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COVID-19 Letter

Indications for Interventional Pain Procedures During a Pandemic

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To the Editor

Coronavirus disease 2019 (COVID 19) has put a tremendous strain on the health-care community. The immense spread of the virus throughout the world coupled with its acute and rapidly progressive disease course has placed all health-care workers on the frontlines. As a result, most states have implemented laws to address manpower, limit ventilator use, and minimize unnecessary waste of personal protective equipment. As a result, elective surgical procedures have been put on hold throughout the country to more effectively manage the ever-increasing COVID 19 patient population. Many COVID patients require airway management and intensive care unit (ICU) treatment, including long-term ventilator support. Operating rooms around the country are now reserved for urgent or emergent cases, and in many instances, anesthesia providers have been reassigned to the ICU or emergency department (ED). Interventional pain procedures are for the most part elective but may be urgent or emergent in some specific situations. As this is the first pandemic most health-care providers have had to deal with in their lifetime, determining which cases are urgent versus elective can be both challenging and difficult in weighing risks versus benefits to each patient. This commentary discusses some of the indications for certain interventional pain procedures in the setting of a pandemic.

According to the American Society of Regional Anesthesia and Pain Medicine (ASRA), procedures that may be performed have been divided into "urgent," and "semi-urgent." Urgent procedures include intrathecal pump refills and device infections requiring explantation. Semi-urgent procedures or conditions include intractable cancer pain, acute post herpetic neuralgia, acute herniated disc and/or worsening lumbar radiculopathy, intractable trigeminal neuralgia, early complex regional pain syndrome (CRPS), or medically resistant pain syndromes (1). Patients with pain conditions have been shown to be immunosuppressed in animal models. This is especially true in patients with post-operative pain (2). Overall, the main goal is to reduce chronic pain patients need to go to the ER where they are over-burdened with COVID-19 patients and decrease the risk of COVID 19 transmission to these susceptible individuals if they were to present to the ED.

Another example of a procedure that would be considered reasonable to perform during this pandemic is vertebral stabilization, whether balloon kyphoplasty or vertebroplasty, to treat an acute compression fracture that is causing the patient significant pain. In this case, the patient's pain may be to the point that oral analgesics are not properly ameliorating their pain, thus they may have to resort to presentation to the ED.

It is in the patient's and pain physician's best interest to continue to address their pain conditions with social distancing via telemedicine or clinic visits with extra precautions. As for procedural visits, we agree with ASRA's guidelines (1). Routine and fast

procedures like epidural steroid injections or joint injections may be indicated to help control painful flare-ups that might otherwise have sent patients to the ED.

These procedures should only be performed if extremely necessary to provide adequate pain relief to prevent an unwanted hospital admission. The provider should limit the number of cases daily and must wear personal protective equipment. It would be prudent to limit the number of staff members assisting in the cases if possible. This would effectively limit potential viral transmission.

With an ongoing pandemic, larger in scope than anything seen in the past century since the Spanish Flu of 1917 – 1918, there is probably no one right answer. New guidelines continue to be published; however, a vaccine will not be ready for some time and therefore, many of the concerns that have led to our current policies will not significantly change in the near future. We as interventional pain physicians must adhere to what the global health-care community is recommending assisting in the flattening the curve, as new therapies are being developed. Our primary objective should remain to put our patient's interests first and provide responsible, quality health-care until the COVID 19 pandemic is successful resolved.

References:

1. Shanthanna H, Cohen SP, Strand N, et al. Recommendations on chronic pain practice during the covie-19 pandemic. www.asra.com/covid-19/cpguidance

2. Page G. G. (2003). The immune-suppressive effects of pain. Advances in experimental medicine and biology, 521, 117–125.