Conflict of interest

We have no conflicts of interest.

Ethics statement/confirmation of patients' permission

Not required.

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Re: Toward a consensus view in the management of acute facial injuries during the COVID-19 pandemic

Sir,

We commend Holmes et al for their recent article regarding the management of facial trauma during the COVID-19 pandemic.[1] They addressed the issue of teamwork among medical professionals to deliver safe care to patients. In this letter, we aim to highlight how public institutions and private practitioners can collaborate to manage patients with facial injuries during the pandemic.

Due to the high infectivity of SARS-CoV-2 and the number of asymptomatic carriers who are acting as transmitters, most governments have enacted containment measures to limit the spread of this disease. These measures have substantially modified our daily clinical practice in oral and maxillofacial surgery (OMFS) and they require us to focus on patients in medical and surgical emergency situations. Furthermore, human and technical resources have been reallocated to intensive care (ICU) and medical units treating patients with COVID-19, thereby changing current hospital practices and reducing resources for more commonplace operating theatre activities (described as scenario B, by Holmes et al).[1]

Emergencies that involve life-threatening conditions (such as haemorrhage or obstruction of the upper respiratory tract) need to be treated without delay in reference medical centres, irrespective of their public or private status.[2] Facial injuries can be managed differently, depending on their severity. While life-threatening cases and patients with multiple injuries require multidisciplinary management in a trauma centre,[3] others can be managed by case-by-case assessment of the complexity of the fractures, and possible referral to a private practitioner. We devised an algorithm based on the need for preoperative or postoperative monitoring in ICU (Fig. 1). We have considered that most closed fractures (such as those in groups 2 and 3 according to Holmes et al)[1] can be managed by private practitioners if the patients do not require monitoring in ICU. We have also devised a degraded procedure involving the use of tracheostomy for complex situations with no possibility of extubation.

In all cases, surgical practices should be adapted to take into account new priorities stemming from the COVID-19 pandemic: operations should be shortened to reduce anaesthetic drug use, aerosolisation should be avoided whenever possible, and all surgeons and staff should wear full protective equipment to limit transmission of the virus, as every patient is potentially an asymptomatic carrier of SARS-CoV-2.[4,5]

We are aware that this strategy cannot constitute a guideline, since it reflects only the situation in the sixth-largest French city, which comprises one public university hospital and a large number of private OMFS. However, it does reflect the importance of the partnership between public and private professionals in providing safe and quality care to our patients.

Ethics statement/confirmation of patients' permission

Not required.

Conflict of interest

We have no conflicts of interest.

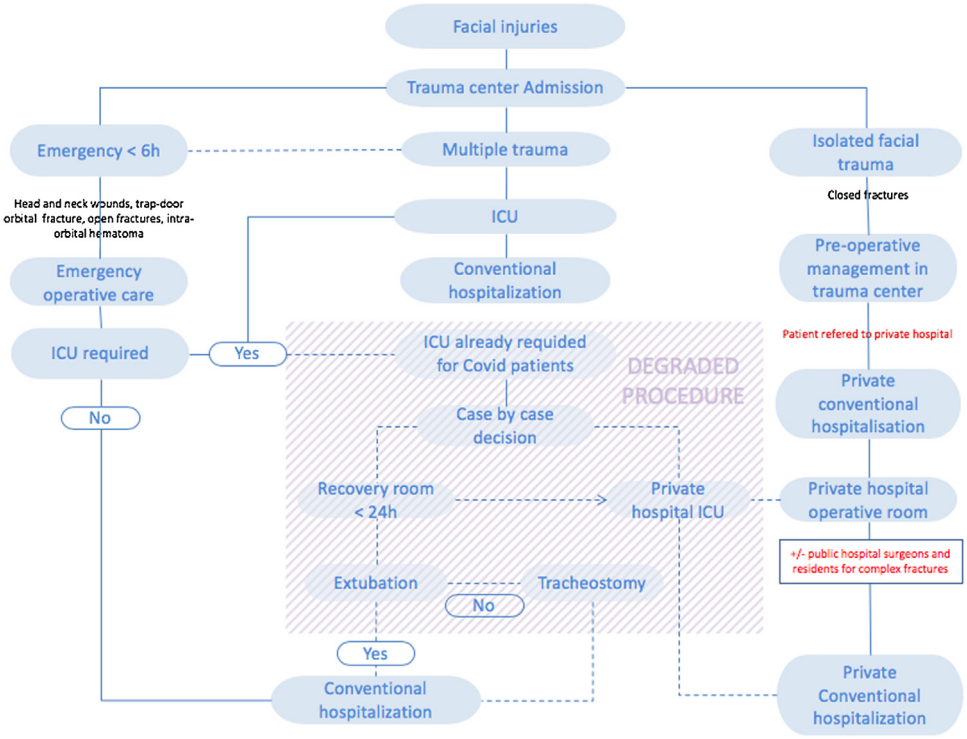

Fig. 1. Algorithm for the management of facial trauma during the COVID-19 pandemic. ICU: intensive care unit.

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