

The impact of the covid-19 pandemic on the workland of a tertiary vascular surgery department

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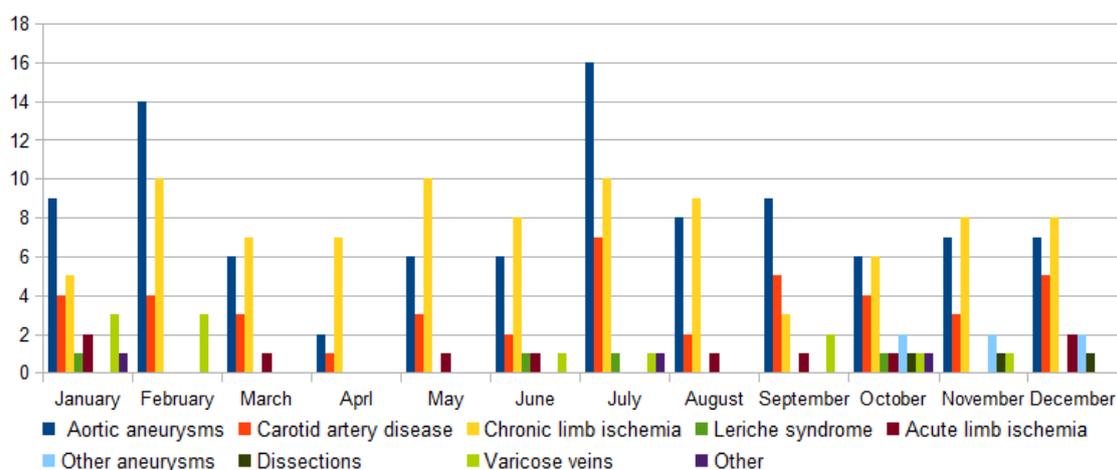
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The COVID-19 pandemic has undoubtedly affected surgical practice worldwide. These changes encompass human resources, the capacity of intensive care units, the choice of treatment, as well as the nature of surgical emergencies.¹

From the beginning of the pandemic until today, many alterations have been established in the department of vascular surgery, of 'Laiko Hospital', Greece. The majority of scheduled operations were postponed and rescheduled. This is mainly due to the reduction of available operating rooms, as well as the fact that part of the staff was absorbed in the newly designed COVID units. Especially during the first lock-down that the restrictive measures were stricter, and according to the

guidelines of the Society for Vascular Surgery as well as the relevant notice from the Hellenic Society for Vascular and Endovascular Surgery, the operations were limited to those considered 'more urgent' or 'more serious'.²⁻⁴ As a result, operations involving varicose veins, intermittent claudication, asymptomatic carotid arteries, and 'small' or asymptomatic aneurysms have been reduced or cancelled.

From the second lock-down onwards, although the operating rooms did not increase, there was no limit to the nature of scheduled operations for carotid stenosis and aneurysmal disease. In contrast, operations for varicose veins and chronic limb ischemia continued to be postponed. (Figure 1)



As a result, patients who in the pre-COVID-19 period would be admitted for inpatient management, such as patients with venous or diabetic ulcers, are now treated as outpatients. In addition, patients with limb ischemia who presented to our emergency department a higher Rutherford score grade of ischemic damage, and this is also a global observation.^{5,6} This is a result of the limitation of surgeries for intermittent claudication and to the patient's phobia of being examined in a hospital in the midst of a pandemic.

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For the smooth operation of our vascular surgery department, the Infection Committee of our hospital created a protocol to prevent of the COVID-19 spread. We perform molecular tests upon the admission of the patient, while in order for the patient to enter the operating room there must be a negative molecular test counting a maximum of three days.

As far as emergency surgeries are concerned, a rapid test precedes the surgery, while a molecular test is taken at the same time.

In conclusion, it is well known that there is a direct correlation between delayed treatment and its consequences in the vascular patient. So as the pandemic continues and selective surgeries are reduced or postponed, there may be an increase in emergency surgeries in the post-COVID period. Given the complex nature of vascular surgery and the comorbidity of the vascular patient, the COVID-19 pandemic is a challenge for the vascular surgery community. It is therefore clear that the COVID-19 pandemic has affected the health system worldwide and in all its areas.

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