GUIDELINES FOR TURBULENT TIMES

This is, unfortunately, a sad continuation of the March editorial penned by Sheraz M. Daya, MD, FACP, FACS, FRCS(Ed), FRCOphth. It would be difficult for me not to follow suit and focus on the burgeoning global pandemic of COVID-19. It is engulfing all functions and factions of our daily lives.

As I'm writing this, I have on in the background an international news channel that displays in the top right corner a real-time count of the number of confirmed global cases and deaths. From the beginning to the end of this dictation, I saw the numbers jump from 615,000 to 618,000 confirmed cases and almost 30,000 deaths. (Five days later, the corresponding numbers jumped to almost 1 million infected and nearly 50,000 deaths!)

In an effort to compose my thoughts and direct my actions in this time of crisis, I consulted the websites of the European and US Centers for Disease Control, the World Health Organization, and the AAO.[1-4] I was pleasantly surprised by the similarity among the guidelines these resources have laid out to the measures we have enforced in our practice. The key concepts of the guidelines are (1) limit how germs can enter a facility; (2) isolate symptomatic patients as soon as possible; and (3) protect health care personnel. I will add my own fourth guideline: practice caution and protection for our family.

In my practice, in lieu of the significant shortage of personal protective equipment and disinfecting equipment, and the given guideline of a 14-day incubation period for the virus, we split our staff into two shifts; shift 1 works for 2 weeks and then is off for 2 weeks while shift 2 works.

Under this new normal, we postpone routine appointments such as annual examinations and follow-ups. All prescription refills are done electronically or over the phone, and we recommend to all glaucoma patients to create a 3-month reserve of their drops. We also carefully triage our patients using telemedicine. For example, we ask patients during a telephone discussion to use their smartphone or camera to provide images of their ocular symptoms. In this way, we can eliminate patients coming into the office for minor issues. Only those who warrant examination are asked to come in.

We are also limiting follow-ups in refractive surgery patients and asymptomatic post-cataract patients. All scheduled elective refractive and cataract surgery procedures have been postponed until further notice.

Patients who must come in for treatment are triaged carefully. Recent travel and personal and family medical history are obtained; we specifically ask about the symptoms associated with COVID-19 (sore throat, coughing, sneezing, and/or fever). When a patient enters our practice, we use an infrared thermometer or an industrial remote thermometer that can scan the forehead from a distance of 1 feet and 3 to 6 feet, respectively. And we provide face masks, gloves, and disinfecting gel to all patients who come in. Additionally, we made a makeshift nylon shield for the opening in our front-office counter. We try to limit contact with charts and papers, which is easy in our facility because we use electronic health records and base our entries on the following: a phone conversation prior to a patient's examination, the in-office conversation with the patient, and video of the slit-lamp examination. This information can be transmitted electronically to the physician who can—in almost 95% of cases—evaluate and care for the patient from a distance.

After each patient leaves a room, that room is disinfected with a proper alcohol-containing spray—the guidelines note concentration of 70% to 95%. All gloves and gowns are disposed.

We are still treating patients who require urgent surgery. I did an emergent glaucoma procedure yesterday and took extreme care measures. We used the minimum possible staff: the anesthesiologist, one scrub nurse, and one circulating person. Only two other staff were in our center, and we minimized staff-patient contact. The pre- and postoperative periods were done in a predesignated room with the patient's name on the door. Everybody in the room was wearing an N95 mask, and the patient was wearing a disposable face mask. Every staff member was wearing eye guards to avoid droplet transmission.

On another note, it is unfortunate that scientific meetings are canceled or postponed, as they are our nutrition for continuing medical education and for sharing our experiences. My practice is exploring more electronic means of communication, and I think that our field is privileged in that regard.

CRST Europe is a valuable tool for staying informed, and I encourage you to go online and look back at previous issues—I'm sure you will enjoy and learn a lot. For real-time coverage of COVID-19 in relation to ophthalmology, a great resource is eyewire.news/covid-19/.

I hope that, by the next issue of *CRST Europe,* we will have an editorial with better news to discuss. But as we enter week 4, we are still not sure when things will improve. As we monitor the ominous spread of this pandemic, my heart goes out to the cities and countries that have been stricken the hardest, and my thoughts go out to all of you who are involved in the care of these patients. I wish you to stay safe! Let us all try to get through this as soon as possible by employing precautions, patience, and perseverance! ■

1. List of urgent and emergent ophthalmic procedures. American Academy of Ophthalmology. https://www.aao.org/headline/list-of-urgent-emergent-ophthalmic-procedures. March 27, 2020. Accessed March 31, 2020.
2. Information for healthcare professionals. Centers for Disease Control. https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html. Updated March 26, 2020. Accessed March 31, 2020.
3. Coronavirus disease. European Centre for Disease Prevention and Control. https://www.ecdc.europa.eu/en. Accessed March 31, 2020.
4. Guidance for health workers. World Health Organization. https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/health-workers. Accessed March 31, 2020.

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