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MINI REVIEW

Our Experience in this COVID 19 Pandemic – A unique perspective of Department of Plastic Surgery at a Government run Institution

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Abstract

The corona virus pandemic which has taken a grip over the world has halted not only the medical fraternity but also impeded the daily life of the citizens. The medical fraternity has taken multiple steps to deal with the COVID pandemic including changes in standard operating protocols, management of patients both routine and emergency.

In countries with limited resources like India, strict measures were taken to handle the expected casualties of the pandemic. Resources in the form of not only materials and consumables but also staff were diverted for frontline management. Diversion of staff included not just allotting duties in COVID wards but also their prior proper training especially for those fields which are remotely associated with respiratory infectious cases.

With others our institute, also has taken this responsibility with great aplomb. There were infrastructural changes, training of faculty and residents even those who are remotely associated with medicine patients, drawing up protocols within limits of the resources available.

Here we reiterate our experiences in this COVID pandemic- how our department was affected and an insight into the happenings during COVID duties

Keywords: COVID-19, Perspective, Plastic Surgery, Personal experiences

1 | INTRODUCTION

Coronavirus disease 2019 (COVID-19), an infectious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)[1] was first identified in December 2019 in Wuhan, China. Since then it has led to the current ongoing pandemic[2,3]

The first case in India was noted in Kerala on 30th January.[4]. In Maharashtra COVID cases were first reported in Pune[5]. The first two positive cases in Nagpur were reported on 13 march 2020[6]. Since then

the incidence of cases has been on an upward hike.

While people were gripped in the fear of contracting the virus, the nationwide lockdown, announced by Prime Minister Narendra Modi on March 24, led to severe disruptions in normal day to day activities of the citizens. With insufficient factual data there was and still is widespread confusion among people[9]

The batten of COVID 19 patients responsibility was first taken up the two government medical colleges in Nagpur i.e. GMC and IGGMC as soon as the case toll started to rise in Maharashtra and with the publishing of country wise guidelines by WHO[3].

With widespread infrastructural changes in the campus, the faculty and residents doctors of various specialities of GMC Nagpur, including our department of Plastic Surgery were geared up to be posted as frontline officers in the newly developing COVID wards.

We hereby post experiences by our department during this COVID pandemic especially how the departmental work was affected, experiences of doctors when posted in COVID wards and problems faced by us.

Infrastructural changes

Trauma care centre which is a two storey building was converted into a comprehensive COVID centre at Government Medical Nagpur on 23 April 2020 (figure 1) The trauma centre has around 225 beds which was divided into three Intensive Care Unit with 25 beds each of each five High Dependency Units(HDU) with thirty beds each.(11). Bed Head panels (figure 2) which included a central suction port, two oxygen ports and four electrical points, were placed in all wards over each beds. New ventilators were procured for all the ICU's.

One of the ICU was a SARI (severe acute respiratory illness) or presumptive ward on the ground floor .The SARI ward was meant to serve for the initial suspect patients before they were tested for COVID. Of these 5 beds were exclusively allotted to Obstetrics and Gynaecology patients.

The trauma care centre operation theatre was converted into an exclusive operation theatre for COVID patients with surgical indications. Few wards in the main building of GMC hospital, which is separate from trauma centre were converted to COVID ward. This also included two plastic surgery wards for male and female patients. These wards were upgraded with central oxygen supply and suction system ports to each bed (figure3). Our patients were shifted to other surgical wards during COVID 19 period

In preparedness for a surge of patients in Mid May,[12] the two storey 90 bedded ICU centre next to plastic surgery theatre was also converted into COVID - ICU.

Multiple Barricades were created to isolate COVID-19 patients movement from other general patients in the main building.

Patient Flow

All COVID suspected patients from COVID OPD, medicine OPD, and casualty were initially admitted in the SARI or presumptive ward, from where all COVID RT-PCR positive patients were transferred to HDU or ICU depending on their clinical status. COVID negative patients were transferred to wards in the main building. They were kept under observation for 14 days. This changed later as per Ministry of Health and Family welfare Guidelines [13] wherein the patients were treated symptomatically and discharged.

COVID positive were treated on indoor basis for 14 days. With patients showing symptomatic improvement a COVID testing was done on 14^{th} day. If this came out to be positive they remained admitted for another 7 days and again tested on 21^{st} day. If COVID testing came out to be negative these patients were discharged. These guidelines were later revised by MOHFW [13] with

Supplementary information The online version of this article (https://doi.org/10.15520/ijmhs.v10i09.3103) contains supplementary material, which is available to authorized users.

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- Patient being discharged (a) if asymptomatic for 3 days and (b) after 10 days of symptom onset
- No need for testing prior to discharge
- Patient was advised to isolate himself/herself at home & self-monitor his/her health for further 7 days

Patient from contact tracing at various quarantine centres which are established in Nagpur like- MLA hostel, VNIT College Nagpur, Symbiosis college were tested at their quarantine centres. Those who tested positive were directly admitted to HDU or ICU depending on condition of patient and ICMR guidelines

The COVID positive patients were divided into three categories viz mild, moderate and severe[13].

- **Mild cases** included asymptomatic patients who had suspected or was a close contact with a positive patient. These cases were kept in quarantine centres.
- **Moderate cases** included Symptomatic / URTI without comorbidity. they had complaints of the following 3 out of 4 of these symptoms ie fever/ dry cough/ Shortness of breath/ Myalgia
- **Severe cases** were Symptomatic / URTI with comorbidity like Obesity / >60 years / DM / HTN/IHD / COPD/Chronic lung disease / Immunocompromised state / Immunosuppressive drugs / CKD

The moderate and severe cases were admitted at the COVID centre.

Training program [7]

All residents and faculty had to undergo a total 18 hrs training over two days, before they were assigned duties in the COVID units. Even dental surgeons and technicians were required to undergo training.

The scheduled training program (figure 4) included didactic lectures on day one. These lectures were taken by various departments such as preventive and community medicine , microbiology, anaesthesia and General medicine. The lectures taught us various protocols in prevention of infection, diagnosing cases, treatment of various categories of COVID patients, critical management of ARDS patients. We were also showed how to work on ventilators and interpret the various graphics on the ventilator screen. This is something which a plastic surgeon doesnot routinely comes in contact with or even learns.

A simple hand washing tip was given which elaborated the 6 steps of hand washing expressed in the pneumonic in local tongue- 'SUMAN-M', Which stands for- S- saral (mean palmar hand),U-ulta(dorsal aspect of hand)M-mooth (means fist),A-aangtha (thumb),N-nakh (nails),M-managat(wrist)this was the acronym which also helped us to teach common public, how to hand wash.

The lectures helped clearing our minds from the vast ocean of confusing information which we get from various scientific and social forums.

The training emphasized about the correct method of donning and doffing of personal protective kit (Figure 5)

On the second day, hands on training was conducted for working on various machines in ICU and indications on how to use them and methods to ventilate patients in respiratory distress. This included mask ventilation with and without reservoir, nasal prongs, non-invasive ventilation, basics of ventilator managements, hands on intubation, routine laryngoscopy and video- laryngoscopy. We practiced on dummies various different intubation methods.

The nurses were trained about giving injection and drugs, nursing patients while maintain self protective measures. The attendants were trained in various disinfection techniques, swab collection and cold chain maintenance. They were also educated regarding procedures of personal protection and community spread prevention

Adjustments in Departmental Work

We were instructed to continue with OPD and routine Procedures as before. Plastic surgery OPD though was working there was major drop in patients during the lock down of two months with only 170

patient coming to our OPD as compared to 989 patients during the same months in 2019.

The total patients operated during this lockdown phase is shown in the table 1. There was a marginal decrease in routine cases operated as both ie patients being admitted through OPD decreased. Patients who came to OPD were also not ready to get admitted and operated as our hospital was converted to a COVID centre and had a fear of contracting the disease.

The emergency cases were affected by only 50 % (Table 1). The emergency cases were being operated as usual though patients from other districts decreased b because of lockdown. This lockdown may also be the cause of less accidents because of less movement of people on roads.

Many a times in the beginning there were no PPE kits available for routine and emergency plastic surgery procedures. Because of social stigmatisation proper history was not being given by the patients and this inadvertently led to the doctors and OT staff getting exposed to COVID positive patients. This especially happened when we operated a case of Upper limb replant who later gave a history of travel from Assam.

Later as PPE kits were made available by the institution and various other NGO's we adopted a strict policy of using PPE kits. To use our magnification loupes we modified our transparency face shields by cutting out two holes for the loupes.(figure 6)

The department of Plastic surgery underwent numerous changes. Plastic surgery wards including both male and female wards were transformed into COVID wards. The plastic surgery patients were shifted to a common surgical ward. We had to adjust with the conflicts of the nurses in those wards as patient management and especially dressing protocols were vastly different as those practiced in our wards. The wards were also non equipped with major dressing equipments and materials commonly used in in plastic surgery.

In addition to regular post graduates academic timetables, the surge in webinars have been an added bonus. This was mainly because of the residents hearing experts in various fields from not only India but all over the world.

My work and experience in COVID Ward

From the department of Plastic and maxillofacial Surgery, Dr Vivek G. Supaha, a third year resident was allotted COVID duty from 4th may to 19th may 2020 .

A total 32 residents were posted in COVID hospital, from various specialities and subspecialties and constituted total 8 teams, 4 residents in each team.

4 teams were assigned to the SARI ward on ground floor and 4 teams for two HDU,s and one ICU.

A Team constituted of a team leader and three other residents from medicine general surgery and paraclinical branches . Our duty schedule was in three rotations 9:00 am -3:00 pm, 3:00 pm -9:00 pm and 9:00 pm-9:00 am forth team was on night off and used to relieve night shift team as shown in table attached (figure-7).

During my posting in SARI ward from 4.5.2020 to 19.5.2020, I Dr.Vivek G. Supaha was a team leader and my team members were Dr. Jitendra Gedam (JR3 General medicine) Dr. Ashwin Damdoo (JR3General surgery) Dr. Atmaram Chowdhari (JR 1Radiotherapy) (Figure 8).

There was categorisation of residents and faculties depending on their specialities (Figure-9).

As the SARI ward was the initial admission ward of all presumptive patients ,we encountered patients ranging from being asymptomatic to critically ill patients. We were given four N-95 masks along with 4 plastic envelopes on the first day of our duty. the masks had to be reused every 4th day by rotation and each used mask to be kept in a separate envelope after use.

The SARI ward being the ward to admit suspected patients, strict measure were to maintain low infection transmission rates. This included patients being given triple layer masks at the time admission and were allotted thoroughly sanitised beds. The patients were kept one metre apart. Patients were asked to wash up and sprayed with disinfectant before admission to ward. There was no provision for any relative accompanying the patient. Patient care was completely done by doctors, two nurses and one ward attendant and one sweeper.

Intially in view of shortage of PPE-kits, we planned one person should go in ward wearing PPE-kit and do all necessary daily work by rotation duty. The file work was allotted to the radiotherapy resident, and if any patient was bad in a general condition requiring intervention like intubation, central line placement two resident used to go inside the ward after donning PPE-kits. Wearing a PPE kit and being in it for 6 hours was a big challenge in mid-summer when the temperature hovered to around 42 to 45 degree centigrade as there was severe perspiration in it, specially with no air conditioners and few ceiling fans. We felt severely dehydrated and tired after doffing the PPE kits. Sometimes because of severe dehydration and body ache in the PPE kit, there was clouding in our judgement and we had to take frequent breaks in between. This increased our requirement of PPE kits.

On my first day, we had 8 patient which were there in our ward. All patient were suspected COVID-19 patients whose throat swab reports were awaited. Like mentioned earlier they were all referred from COVID OPD, medicine OPD, respiratory medicine OPD. These were patients who fitted in diagnostic criteria of SARI[8] as per ICMR guidelines . We had to manage these patients till their report came. This included sending all routine investigation like CBC, LFT, KFT, Chest X-ray and throat swab for COVID 19.

All patients were prophylactically started with following treatment regimen, “cocktail regimen” as we use to call it, which included

- Tab Azithromycin 500 OD
- Tab Tamiflu 75mg bid
- Tab .Vit C OD
- Tab Zinc OD
- Tab Pantocid 40 mg
- Tab Paracetamol 500 mg TDS

Patients who developed fever -fever profile investigation were done along with strict fever charting. Those who had radiological findings on chest X-ray like consolidation, effusion they were started on intravenous antibiotics.

ENT residents who were exclusively posted for throat swab collection used to came at 9.00 am & 3:00 pm daily. The nasopharyngeal and oropharyngeal swabs were collected and placed in the same tube to increase the viral load, one attendant has to be accompanied with him for carrying cold chain (VTM)Virus Transport Medium[(14)].

On 1st two days HIV kit was given as PPE kit , which was open from the back and extending up to knees only, no face shield, no eye protection. We called our MARD president and good quality PPE-kit were immediately provided to us by MARD.

During my posting I encountered many Obstetrics patients. We conducted 3 vaginal delivers with the help of Obstetric resident. I personally assisted in two deliveries. Two labor patients had to be shifted to COVID OT for emergency Caesarean section. These two patients came out to be positive later.

Unfortunately, we had 3 mortalities in SARI ward. One case was carcinoma lung with multiple metastasis. Patient was breathless on admission and was immediately intubated. He expired within half an hour of admission. His post-death throat swab was sent which came negative and body was handed over to relatives. Another patient with carcinoma bladder with septicaemia was admitted with respiratory symptoms, also could not be revived in spite of all resuscitatory efforts, even his report was negative for COVID -19 . The third patient was MDR -TB whose COVID 19 report came positive. He was shifted to HDU-5 and died after 2 days. His body was disinfected and packed and sent to incineration. It was not handed over to relatives. But just before packing the body face was shown to the relatives for MLC and identification purposes.

Problems, crises and solution to it

We had many difficulties like poor quality PPE kit, N-95 masks, no blood collection bulbs etc, limited attendants .

We had to think of local solutions to these problems without causing breach in preventive measures. For e.g. I mobilised blood sample collection bulbs from

my juniors maintaining social distancing at the same time.

Many a times there was difficulty in procuring sample request forms in our wards. Since we were in isolation we had little money with us for emergency .

Just so that patient sampling and decision making was not delayed we had to pool this loose change to get the forms photocopied by the attendant instead of waiting for fresh form supply by the medical stores which was a huge challenge.

Another problem we noticed was that common washroom was provided for all male and female patients in our ward, making them it too uncomfortable, so we made a timetable which alloted alternate hour to male and female patients, plan worked well..!

Sometimes because of inadequate resources, the doctor in PPE KIT shouldered the responsibility of staff nurse like giving tablets and injections.

Though microbiology lab was functional for 24 hours, ENT resident used to came at 9:00 am and 3:00 pm only and due to lack of attendant to carry transport medium, samples could not be reached lab on time and there was undue burden of repeated sampling on resident. Two patients whose reports were delayed and found to be positive after 4 days, reason being inadequate sample and breakage of cold chain because of unavailability of attendant at the right time.

Personal Experience- Our ray of hope

In the early phase of the pandemic, eight resident doctors and four paramedical staffs of GMC Nagpur were quarantined after they came in contact with a Diabetic and Hypertensive patient, who deliberately hid the history of his being in contact with his COVID positive younger brother who was already under treatment at IGGMC[10]. This lead panic not only among the residents but also their families on hearing about the incident. The importance of the pandemic was then realised among the residents. This also lead to the personal protection measures being strictly followed in casualties not only by doctors but also by the nurses and attendants.

During this extreme gloom and stressful work, with daily increasing death toll seen worldwide, we found happiness when our patients came out safely and were being discharged happily. The smile on their faces was what which kept us going.

I and my other colleague are exams going and appearing for my final year examination, so it was difficult for us to concentrate on studies after corona duty so, still I used to study 3-4 hour each day while resting in my isolation room. As the exams were indefinitely postponed until further notice we readily signed up for COVID duties. We all were quarantined for 7 days before joining our respective departments. In the end, we all felt we made contribution to the society.

To show their support various organisations over the city helped the institution by donating PPE kits and masks. Various departments in the hospital itself also helped the doctors by providing the wards with eatables and snacks

In India, it has also shown a certain degree of unity among the citizens. It has inspired many health care workers to get out of their comfort zones and fulfil their responsibilities to their country and the people

It was a different but life learning experience during our posting in the COVID wards. We carpooled from our isolation hotel to our COVID wards. This helped us in develop bonding between resident of different specialities like anatomy, preventive and community medicin etc especially those we never used to come in contact in our otherwise daily routine.

Our residential arrangement was made in Centre Point Hotel one of a best 3 star hotels in the city, in Lokmat square. Our daily requirements of sanitization, hotel laundry, food arrangement were very well taken care off. We are grateful and thankful to the owner of the hotel for his selfless and non-profit based service and provided isolation arrangement to working doctors and nurses and other staff so our families could be protected from exposure. Especially considering the prejudice that the fighters of COVID were subjected to in various parts of the country (reference)

2 | CONCLUSION

As aptly said by sir John F. Kennedy

"Every area of trouble gives out a ray of hope; and the one unchangeable certainty is that nothing is certain or unchangeable."

Managing initial stages of COVID outbreak taught us following lessons firstly departmental emmergency plans must be ready for manpower cuts and redistribution of departmental work for such nation wide emergencies, secondly administrative leadership is very important for reorganisation of operative procedure list and completing it ,.lastly embracing technology is important for not only for clinical practice ,administration, communication, interdepartmental meetings and attending webinar on COVID-19 changing guidelines well as various plastic surgery topics .

Although we have dedicated our careers to plastic surgery, in times of need, we can and do have a role to play in pandemic situation.

CONFLICT OF INTEREST –None

figure 1: COVID centre at Government Medical Nagpur

figure 2: Bed Head panels which included a central suction port, two oxygen ports and four electrical points, were placed in all wards over each beds

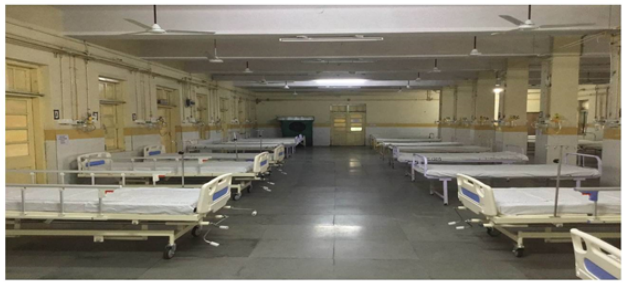
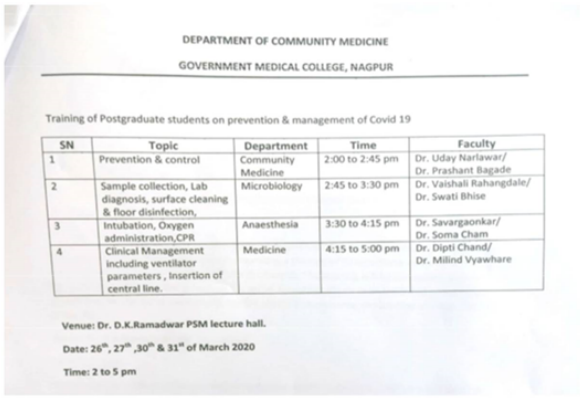


Figure3:plastic surgery wards were upgraded with central oxygen supply and suction system ports to each bed



DEPARTMENT OF COMMUNITY MEDICINE

GOVERNMENT MEDICAL COLLEGE, NAGPUR

Training of Postgraduate students on prevention & management of Covid 19

SN	Topic	Department	Time	Faculty
1	Prevention & control	Community Medicine	2:00 to 2:45 pm	Dr. Uday Narlawar/ Dr. Prashant Bagade
2	Sample collection, Lab diagnosis, surface cleaning & floor disinfection,	Microbiology	2:45 to 3:30 pm	Dr. Vaishali Rahangdale/ Dr. Swati Bhise
3	Intubation, Oxygen administration,CPR	Anaesthesia	3:30 to 4:15 pm	Dr. Savargaonkar/ Dr. Soma Cham
4	Clinical Management including ventilator parameters , Insertion of central line.	Medicine	4:15 to 5:00 pm	Dr. Dipti Chand/ Dr. Milind Vyawhare

Venue: Dr. D.K.Ramadwar PSM lecture hall.

Date: 26th, 27th ,30th & 31st of March 2020

Time: 2 to 5 pm

Figure 4:The scheduled training program

figure 5: To use our magnification loupes we modified our transparency face shields by cutting out two holes for the loupes

ty patterns of subteams in PRESUMPTIVE WARD - GROUND FLOOR - 30 BEDDED

	MORNING SHIFT	AFTERNOON SHIFT	NIGHT SHIFT
DAY 1	C1	C2	C3
DAY 2	C4	C1	C2
DAY 3	C3	C4	C1
DAY 4	C2	C3	C4
DAY 5	C1	C2	C3
DAY 6	C4	C1	C2
DAY 7	C3	C4	C1
DAY 8	C2	C3	C4
DAY 9	C1	C2	C3
DAY 10	C4	C1	C2
DAY 11	C3	C4	C1
DAY 12	C2	C3	C4
DAY 13	C1	C2	C3
DAY 14	C4	C1	C2
DAY 15	C3	C4	C1
DAY 16	C2	C3	C4

Figure-6 :Our duty schedule was in three rotations 9:00 am - 3:00 pm, 3:00 pm -9:00 pm and 9:00 pm-9:00 am forth team was on night off and used to relieve night shift team.

STAFF PATTERN FOR PRESUMPTIVE WARD - GROUND FLOOR - 30 BEDED

		TEAM LEADER	RESIDENT/ M.O.
TEAM	TEAM C1	DR SHRINKANT BAISARE (TB CHEST)	DR AMIT SHRAWANKAR (JR3) MED DR NIKITA INGLE JR3 PHARMAC DR N NAMA (JR3) SURG
	TEAM C2	DR N BAKHLE LECT NEUROSURG SSH	DR ITISHREE PANDE BIOCHEM JR DR FAISAL AHMED MED (JR3) DR G HATWAR (JR3) SURG
	TEAM C3	DR JUBIN LECT (ANAES SSH)	DR DHEERAJ KARDE MED (JR3) DR PURVI RATHOD JR3 RT DR D MOHAMMAD (JR3) SURG
	TEAM C4	DR VIVEK SUPAHA SR PLASTIC SURG	DR JITENDRA GEDAM MED (JR3) DR ATMARAM C JR1 RT DR A DAMDOO (JR3) SURG

THESE TEAMS WILL WORK FROM 04.05.2020 TO 19.05.2020

- figure- 7 :Our duty schedule was in three rotations 9:00 am - 3:00 pm, 3:00 pm -9:00 pm and 9:00 pm-9:00 am forth team was on night off and used to relieve night shift team

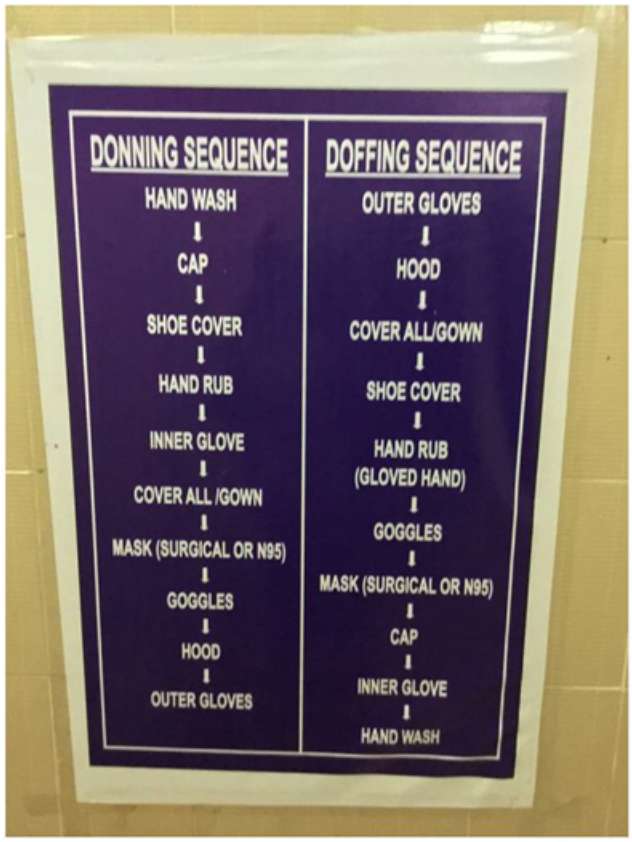
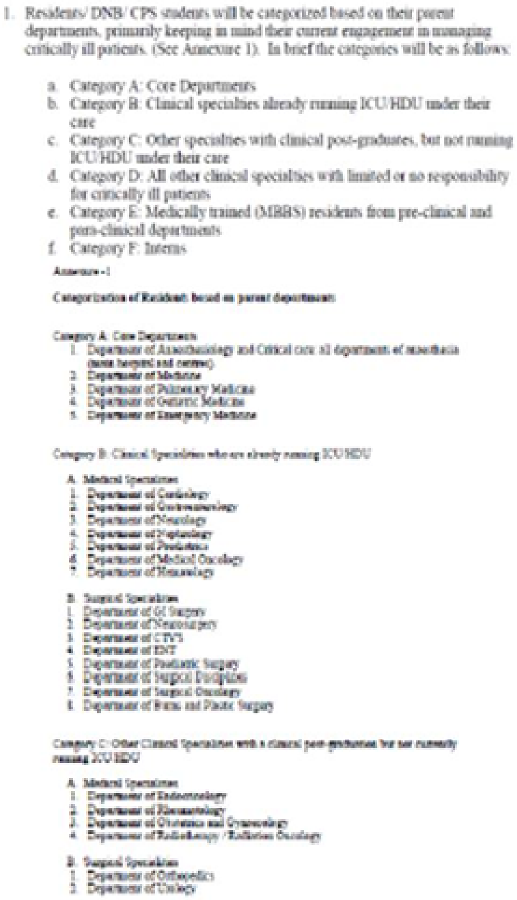


Figure 8:- Procedure for donning and dofffing of Personal Protection Kit (PPE-Kit)

	April 2019	April 2020	May 2019	May 2020
OPD	498	78	491	92
Total Surgeries	99	35	109	42
Routine	66	15	64	18
Emer-gency	33	20	45	24

Table 1:- Statistical data of plastic surgery work in lock down period compared to previous year



1. Residents/ DNB/ CPS students will be categorized based on their parent departments, primarily keeping in mind their current engagement in managing critically ill patients. (See Annexure 1). In brief the categories will be as follows:
   a. Category A: Core Departments
   b. Category B: Clinical specialties already running ICU/HDU under their care
   c. Category C: Other specialties with clinical post-graduates, but not running ICU/HDU under their care
   d. Category D: All other clinical specialties with limited or no responsibility for critically ill patients
   e. Category E: Medically trained (MBBS) residents from pre-clinical and para-clinical departments
   f. Category F: Interns

Annexure-1

Categorization of Resident based on parent department

Category A: Core Departments
1. Department of Anaesthesiology and Critical care all departments of anaesthesia (main hospital and centres)
2. Department of Medicine
3. Department of Pulmonary Medicine
4. Department of Geriatric Medicine
5. Department of Emergency Medicine

Category B: Clinical Specialities who are already running ICU/HDU

A. Medical Specialities
1. Department of Cardiology
2. Department of Gastroenterology
3. Department of Neurology
4. Department of Nephrology
5. Department of Paediatrics
6. Department of Medical Oncology
7. Department of Haematology

B. Surgical Specialities
1. Department of GI Surgery
2. Department of Neurosurgery
3. Department of CTVS
4. Department of ENT
5. Department of Paediatric Surgery
6. Department of Surgical Disciplines
7. Department of Surgical Oncology
8. Department of Burns and Plastic Surgery

Category C: Other Clinical Specialities with a clinical post-graduates but not currently running ICU/HDU

A. Medical Specialities
1. Department of Endocrinology
2. Department of Rheumatology
3. Department of Obstetrics and Gynaecology
4. Department of Radiotherapy / Radiation Oncology

B. Surgical Specialities
1. Department of Orthopedics
2. Department of Urology

Figure 9:- Categorisation of specialities depending on current engagement in managing critically ill patients.

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