (see the model in Annex 4).

**Minimally invasive procedures**\(^3\)

- The closer the face, the higher the risk of contamination. Nasopharyngeal procedures, such as intranasal examination or dressings, are extremely contaminating.
- Aerosols of COVID-19 can remain in the air for up to 3 hours. The correct dispersion of aerosols consists of laminar flow from the environment, which is practically impossible in offices. Whenever possible, improve the ventilation of rooms.

**Surgical procedures in a hospital setting**

**Health institution evaluation**

- Respect the classification of the Hospital or Clinic for COVID-free or that there is a safe flow established for non-COVID-19 patients. Check the availability of COVID-free ICU beds.
• In general, hospitals have adapted to the routine change in the disinfection of rooms and equipment, since it is known that COVID-19 can remain on surfaces and in the air for a long time.

**Patient selection for surgery**

• Absence of changes to the questionnaire made in the scheduling (see questionnaire suggestion in Annex 2).
• Patient without comorbidities (low surgical risk).
• Elective surgery only after 1 or 2 months in patients who had COVID-19:
  • Higher risk of thrombosis after the eighth day of symptom onset and up to 2 months after infection (data not scientifically confirmed). D-dimer levels, inflammatory cytokines, and liver enzymes are often altered during the disease, further compromising any surgical stress.
• Only admit patients with a negative RT-PCR test for COVID-19 48 hours before or positive IgG for elective surgeries. Remember that no test has 100% sensitivity. There is always the possibility of a false negative.
• Give preference to outpatient surgery and surgery lasting <3 hours.
• Prefer sedation or locoregional anesthesia, since there are reports of cases of activation of COVID-19 after orotracheal intubation in elective patients. In addition to a higher risk for the anesthesia team.
• There is a higher incidence of contaminated otolaryngologists than other specialties due to nasopharyngeal manipulation.

**Surgical tactics and team protection**

• Every patient with negative tests should be considered a potential COVID-19 vector.
• Protective equipment suitable for the whole team.
• Special care must be taken in surgeries that generate aerosols, such as laparoscopies and electrocautery. Use electrocautery when necessary at minimum power and assisted by a vacuum cleaner.

**DISCUSSION**

Initially called coronavirus, now called SARS-CoV-2, it appeared in Wuhan, China then spread throughout the world. On March 11, the World Health Organization (WHO) declared a state of a global pandemic. In Brazil, we had the first case diagnosed in February, and the last official number, until the conclusion of this review, was 310,087 confirmed cases and 20,047 deaths. Brazil’s mortality rate is 8.5 deaths/100 thousand inhabitants, with 18.5 in the North and 1.2 in the South.

There have been two major coronavirus epidemics in the recent past, the Severe Acute Respiratory Syndrome (SARS) in China in 2002 and the Middle East Respiratory Syndrome (MERS) in the Middle East in 2012. These two epidemics had higher lethality rates, 11%, and 34.3%, respectively, but were much less comprehensive. The new coronavirus, SARS-CoV-2, although less lethal, has higher infectivity and greater inter-human transmission capacity, characteristics that were essential for the installation of the pandemic, and the fact that the world is increasingly globalized. The lethality of COVID-19 was estimated at 2.3%, but it is probably overestimated since asymptomatic or oligosymptomatic cases (estimated at 80%) are not computed. The transmission rate (R0) is at least 2 to 2.5 people infected per infected patient, and this number only decreases with social isolation or the development of population immunity. Controlling contagion is even more difficult, considering that it is estimated that between 30 and 50% of transmissions occur by pre-symptomatic or asymptomatic patients for an uncertain time. The forms of transmission found so far include direct contact, aerosols, and fomites (contaminated surfaces). Table 1 shows COVID-19’s half-life and maximum residence time on surfaces. A lipid layer surrounds the virus, and the decontamination guidelines must follow official disinfection protocols. Any form of detergent or disinfectant is known to be effective against COVID-19.

**Table 1. COVID-19’s half-life and maximum residence time on surfaces**

<table>
<thead>
<tr>
<th>Surface</th>
<th>Average life (h)</th>
<th>Maximum time (h)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aerosols</td>
<td>1.5</td>
<td>3</td>
</tr>
<tr>
<td>Plastic</td>
<td>6.8</td>
<td>72</td>
</tr>
<tr>
<td>Cardboard</td>
<td>4</td>
<td>24</td>
</tr>
<tr>
<td>Copper</td>
<td>1.5</td>
<td>4</td>
</tr>
<tr>
<td>Stainless steel</td>
<td>5.6</td>
<td>48</td>
</tr>
</tbody>
</table>

**Clinical condition**

Initially, the virus colonizes the oropharynx and nasopharynx, and, from the fifth day on, it is already found in the trachea and bronchi. The symptoms are very diverse, and 80% of patients have mild symptoms...
or none at all. The most frequent symptoms are described in Table 2. COVID-19 is now considered a systemic disease and not just a respiratory illness. Lethality is higher in risk groups, but the evolution is uncertain, even in individuals outside the risk group. The worsening of the condition may be associated with alteration in coagulation, with microemboli and embolisms, and changes in liver function. When altered, the complete normalization of lung function is not yet defined, but the disease does not appear to leave sequelae.

Table 2. Frequent symptoms of COVID-19%

<table>
<thead>
<tr>
<th>Symptom</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sore throat</td>
<td>12.4</td>
</tr>
<tr>
<td>Nasal congestion</td>
<td>3.7</td>
</tr>
<tr>
<td>Anosmia</td>
<td>40</td>
</tr>
<tr>
<td>Fever</td>
<td>85.6</td>
</tr>
<tr>
<td>Cough</td>
<td>68.7</td>
</tr>
<tr>
<td>Tiredness</td>
<td>39.4</td>
</tr>
<tr>
<td>Myalgia</td>
<td>15.6</td>
</tr>
<tr>
<td>Nausea or vomiting</td>
<td>6.8</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>5.3</td>
</tr>
</tbody>
</table>

Tests for COVID-19

One of the measures adopted for screening for elective patients’ hospitalization is the testing of both the medical team and the patient. However, several considerations regarding the sensitivity of the tests available vary according to the methodology used in the tests and their manufacturers.

RT-PCR (COVID-19)

The exam identifies a specific RNA sequence for COVID-19, present in both the active virus and a fragment of the virus. It is collected in the nasopharynx and oropharynx, where it is present and detectable between the third and seventh days after the appearance of symptoms. Sensitivity in asymptomatic patients is very low and therefore has a high false-negative rate. We cannot be sure that the patient who comes to the office or hospital is not infected if the result is negative. This creates risk for the team and makes the health service a vector of contamination since COVID-19 can be observed dispersed in the air within 3 hours after the patient remains in the environment. Every asymptomatic patient with a negative or untested test should be considered a potential carrier of COVID-19.

Serology (IgM, IgA, and IgG)

The presence of IgM and IgA, which indicate recent infection, can be detected from the fifth day of infection onset and IgG, produced by the body later, from the second week. IgG patients can be considered cured, but there is a discussion of IgG’s ability to confer or indicate permanent protection. And it is not sure whether even immune, the patient could not be colonized and transmits any viruses in the oronasopharynx. The convalescent COVID-19 patient is potentially protected and will probably not be a chronic carrier of the virus, but more scientific evidence is lacking. Therefore, the care of social distance and hygiene of cured patients and health professionals must be the same. There is no “immune passport” that provides 100% security. Table 3 illustrates the interpretation of serology.

Table 3. Graph for interpretation of results for the diagnosis of COVID-19.

<table>
<thead>
<tr>
<th>Result</th>
<th>PCR</th>
<th>IgM</th>
<th>IgG</th>
<th>Clinical Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative</td>
<td>Negative</td>
<td>Negative</td>
<td>Negative</td>
<td>Negative</td>
</tr>
<tr>
<td>Positive</td>
<td>Negative</td>
<td>Negative</td>
<td>Negative</td>
<td>Infection.</td>
</tr>
<tr>
<td>Positive</td>
<td>Positive</td>
<td>Negative</td>
<td>Negative</td>
<td>Initial stage of infection.</td>
</tr>
<tr>
<td>Positive</td>
<td>Positive</td>
<td>Positive</td>
<td>Positive</td>
<td>Active stage of infection.</td>
</tr>
<tr>
<td>Positive</td>
<td>Negative</td>
<td>Positive</td>
<td>Positive</td>
<td>Final stage of infection.</td>
</tr>
<tr>
<td>Negative</td>
<td>Positive</td>
<td>Negative</td>
<td>Negative</td>
<td>Initial phase with false negative PCR. Repeat PCR for confirmation.</td>
</tr>
<tr>
<td>Negative</td>
<td>Negative</td>
<td>Positive</td>
<td>Negative</td>
<td>Previous contact.</td>
</tr>
<tr>
<td>Negative</td>
<td>Positive</td>
<td>Positive</td>
<td>Positive</td>
<td>Evolving infection. Repeat PCR.</td>
</tr>
</tbody>
</table>

Source: www.fleury.com.br

The rapid tests used have helped to understand better the prevalence of infection in different locations around the world. These tests detect both IgM and IgG, but do not discriminate against them. However, a validation study carried out at the Hospital das Clínicas of FMUSP, shows that when using the blood from the fingertip, we obtain test sensitivity of only about 55%, which increases to the excellent rate of 96% when we use their serum patients in the test1.

Telemedicine

Still, with temporary legislation, the CFM determines that during the COVID-19 outbreak, telemedicine can be used for tele-orientation, guiding, or referring patients in isolation, telemonitoring, or even teleconsultation between health professionals. In other countries, the use of telemedicine has been widely used to prevent the patient from attending the office, in the form of pre-consultation and screening. Among the subspecialties of plastic surgery, in oculoplasty, telemedicine has shown to
be feasible in evaluating the patient. We emphasize the importance of completing informed consent for telemedicine (see the model in Annex 3).

Clinic

We have to provide maximum protection to our employees and patients, but we question whether this would be possible in the case of COVID-19. The protection of both staff and our patients depends on adaptations already established in protocols.

• The virus can remain on surfaces for a long time (Table 1). And the disinfection of the environment must be carried out between visits.
• Remove ornaments, plants, and magazines.
• Remove material and objects on benches and tables.
• Acrylic protection for reception or limit 1.5m distance from reception.
• Increase space between chairs. The recommended minimum distance is 3m between people.
• Reduced schedule.
• Environment disinfection:
  • 70% alcohol in equipment;
  • Sodium hypochlorite (bleach) 0.1 to 0.5% for surfaces.

Consultation

Medical attention (Figure 1):

Figure 1. Algorithm for surgical procedures. Algorithm proposed by Stahel, in 2020\textsuperscript{88}, for risk stratification and decision for surgery during the COVID-19 pandemic. \textbf{Abbreviations:} ASA: American Society of Anesthesiologists; CHF: Chronic heart failure; COPD: Chronic obstructive pulmonary disease; COVID: Coronavirus disease; ICU: Intensive care unit; PAR: Post-anesthetic recovery.
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**Staff**
- Exhaustive training of staff and requirement to comply with the guidelines: https://portal.fiocruz.br/coronavirus/material-para-download
- Staff mask should be with a filter, like the N-95. Surgical masks do not entirely protect. Whatever the procedure, the N-95 must be used.
- Face shield for total face protection.
- Hand brushing early in the day.
- Disposable apron.
- Shoe covers.
- Gloves.
- Cap.
- Gel alcohol in all environments.

**CONCLUSION**

There is a profusion of editorials and articles establishing rules and algorithms for indicating or suspending surgical procedures. The suspension of mass surgeries, as occurs worldwide, should have still immeasurable consequences, both health and economic, including worsening the patient’s surgical condition because of confinement. The ideal situation

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**Figure 2.** Impact of the pandemic on surgical procedures routine. Graph adapted from Soreide et al., In 2020, the threshold for a given health system can be broken by a wave of infected patients. The ability to maintain at least urgent or emergency surgeries may not be sustained, leading to a possible additional loss of life not related to the pandemic disease itself, but as collateral damage. Reduction or suppression strategies can be long-lasting (tail effect) and affect elective capacity and, with the risk of worsening the disease or function or have a detrimental impact on the prognosis.
for resuming our activities’ normality is not yet visible on the horizon, as shown in the graph in Figure 2.

In the world literature, there is no recommendation other than this at the moment: POSTERGING NON-ESSENTIAL ELECTIVE SURGERIES. Even knowing our patients’ health repercussions and economics for keeping us away from daily activities, we are facing a pandemic without limits or positive consequences. Our practice is based on the principle: primo non nocere. Based on evidence found in the literature:

- Follow the guidance of the government and professional bodies.
- Slowly open the office when the pandemic is under control.
- Screening before the face-to-face consultation with a questionnaire by phone, e-mail, or electronic message. Adopt telemedicine as a primary tool for screening and diagnosis when possible.
- Provide written information on safety protocols and updates on the pandemic to prevent further contact between staff and patients. Downloadable materials available at https://portal.fiocruz.br/coronavirus/material-para-download.
- Safety protocols for patients.
- Personal protective equipment is suitable for staff.
- Do not forget that COVID-19 can be considered an accident at work;
- The smaller the number of individuals in the environment, the lower the risk of transmission.

We created a flow chart to assist in decisions regarding the indication of plastic surgery (Figure 3).

Figure 3. Flowchart proposed for plastic surgery due to COVID-19.
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COLLABORATIONS

BLB
Analysis and/or data interpretation, Concept and design study, Conceptualization, Data Curation, Final manuscript approval, Methodology, Project Administration, Supervision, Visualization, Writing - Original Draft Preparation, Writing - Review & Editing

CI
Analysis and/or data interpretation, Concept and design study, Conceptualization, Final manuscript approval, Methodology, Supervision, Visualization, Writing - Original Draft Preparation, Writing - Review & Editing

DPN
Final manuscript approval, Visualization, Writing - Review & Editing

PGB
Analysis and/or data interpretation, Conception and design study, Final manuscript approval, Investigation, Methodology, Supervision, Visualization, Writing - Original Draft Preparation, Writing - Review & Editing

REFERENCES


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E-mail: beatriz@lassance.com
Appendix 1. A suggestion of material to be delivered to the patient. Available for download on the Oswaldo Cruz Foundation website:

Source: https://portal.fiocruz.br/sites/portal.fiocruz.br/files/imagensPortal/uso_de_mascaras_como_utilizar_mascara_caseira_rgb_a5.jpg
Appendix 2. Questionnaire for telephone screening or sent to the patient before the consultation.

Preliminary COVID-19 infection risk questionnaire

Date: / / Name:
CPF:----------------- Address:

Major symptoms
Fever > 37.50 ( )yes ( )no
Cough ( )yes ( )no
Tiredness ( )yes ( )no
Shortness of ( )yes ( )no

Minor symptoms
Sore throat ( )yes ( )no
Headache ( )yes ( )no
Muscle pain ( )yes ( )no
Nasal congestion ( )yes ( )no
Nausea ( )yes ( )no
Vomit ( )yes ( )no
Diarrhea ( )yes ( )no
Loss of taste or smell ( )yes ( )no
Conjunctivitis ( )yes ( )no

Epidemiology
In the last 14 days
Have you had contact with patients with confirmed COVID? ( )yes ( )no
Have you had contact with patients suspected of COVID? ( )yes ( )no
Any family members with any of the above symptoms? ( )yes ( )no
Have you been to an environment with a concentration of people? ( )yes ( )no
Have you been in a health service? What? ( )yes ( )no
Works from home office ( )yes ( )no
Does the workplace use protective equipment? ( )yes ( )no

In the last month
Have you traveled or had contact with anyone who has traveled? ( )yes ( )no
If so, what's the place?

Any other information that you consider important that your doctor knows about the COVID-19 pandemic?

Date ______________________________ Signature: __________________________

Source: Adapted from recommendations of the European Society of Plastic Surgery (EURAPS)®.
Appendix 3. Telemedicine - Model of consent term, information, and clarification of the patient.

Name: 

RG: ___________________________________________________________________________ CPF: ___________________________________________________________________________

• 1. From the preliminary information:
1.1. Having regard to the period of exceptionality caused by the COVID-19 pandemic;
1.2. Considering the positive manifestation of the Federal Council of Medicine to authorize the population's care via Telemedicine;
1.3. The patient is aware that it is exceptional care, while the manifestation of COVID-19 lasts;
1.4. The patient is aware and agrees that remote care may be rejected if the patient's necessary effect does not have the required impact on the patient, or may be replaced by the face-to-face consultation, at the discretion of the physician;
1.5. The patient is aware that the doctor will safeguard the confidentiality and integrity of the information.

• 2. Of the risks:
2.1. I declare that my express and spontaneous desire to pass medical information about me through online means of communication (at a distance) is subject to the following situations:
   - loss of connection during teleconsultation;
   - need for a new connection for continuity of teleconsultation;
   - variation in the establishment of the connection.
2.2. I declare that I am aware that the information provided by me, via online, may be recorded and stored by the doctor mentioned above, who will keep due confidentiality as required by law.

• 3. From the final considerations:
3.1. I declare that I am aware that the procedure concerned will not be carried out without the prior face-to-face consultation to be carried out with my doctor and that my refusal to comply with this protocol will result in the non-performance of the services provided by the doctor, not providing any such duty of redress;
3.2. For this reason, I declare to be aware that telemedicine care was chosen by me, together with my doctor, because of the impossibility of face-to-face consultation, due to the COVID-19 pandemic, and I express my consent to perform the consultation in question.
3.3. I have been informed even if, if I do not choose to pay the fees, if applicable, I should go to an outpatient clinic or hospital for face-to-face care.

( ) I understood and have no doubts.

____________________________________________________________ of ________________________________ of ________________________________.

Signature of the patient or guardian (legible).

____________________________________________________________

Physician's Signature

Source: https://www.sbmastologia.com.br/medicos/noticiasmedicas/modelo-de-termo-de-consentimento-e-esclarecimentos-ao-paciente-sobre-teleconsulta/
Appendix 4. Suggestion of an informed consent form (used in whole or parts).

INFORMED CONSENT FORM AND TERM OF RESPONSIBILITY FOR PERFORMING PROCEDURES AND SURGERIES DURING THE COVID-19 PANDEMIC PERIOD.

I, ______________________________________________________________________

(a) of the RG

of ______________________________________________________________________

by Dr. (a)

COVID-19 - I was duly clarified by the surgeon, and I am fully aware of the risks to which it will be exposed in the perioperative and immediate postoperative period, especially during the hospitalization period, referring to possible and possible contamination by COVID-19, also called a new coronavirus. Such risk will result from contact or approximation with other infected people, even if asymptomatic or even with other health professionals and with medical-hospital materials that may be infected. I am aware that any infection with COVID-19 may cause fever, muscle pain, difficulty breathing, and even death in my body.

In the immediate postoperative period, I commit to performing a home quarantine, for 74 (fourteen) days, a period in which I will not have any physical contact with third parties. I will systematically sanitize myself with alcohol gel, as explained by the surgeon and, even inside the residence, I will use the respiratory mask during the 74 (fourteen) days.

In the immediate postoperative period, I commit to, during the 74-day home quarantine, to be available to my Plastic Surgeon, for remote monitoring, through teleconsultation and telecare, as authorized exceptionally by the Federal Council of Medicine and the Ministry of Health.

( ) I understood and have no doubts.

___________________________________________________________________________

Signature of the patient or guardian (legible).

___________________________________________________________________________

Physician’s Signature

___________________________________________________________________________

Witness signature