COVID-19 Pandemic and Anesthetic Challenges in Indian Scenario

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Due to the widespread nature of the COVID–19 pandemic, the safety of anesthesiologists is an international concern. Many international societies have issued consensus statements or guidelines for the anesthesiologists during the COVID–19 pandemic.1,2 These guidelines should be adopted strictly to prevent disease transmission. As the pandemic progresses, patients ranging from asymptomatic carriers to those who present with a false negative COVID–19 test may approach the anesthesiologist. Thereby, in this situation, the need arises for proper precaution for all aerosol-generating medical procedures, and anesthesiologist should renew their familiarity with airborne isolation procedures, which are seldom necessary in routine anesthesia practice. However, to follow all the steps of these guidelines properly is challenging in the Indian scenario. Local modification for safety of healthcare workers is the need of the hour.

The Royal College of Anesthetists and the Canadian Anesthesiologists’ Society have advocated using powered air purifying respirators (PAPR) during the COVID–19 pandemic.3,4 However, many Indian scenarios due to the lack of video laryngoscopes in some operation theater complexes.5 For us, a standard Macintosh blade and a bougie is likely the best option, but one should be careful while removing the bougie or stylet, so as not to spray secretions on the team. Double gloving for airway management and discarding the outer glove immediately afterward has been shown to decrease environmental contamination. Confirming correct depth of tube insertion is extremely difficult, as auscultation of the chest is problematic when wearing the PPE. It is recommended instead to observe bilateral chest expansion, end-tidal CO2 waveform, and respiratory parameters. However, all ICU setup may not have capnography. The guidelines recommend careful monitoring of airway cuff pressure to avoid airway leak.1,6 However, cuff pressure monitoring device may not be available in the peripheral centers of India. Another similar concern is the availability of closed tracheal suction.

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COVID–19 is a far more extensive challenge encountered by the global medical community. Yet, the key principles of meticulous team-based planning in accordance with local protocols and strict adherence to barrier precautions remain crucial. “Standardized practice” should be developed according to the local institutional policies. It is thus important that anesthesiologists are well-prepared with local modifications of these guidelines and ready to act when called upon.

Conflict of Interest
The authors hereby declare that they have no conflict of interest.
References


