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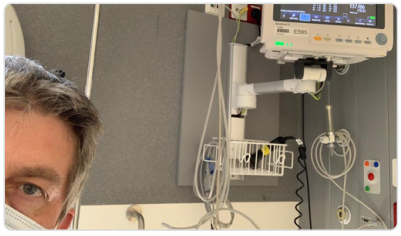
Welcome to ESRA Updates

November 2020 | Issue 03



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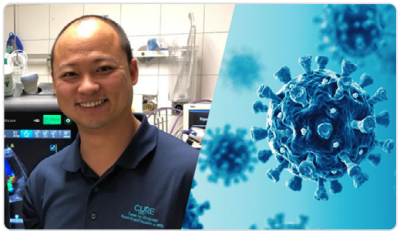

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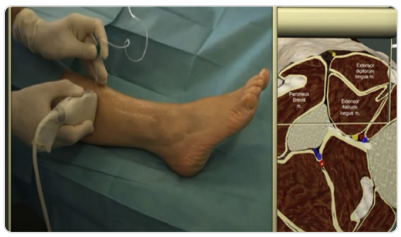

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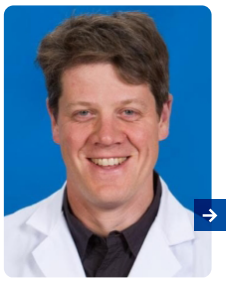

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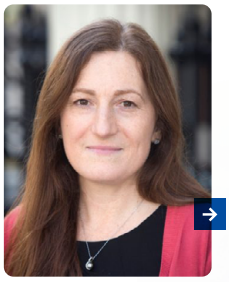

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My life during and after being sick with Covid-19

Steve Coppens (Co-editor of ESRA Updates, UZ Leuven, Belgium) @Steve_Coppens

> “ It was a rather frightful experience to be on the other side of the care program, looking up at the emergency department ceiling, hoping for the best but expecting the worst. ”

I am cured but I still vividly remember my experience with the sickness. It’s lingering aftermath still affects me to this day.

When the department of anesthesiology at UZLeuven, Belgium opened up their own ICU for Covid-treatment, we were all pumped to help out. Our other routine ICU units had filled up and it was our turn to help out the needy!

I was on call in our brand-new readymade ICU first night when the first patients arrived. The changing into full PPE is nightmarish and can only be fully understood by people who had to work in that attire for hours on end. Twenty-four hours and some intubations later I was tired but happy with a job well-done. The next few days I worked as ultrasound vascular access expert at the normal Covid-19 wards putting in central and midline catheters.

It was only a week later that I felt this enormous tiredness set in. It wasn’t really a feeling I had ever experienced before. Even now it is still pretty hard to explain. Imagine your body weight being doubled or even tripled. Every step you take feels like your wading through a marsh, which holds you back. I fell asleep at my desk at least five times during normal working hours. The strange thing is I had no other symptoms, no cough, no respiratory difficulties or fever. I didn’t experience any taste or smell deterioration either but somehow this huge lethargy and overwhelming tiredness just didn’t feel right. I did not connect the dots just yet though.

The next day however this fatigue kept getting worse, I finally decided to check on my pulse oximetry. It read 93… and only then did I realize the exhaustion was probably the real deal.

It took me some time to convince anybody I needed a test. The symptoms I had could have just been stress, anxiety and the feeling of being overwhelmed by the new tasks and the changing reality of a covid-19 world.

At the end of the next evening I received a swab, basically still only feeling extremely feeble and weary. Next day I got a pretty dry message over the phone telling me, I tested positive. I received the news without really thinking about the implications. I just checked my work e-mail and sent out a message to my colleagues. I would go into quarantine and I didn’t really feel sick, so I would see them back in two weeks’ time probably. Little did I know at the time.

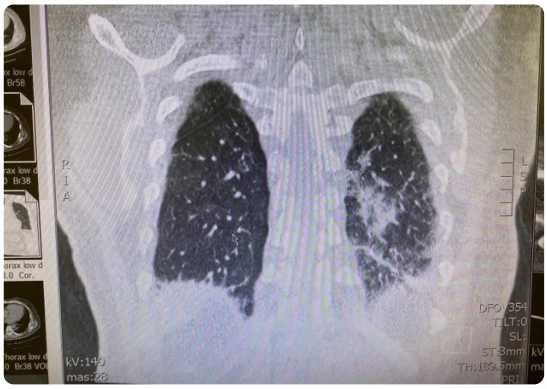
«[…] somehow this huge lethargy and overwhelming tiredness just didn’t feel right.»

It wasn't till 4 days after my positive swab that I started to have some respiratory problems. It was very subtle at first, I didn't even notice till my partner said I was breathing heavier and faster than normal. It was the beginning of what would become a real terrifying ordeal. All the other symptoms came into quick succession. Coughing, sweating, fever, even the crushing tiredness became more imposing. I sank into sleep for most of the day, lost all appetite except for sipping some water or tea. I ultimately decided that the symptoms where really alarming and I decided to go check up at the emergency department.

I distinctly recall being hauled over to radiology to perform a CT-scan. They took a blood gas and a full blood check up and I received an IV-line. It was a rather frightful experience to be on the other side of the care program, looking up at the emergency department ceiling, hoping for the best but expecting the worst.
The news that I had typical covid-19 lung lesions not that severe to warrant ICU admission, came kind of as a surprise but also a huge relief. I promised to return as fast as I could if the situation took a turn for the worst and hoped this would be as bad as it got.

However, the respiratory distress lasted another week and exhaustion took almost all of the rest of my power. At the end of the second week of breathlessness I felt like I was on the losing end of the battle. Nevertheless, after one of the worst bouts of fever, I started to respire more relaxed. A gastroenteritis lasting a full third week ended the worst of my disease.

Finally, I could start working on my condition again. I wasn't really expecting it to be that hard though. Mere walking felt like fast running. I perceived using the stairs like I had to pass an insurmountable obstacle. In addition, I began to notice that although I did not lose taste or smell, the virus had changed at least part of my olfactory sensations and taste buds. To my terror I discovered I could not stand the taste, nor the smell of coffee anymore. What a disaster for an anesthesiologist! The horror!!! (😃) When I started to prepare meals and started cooking again, my partner noticed I made it so spicy and hot it was beyond eatable for her anymore. The dulling of my flavor senses has gradually gotten better since, however it remains changed to this very day.



«The news that I had typical covid-19 lung lesions not that severe to warrant ICU admission, came kind of as a surprise but also a huge relief.»

Besides all that I still experience some focus issues. Concentration is not as it used to be. I tend to be even more forgetful then I already was (those who really know me, understand my chaotic character and agenda 😃). Strangely enough I seem to have a harder time hearing and understanding soft voices, I searched online for info, though I never found any others complaining about auditive decline it certainly has changed since my illness. Finally, I decided on buying a home trainer and getting some muscle back. Gradually I recovered some of my strength. It took me a full 6 weeks to get back to work and I started part-time for the first week. I had really missed my colleagues and the work I do. Although on calls were really hard and the convalescence is still on ongoing process, I feel like I just won a very special battle.

This period of my life was not purely perceived as negative. I learned there are lots of people who care for me. I was overwhelmed by the amount of messages from all my colleagues in the ESRA, at my hospital, family and friends. Through this story I would also like to thank each and every one of you who mailed me and wished me swift return of health.

I also learned again the value of a healthy body. Guess the cliché is absolutely true you only value things when you truly risk of losing it. In fact, I started living a little bit healthier than I had before Covid-19. Losing a few kilograms helped me stimulate some exercise and get more in shape.

I guess all in all you could say the experience made me lose some things, but I also gained a lot. It has changed my way of thinking and maybe even my whole life.

My transformation through COVID-19


Athmaja Thottungal, MBBS, FRCA, FFPMRCA, EDRA, FIPP (Kent and Canterbury Hospital, UK) @athmathottungal

> " The thought of self-control and changing the situation brought me back to the world of Yoga. "

As any other new year, in 2020 January, my personal and professional life was filled with new year resolutions, plans for various meetings, lectures, teaching, holidays and new research ideas in the field of Regional anaesthesia and Pain medicine. I kicked off my exciting journey by attending the 16th ESRA Winter Scientific meeting on 12-17th of January in Langenfeld, Austria as a faculty lecturing and demonstrating ultrasound guided regional anaesthesia blocks. It was a great week of teaching and learning. A week after I travelled to Tignes le lac, France on 22nd January to lecture and demonstrate ultrasound guided chronic pain interventions at the London Pain Forum 8th "Advances in Pain Medicine" International Winter Symposium. After these two air travel I started having a cough by the end of January. The news of Covid 19 spreading to Europe was coming out during this time. But I did not feel anything unusual than a normal cold and cough that is common in the winter season. The cough persisted for two weeks which was unusual. I was already committed as a faculty and examiner for FIPP (Fellow of Interventional Pain Practice) and CIPS (Certified Interventional Pain Sonologist) examinations conducted by the WIP (World Institute of Pain) which was scheduled for February 13-18th at Miami, Florida. As I felt my cough was better, I set off to Miami on 13th February.

Listen to the patient

On my return to UK, after 3 days I started having shortness of breath and dry cough. I felt very unwell and had to come off work. After two days started having fever, sore throat and severe myalgia. It was the time the news about the Covid was spreading like a wildfire. I was treating myself at home like a winter viral infection. I started thinking the possibility of Covid-19 infection considering the travel history, reported case locations and after 7 days of misery. My shortness of breath became severe and I could not get out of the bed other than just for going to toilet. Now retrospectively that week is just a hazy memory. The severe cough caused significant chest pain; both pleuritic type and mechanical costochondritis pain. I attended the hospital as I was starting to struggle for breath. An x ray was taken, and it was reported as "normal" As Oxygen saturation was 96% and other vitals stable, they sent me back home. The advice was to treat with antibiotics as it was nearly 3 weeks of chest infection altogether. The misery continued as the chest pain became very severe and shortness of breath increased. I attended the emergency department again after the advice from the 111 service here in UK.

By this time, the Covid-19 situation was getting out of control in many places, the protocols for testing was changing every day and the advice was to wait and see. The guidance at that time was not to test unless the travel was into hot spots like Wuhan or Spain. A routine blood test was done which was only showing some signs of infection. They changed the antibiotics to another one and I was sent home. Two weeks continued like this and my husband and 8-year son started showing symptoms. Husband had severe dry cough, sore throat, myalgia and fever and son had only dry cough and fever. They both got better after two weeks even though my husband's cough continued for nearly 4 weeks.

My cough and shortness of breath continued for further 3 weeks. As the guidelines changed by that time, we were offered a Covid testing which was almost 4 weeks since the infection started. As expected, it came back as negative. Clinically I had my left middle and lower lobe pneumonic changes. I had 4th course of antibiotic prescribed by GP which caused severe alteration of LFT. Clinically I had all the classical symptoms of Covid-19. But as the infection was during the early period of the Covid curve, the possible diagnosis was missed clinically. The chest pain and shortness of breath took nearly 6 weeks to get better. I was referred to a chest clinic and was reviewed by a chest physician after nearly 8 weeks following the first infection. By this time everyone was familiar with the classical radiological signs and haematological changes of Covid. I was given a retrospective diagnosis of possible Covid-19 infection at that time.

During my medical school training; I was taught by a great teacher that the clinical diagnosis is always with your patient itself. As a clinician we need to learn to listen to them properly. That will give you the clues for the correct diagnosis. My journey was the best example of this. It was a very emotionally and physically draining experience.

Aftermath

As I was recovering, I started noticing severe fatigue, mental "fogging" and breathlessness continuing. The multiple joint pain was severe enough to cause me struggle to get down the stairs. From a very physically and mentally active personality, I became a person who just wanted to take rest all the time. Even 20 minutes' walk was a struggle. As I learned more about Covid, it became more clearer that being an Asian female and diabetic (gestational diabetes continuing) I fall into the higher risk category for severe infection. There were several articles published about "post Covid" syndromes.

Trying to be "normal" again

I returned to full time work after 6 weeks of illness and recovery. But very soon I realised that my physical body and stamina has not recovered fully. As the "new normal" that we call now, all the consultations were remote over the phone or via video. As a Pain management clinician, I never felt comfortable making a diagnosis without the full physical examination of my pain patients. But that was the possible option due to the lockdown and social distancing guidelines. As a patient when I was on the receiving end, I was getting the same. The physiotherapy online told few exercises for improving my lung function which did not make much sense as it was just a protocol driven verbal exercise. I wondered if it was that difficult for me, what will the situation of a frail elderly person who find very difficult to comprehend our complex instructions over the phone? I did not feel it was "normal" and was not prepared accept the situation that I was in. As the saying goes- don't be a problem but be a solution; I decided to take over my own recovery.

«As the saying goes, don't be a problem but be a solution; I decided to take over my own recovery.»

A new era begins in my life

The thought of self-control and changing the situation brought me back to the world of Yoga. For me the connection with Yoga was purely in the form Asanas (postures/exercises) for the physical fitness aspect before and the other components of Yoga like Pranayama (breathing techniques), Dhyana (meditation), Yukthahara (right type of food and inputs) were neglected.

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Yoga and me

The word "Yoga" means union in Sanskrit language. Yoga is essentially a spiritual discipline based on subtle science which focusses on bringing harmony between mind, body, human and nature. It teaches the art and science of healthy living.

It dates back to the Indus Saraswathi Valley civilization – dating back to 2700 B.C., has proved itself catering to both material and spiritual upliftment of humanity. As per the Yogic scriptures, the practice of all components of Yoga leads to the union of individual consciousness with the universal consciousness. It resonates with the modern science that the universe is just the manifestation of quantum firmament.

Inner engineering and daily Yoga practice

I came across Inner Engineering programme offered by Sadhguru Jaggi Vasudev from South India during this recovery time. He is a Yogi, mystic and visionary who started a non-profit voluntary organisation called Isha Foundation. The inner engineering programme is an online training programme that guides you to learn how to look into yourself and start engineering your life the way you want it to be. (www.Innerengineering.com) This has changed my perception about self management and started doing the regular Yoga practise as well. My typical daily 1-1.5 hours of Yoga practice now consists of Upa Yoga (warm up), 12-24 cycles of Surya namaskar (sun salutation), Different types of Pranayama (breathing techniques) including Simha Kriya (specifically to improve respiratory immunity), various Asanas (Yoga poses) and Dhyana (meditation) along with Yukthahara (right food selection). There are several scientific studies showing how these practises reduce the stress levels, improve the body function, immunity and also enhances your total wellbeing. Currently I am on the road to almost full recovery. My lung capacity has improved dramatically, the joint pain and myalgia settled, feels more energetic as the fatigue is disappearing and more positive about life as a whole with clarity in my thought process again. I realised what I was missing even while doing some "Yoga" before. As it says- you will only see what your mind knows. This has been my greatest self-realisation so far.

The lessons learned to move forward

The year 2020 will not be forgotten very soon by the world. The Covid-19 virus has given us all an opportunity to understand our limitations and propels us to reflect upon these lessons learned. As a human race we have to change our ways for a better future life. This has taught us to slow down, reconnect with nature, relations and cherish what is important in life. I have definitely learned to be more joyful in life and appreciative of what is actually important as an individual. Yoga has given me that transcendental wisdom to root myself firmly showing the purpose and peace to move forward in a very positive way.

I have seen the COVID-19: My Personal Lung Ultrasound Experience

Yale Tung Chen (Hospital Universitario La Paz, Spain) @yaletung

> “ This experience was the best lesson I could have before returning to the trenches. ”

It is been almost 6 months since the day I got infected with SARS-CoV-2. During my previous night shift, I started with low-grade fever, chills, and myalgia; I did not doubt for a second that I had to have the test for SARS-CoV-2. That same day, I treated many COVID-19 patients, and they had these same cold-like symptoms, remarkably many of them did not have a known epidemiological contact, and therefore the source of the infection could not be traced, that was the sign that the virus was already among us for a while. I performed a quick nasopharyngeal swab on myself, and without time to have any other tests done, laboratory or X-ray, I self-quarantined at home waiting for the result. And finally it came in the midst of the night; I received a call telling me “sorry my friend, your result came back positive”.

In the morning, as my symptoms aggravated, and knew some new started to appear: headache, mild diarrhea, dry cough, loss of smell and taste… I regretted not having more tests done the day before, at least a chest X-ray… but, at that moment, honestly, it was a relief to have my hand-held ultrasound device at home.

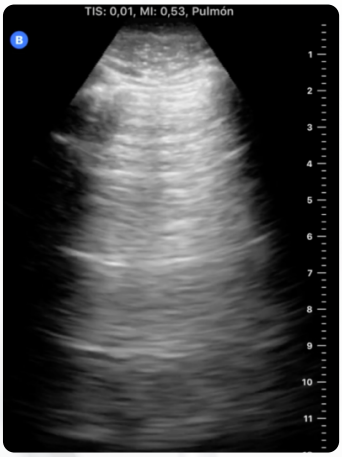
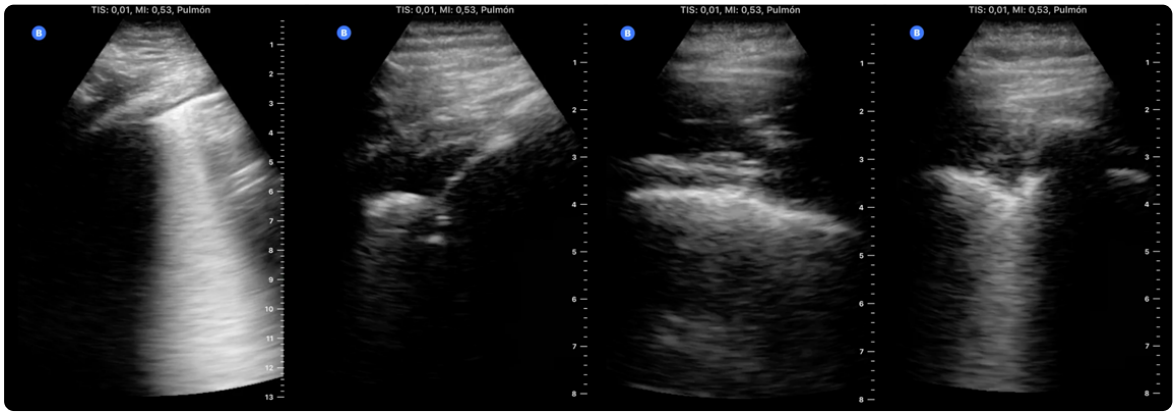


Figure 1

There is now growing evidence regarding the imaging findings of COVID-19, but at that time, the only studies were performed via CT scan or X-ray. With my ultrasound probe, I scanned following 12 zones: superior and inferior of anterior, lateral and posterior lobes of both hemithorax. I felt relieved (didn’t last long) to see there was a normal A-line pattern (figure 1). This A-line artifact is the physiologic horizontal reverberation, parallel to the pleura that you would expect in a healthy situation.

What still impresses me most about this disease is its dynamic course, with sudden changes during its evolution until resolution. In this rapid changing situation, we see one of the greatest advantages and main indications of ultrasound, since it is a safe technique that can be performed at the bedside, becomes an attractive tool for monitoring the evolution of any appropriate disease, like COVID-19. In my case, as my symptoms waxed and waned, so did my lung ultrasound. As the disease progressed, I saw all the possible lung findings, from the initial posterior B-lines (figure 2) to small pleural effusions (figure 3), irregular pleural line (figure 4) and finally subpleural or small consolidations (figure 5), especially in posterior and lateral areas. To see the evolution of the disease on figures 1-5 on live lung ultrasound scans, click on the *video link*.



Figures 2, 3, 4 & 5

In lung ultrasonography you shouldn't expect to see a high diversity of signs. The B-lines are vertical artifacts that arise from the pleura and extend to the bottom of the screen without fading, the irregular pleural line where you can see an indented or broken pleural line and consolidations, of different sizes. It is the combination and distribution of these different signs in the proper clinical history what will give you the clue of what is happening.

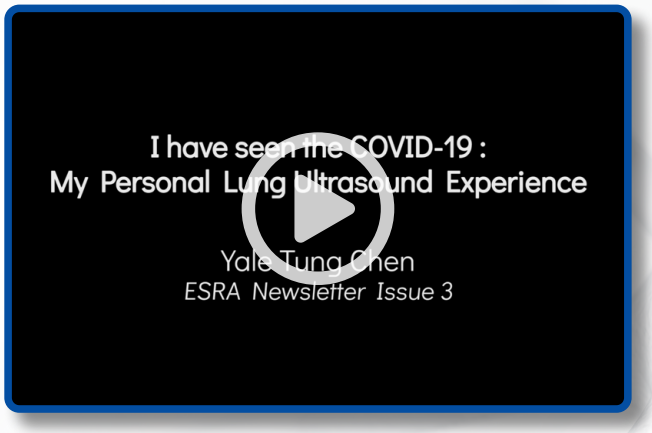
In my case, my impression was that I wasn't feeling worse when I had more B-lines, but when the subpleural consolidations started to appear and spread. Each time I had a new subpleural consolidations, there was a worsening in my symptoms coming: more myasthenia, cough, and diarrhea. Following the second week, the subpleural consolidations were replaced by B-lines, and the long-awaited improvement of my symptoms. After that, the irregular pleural line persisted much longer.

Surprisingly, during the third week, things started to worsen again, and on ultrasound there was a big consolidation appearing in one lobe, that was my sign for a therapy shift towards antibiotics. From then on, my symptoms slowly started to disappear. However, for my lungs, it took them a little bit longer, since eight weeks from the symptom onset, after recovering and testing negative for SARS-CoV-2, I still had several areas with B-lines, as well as thickening of the pleural line. This is something you could expect also during the resolution phase of any common pneumonia, and longer than that, might be an early sign of fibrosis.

As a firm 'sono-believer', I found it extremely useful switch from guessing to SEE my disease, monitor for sonographic progression and or resolution, and quickly detect complications. After this experience and having returned to work, I would have no excuse to irradiate my patients before scanning them, just the same way I went through.

Definitely, this experience was the best lesson I could have before returning to the trenches.

Watch video illustrations



Suggested reading:

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Covid & pregnancy

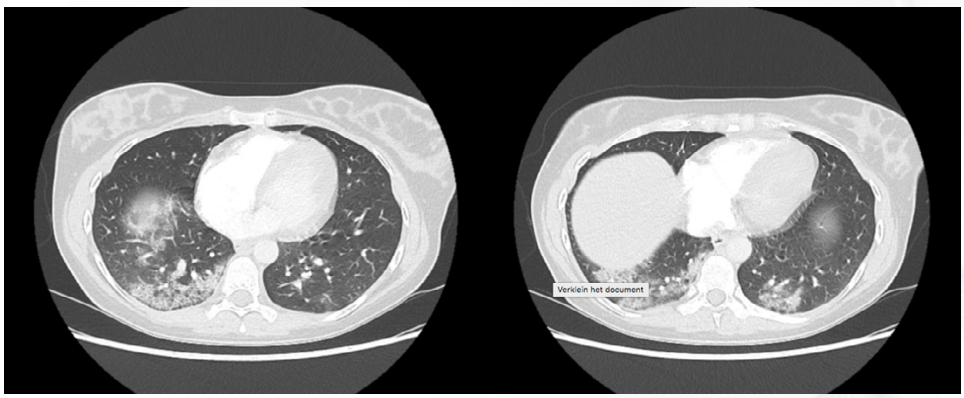
Stephanie Poels, MD (Academic Hospital Turnhout, Belgium)

> “ At 31 weeks gestation, I was diagnosed with a Covid-19 pneumonia and admitted to the hospital. ”

As anesthesiologist and intensive care specialist, I was working in the OR and intensive care unit when Covid-19 started to spread through Europe.
In the beginning of march 2020 we were preparing our intensive care unit for the Covid pandemic. Adaptations were made to double our ICU capacity and protocols were written to admit and treat the first Covid patients.
In this period I started to experience a sore throat, dry cough and shortness of breath. Also, I developed a fever up to 39°C and was feeling unwell.
A Covid test (PCR) came back negative. After seven days of quarantine at home the fever cleared up and I resumed work.
However my dyspnea and fatigue persisted, but I attributed these complaints to my pregnancy.

Because I was pregnant, I was deployed in our non-Covid ICU.
In this period Covid testing and personal protection equipment (PPE) were scarce and only used in highly suspected or confirmed cases. One of the presumed non-Covid patients I took care of turned out to be Covid positive. During this period I had performed high risk procedures without PPE.

About one week later, at 30 weeks gestation, I developed a fever again (39.6°C) and my dyspnea got worse. I got hypotensive and had multiple syncopes. A Covid test was repeated and came back negative again. Laboratory tests only showed a mildly elevated CRP. A chest X-ray was not performed considering my pregnancy. Obstetric ultrasound showed a normal biophysical profile. I was advised to recover at home.



«[...] a contrast-enhanced chest CT was performed, showing bilateral ground glass opacities and crazy paving pattern with a consolidation in the right lower lobe.»

My condition deteriorated however. I remained febrile, the shortness of breath kept increasing and at this stage I also developed anosmia.
Vital signs showed borderline hypotension and my saturations started to drop to 95%. Clinical examination revealed crackles at the right lower lung base, tachy- and dyspnea.
New biochemistry revealed a further elevated CRP of 74 mg/L, lymfopenia (0.6 x 109/L) and thrombocytopenia (134000/µg/L).
All cultures (including haemocultures) and Mycoplasma serology came back negative.
After consulting a university hospital, a contrast-enhanced chest CT was performed, showing bilateral ground glass opacities and crazy paving pattern with a consolidation in the right lower lobe. Pulmonary embolism was excluded. Cardiotocography (CTG) now showed fetal tachycardia.

«CTG for fetal monitoring was performed two times a day and remained reactive and variable.»

At 31 weeks gestation, I was diagnosed with a Covid-19 pneumonia and admitted to the hospital. I was treated with oxygen, antipyretics, empiric antibiotics for five days and thrombosis prophylaxis. Corticosteroids for fetal lung maturation were not administered, as they were advised against at the time in Covid-19 patients and there were no signs of fetal distress or impending premature labor.
CTG for fetal monitoring was performed two times a day and remained reactive and variable. My husband, who is a surgeon, cancelled his on call activities and stayed at home in quarantaine with our son for 14 days. They were both asymptomatic and were never tested, following the guideline at that time.
After six days I remained afebrile again and was discharged home with oxygen, which I needed for two more weeks. Thrombosis prophylaxis was continued up to 37 weeks gestation. When I got home, I did not isolate myself from my husband and son since I was no longer considered contagious and it would have been very difficult to organise.

For several weeks the fatigue and dyspnea persisted but after all I made an almost complete recovery – except for the anosmia. I delivered a healthy baby girl at 40 weeks of gestation. Fortunately I recovered enough to give normal birth and no caesarean section was needed.

Despite the good outcome, I prefer not walking down this memory lane too often. The isolation in the hospital and the fear for preterm or urgent delivery made it a mentally challenging experience for me. I feel like I missed out on an important part of my pregnancy and was not able to enjoy it. I also feel guilt towards my collegues that I was not able to help out when they were working long shifts in difficult circumstances.

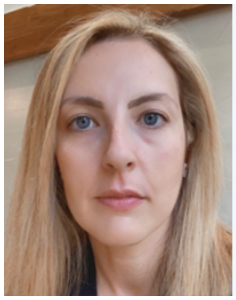
COVID-19 pandemic: testimonials from trainees


Maria Tileli (Asklepieion Hospital of Voula, Greece)


Theodor Bot (Emergency County Hospital Cluj-Napoca, Romania)


Rita Mesquita Ribeiro Da Graça (Hospital Center of Trás-os-Montes and Alto Douro, Portugal)

Ivana Jurincic (University hospital of Rijeka, Croatia)



> " There are numerous stories across the world by trainees having to step up their roles, inspiring stories with resourcefulness of caring for Covid-19 patients [...]. "

Maria Tileli
ESRA Residents and Trainees Representative, Greece

The Covid-19 pandemic has impacted significantly on speciality training. This was reflected across all specialties. Although most anaesthetic trainees retained their customary role, a significant number were redeployed to Covid-19 units. The trainees had to step up their role by making decisions on critically ill infectious patients, ethical issues collided with budgetary constraints and allocation of scarce resources.
Does true altruism exist?
Those having to deal with work related anxiety due to provision of personal protective equipment, had a direct effect on their mental wellbeing, which superimposed on family and led to domestic disruption. The impact on the trainees mental health and all healthcare professionals, emphasised and refocused our attention towards our wellbeing.

Trainees are also still enduring the major challenge of comprehending the new educational needs, posed by the new healthcare environment, while maintaining a high standard of care, along with training. Across the world we saw educational activities being cancelled, postponed examinations and rotations, vital to our progress through training. Education had to evolve radically by adopting modern teaching modalities, such as e-learning and webinars.

There are numerous stories across the world by trainees having to step up their roles, inspiring stories with resourcefulness of caring for Covid-19 patients, during a time of uncertainty and despite personal risk. We should be proud of the empathy and profound dedication exhibited by trainees during these strange times.

> “ It was something completely new, we didn’t know what we are fighting against and had very little information about this new virus [...] ”

Theodor Bot
ESRA Trainee Representative, Romania

Thank you to all trainees!

My name is Theodor Boț and I am an Anesthesia and Intensive care trainee, in the final year of the programme, in Cluj-Napoca, Transylvania, Romania.

My country was a little more “protected” at the beginning of this pandemic, so the inevitable phone call came only on March the 22nd. The phone call through which we, myself and 7 other trainee colleagues, were summoned to the Intensive Care unit which, beginning with that week-end, received the first 3 critical cases of Covid-19 patients.

We already knew from our European colleagues that the situation was, to say the least, difficult, we had talked to them beforehand. We had seen it in the media how high-performance medical systems couldn’t handle the huge wave of patients.

We spent there the next 3 months, in the so-called “first line”,covering shifts after shifts and caring for patients after patients.

Slowly, the hospitals filled up and more and more trainees were called in this “first line”, which most of the times felt like the only line.

Was it difficult? At the beginning, yes, overwhelming. It was something completely new, we didn’t know what we are fighting against and had very little information about this new virus, which creates lung damage up to 90%. But we didn’t give up, trying ventilation mode after ventilation mode, spending days trying to improve all the affected organs.

It’s been definitely a few stressful months. The work in Covid-dedicated hospital was exhausting, because of both intellectual involvement in giving the patients the best treatment, as well the psychological discomfort that there is a chance that a mistake of dressing or undressing the equipment will lead to our infection, as well as our intense physical exertion. But none of us pulled back.

That’s why I bow in front of all my resident colleagues in Anesthesia and Intensive Care, Infectious Diseases, General Medicine, which helped save the lives of thousands or tens of thousands of patients. Resident colleagues who spent hundreds or thousands of hours next to the Covid-19 patients. Resident colleagues from wherever they are because the pandemic has hit hard all over the world.

The second phone call, probably inevitable as well, came on the first of October – the one through which I had been informed that I am confirmed as being positive with the infection with Sars-Cov-2. For other colleagues of mine, the second phone call had been made months or weeks before. For others, the phone rings just now. After the mandatory isolation period, everyone returns to work. Back in the “first line”, back next to the Covid-19 patients, grateful for our health restored.

That’s why I bow in front of them once more.

Sending a good thought to everyone and stay safe wherever you are!

> “ It was necessary to overcome insecurities to be able to correspond to the new responsibilities and face this challenge with so much of unknown ”

Rita Graça
ESRA Trainee Representative, Portugal

Being an anesthesiology resident during the COVID-19 Pandemic

I understand being a doctor is much more than a specialty, it is a way of life that prepares us to deal with joy and health, but also with suffering, pain and death. A way of life that prepares us for the hard scenario in which a hospital can become.

I started and embraced my journey in anesthesiology training with this idea very present, but I was far from imagining living pandemic times like the one we are living nowadays... Times when I had to assume more responsibilities in order to be possible to guarantee medical care to all the patients, times of change in hospital dynamics, times when it is at the same time important to strive so that our training does not fall second. These are difficult times! It was necessary to overcome insecurities to be able to correspond to the new responsibilities and face this challenge with so much of unknown, the COVID 19.

We all grew up, we all dressed up of strong ones, we all became different!

Anesthesiology, as a specialty of great versatility and with a wide area of activity, has become central to adjustments in hospital dynamics in Portugal. Many anesthesiology residents were fundamental to implement contingency plans and were called to take their position on the
front line. We did not hesitate to demonstrate why anesthesiology is a central specialty in hospitals, we showed our adaptation capabilities even in extraordinary times, when there is no time to tune weapons. Beyond the tasks of everyday anesthesiology resident, we stood tall on the COVID-19 triage tents, on the emergency room, on the intubation teams and on the ICU.

Our training is based on pillars of monitoring, organization and safety. The new reality imposes multiple risks for the anesthesiologist, due to the daily procedures that generate aerosols. Once again, the use of regional anesthesia has proven to be fundamental, allowing alternatives to aerosol-generating techniques, maintaining the safety of the patient and health professionals, allowing for a higher turnover between cases and assuring a better post-operative recovery. Thus, in my practice, regional anesthesia showed to be a good way to optimize the safety of the entire team, an aspect that I consider fundamental for us to be able to continue to perform our functions and contribute towards victory against SARS-Cov 2.

In these difficult moments, I would like to end by recalling a sentence by Maya Angelou:
“Courage is the most important of all the virtues because without courage, you can’t practice
any other virtue consistently”.

Courage!

" I realized this was much more of a challenge that I thought it was going to be "

Ivana Jurincic,
Anesthesiology Trainee, Croatia

I am a resident in the Department of Anesthesiology and Intesive Care and for the last two months I have been working in the Respiratory Center for COVID 19 patients.

I'm used to work in stressful situations and with criticaly ill patients so I didn't think this was going to be difficult for me. During the time spent in the personal protective equipment, sometimes for hours, I realized this was much more of a challenge that I thought it was going to be. I never felt scared for my own health because I was wearing all the necessary equipment all the time, but I was afraid of making a mistake during some invasive procedures or that I was going to overlook something on the ultrasound when wearing blurred glasses.

When I would become more sweaty under the suit I would try to finish my job faster and I know that there would be room for mistake then. So in time I've learned to calm myself.

I also feel sorry for awake patients because it must be hard not only not to be able to see your family but the only people you are in contact are medical workers in some white suits. I would talk to them much more then I usually do with patients because I wanted them to feel safe and not alone and after a while all of them where so grateful for the job that we were doing, and many of them told us how much they appreciate what we are doing because they saw it was not easy for us.

Now I'm glad that I am a part of the team in a Respiratoy Center because it offers a new challenge and great experience for me to become a better doctor.

Q&A bonus webinar: Neuraxial analgesia and anesthesia for labour and delivery


Frédéric Mercier MD PhD (Hospital Antoine-Béclère - Paris, France)


Nuala Lucas (Co-Editor of ESRA Updates, Norwick Park Hospital, Harrow, UK) @noolslucas

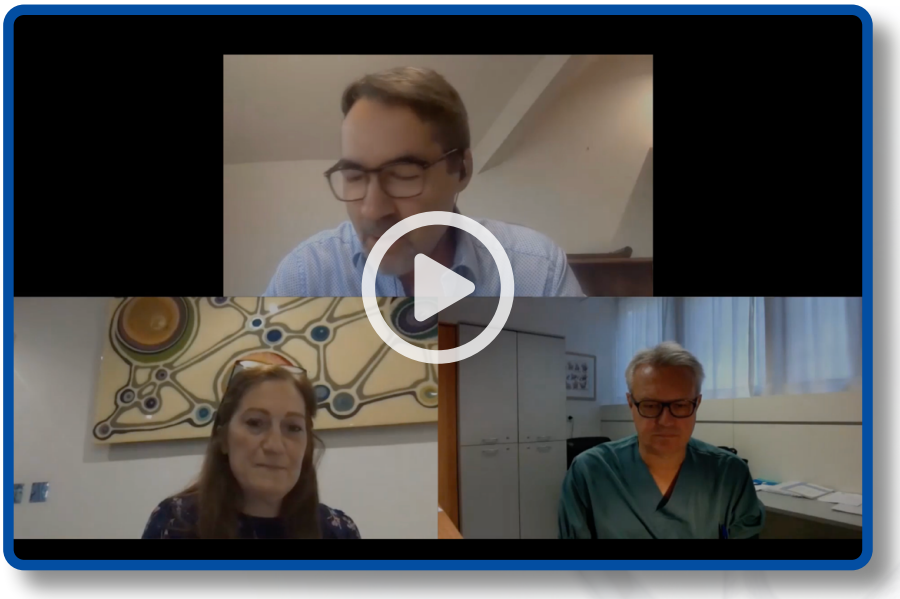

Marc Van de Velde (Chair of PROSPECT, UZ Leuven, Belgium) @MarcVandeVelde6

On Thursday 27th August 2020, our ESRA webinar «Neuraxial analgesia and anesthesia for labour and delivery» took place. This live session was a great success with 1900 registrations, 770 unique viewers and more than 130 questions asked by attendees.

In view of these positive results, the panel gathered once again to record a Q&A bonus webinar to go further into this subject and answer as much pending questions as possible.

This video is available to all.
The live session recording is available for ESRA members on the Academy section.

Watch the replay on the ESRA Academy



Chair: *Frédéric Mercier (France)*
Speakers: *Marc Van de Velde (Belgium), Nuala Lucas (UK)*
Duration: *1h*

PROSPECT guideline for hallux valgus repair surgery & Ultrasound-guided ankle block


Katarzyna Korwin-Kochanowska (University Hospitals of the KU Leuven, Belgium)


Arnaud Potié (University Hospital of Lausanne and University of Lausanne, Switzerland)


Kariem El-Boghdadly (Guy's and St Thomas' NHS Foundation Trust, King's College London, UK)


Narinder Rawal, MD PhD (University Hospital of Örebro, Sweden)


Girish Joshi, MD (University of Texas Southwestern Medical Center, US)


Eric Albrecht (University Hospital of Lausanne, Switzerland) @DrEAlbrecht


Alain Delbos (ESRA Past President; Medipole Garonne, France) @alaindelbos


Steve Coppens (Co-editor of ESRA Updates, UZ Leuven, Belgium) @Steve_Coppens


Olivier Rontes, MD (Medipole Garonne, France)

Philippe Marty, MD (Medipole Garonne, France)

Clément Chassery, MD (Medipole Garonne, France)

prospect
procedure specific postoperative pain management

PROSPECT recently published a guideline concerning Hallux Valgus repair. This ESRA's working group, PROSPECT, developed this systematic review with the objective of assessing the available literature on pain management after hallux valgus repair, evaluating postoperative pain outcomes (pain scores and analgesic requirements) as the primary outcome, other recovery outcomes including adverse effects and the limitations of the available data. Ultimately, recommendations for pain management after hallux valgus repair surgery were created. Hallux valgus repair is a very common procedure that might be performed as inpatient or outpatient basis, associated with moderate to severe pain. You can find it here.[1]

ESRA Updates is adding a review paper about ultrasound-guided ankle block :


Best Practice & Research Clinical Anaesthesiology

Ultrasound-guided ankle block. History revisited

Click here to read this reference paper.[2]

1. Katarzyna Korwin-Kochanowska*, Arnaud Potié*, Kariem El-Boghdadly, Narinder Rawal, Girish P. Joshi, Eric Albrecht, PROSPECT/ESRA Working Group Collaboration. *Co-primary authors
PROSPECT guideline for hallux valgus repair surgery: A systematic review and procedure-specific postoperative pain management recommendations, Regional Anesthesia & Pain Medicine 2020;45(9):702-708. DOI: 10.1136/rapm-2020-101479

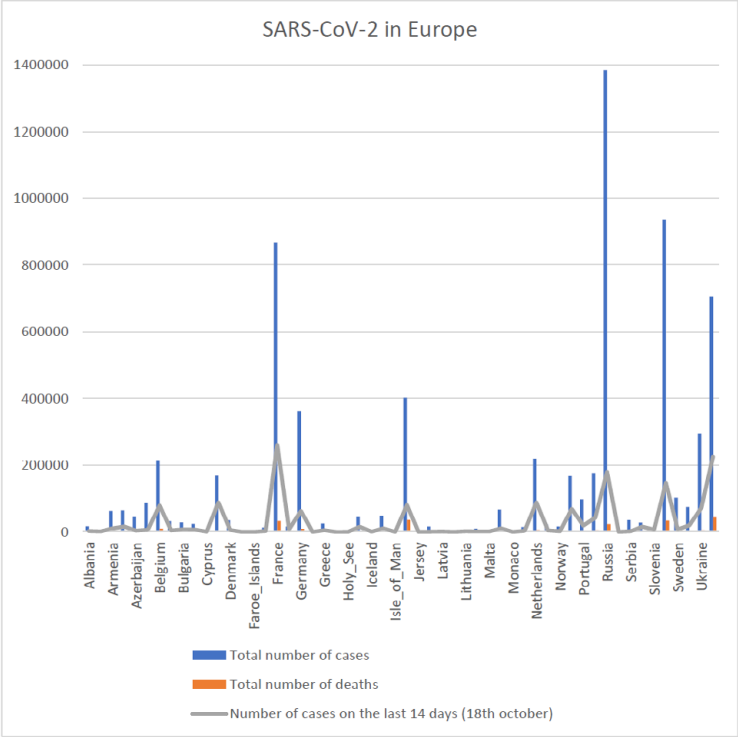
2. Delbos A, Philippe M, Clément C, Olivier R, Coppens S. Ultrasound-guided ankle block. History revisited. Best Pract Res Clin Anaesthesiol [Internet]. 2019;33(1):79–93. Available from: http://www.sciencedirect.com/science/article/pii/S152168961930014X
https://doi.org/10.1016/j.bpa.2019.05.002

Editorial

Clara Lobo (Editor of ESRA Updates; Cleveland Clinic Abu Dhabi, UAE) @claralexlobo

Dear Colleagues,

The world is facing the 2nd wave of SARS-CoV-2 infection. According to the European Center of Disease Control, it is estimated that by October 18th, 2020, Europe counts with 6 976 052 cases of SARS-CoV-2 infections, graphic 1. The top five countries reporting most cases are Russia (1 384 235), Spain (936 560), France (867 197), United Kingdom (705 428) and Italy (402 536). The number of deaths attributed to SARS-CoV-2 infection are 240 306, graphic 1. The top five countries reporting most deaths are United Kingdom (43 579), Italy (36 474), Spain (33 775), France (33 392) and Russia (24 002)



Graphic 1. Geographic distribution of the total number of cases of SARS-CoV-2, deaths and last 14 days number of cases by European country, according to ECDC (https://www.ecdc.europa.eu/en/geographical-distribution-2019-ncov-cases)

Several studies reflect the higher vulnerability of healthcare workers (HCWs) to infection by SARS-CoV-2. In a series of 138 patients from Wuhan, China, 29% of the cases were HCWS.[1] On a later case series including 72,314 COVID-19 cases, the proportion of HCWs was much lower (3.8%).[2] In Spain, 22% of all the COVID-19 cases have been among HCWs, and in Italy, 20% of responding HCWs were infected.[3,4] Approximately 10% of HCW involved in aerosol-generating procedures of patients with suspected or confirmed COVID-19 were either diagnosed with new COVID-19 infection or required self-isolation or hospitalisation with new symptoms.[5]

In this issue of ESRA Updates we collect the testimonies of some European anesthesiologists infected with SARS-CoV-2. They are real and inspiring stories, where our colleagues honestly expose their concerns, fears and anxieties and, how they dealt with the disease, anxiety and recovery. They are courageous testimonies that fill our hearts.

Among the many frontline soldiers fighting SARS-CoV-2 were residents. ESRA residents present in an article coordinated by the ESRA residents & trainees committee their valuable contribution in each European country.

Besides the COVID-19 pandemic, on Thursday 27th August 2020 our ESRA webinar «Neuraxial analgesia and anesthesia for labour and delivery» took place. This live session was a great success with 1900 registrations, 770 unique viewers and more than 130 questions asked by attendees. In view of these positive results, the panel gathered once again to record a *Q&A bonus webinar* to go further into this subject and answer as much pending questions as possible.

3000 registrations, 1700 online participants, 5.6 million twitter impressions, 111 international Key Opinion Leaders, 17h of online continuous broadcasting! This was the result of a joint effort between ESRA and ASRA Societies: anesthesiologists from all over the world participated on the 19th of September to the e-Congress to discuss topics from Regional blocks, Chronic pain, Point of Care Ultrasound, postoperative pain management, peri-operative medicine… program and replay are available for one year : click here to access the e-Congress website.



Finally, and because even in times of pandemic scientific research does not stop, we present the latest recommendations published by PROSPECT: *PROSPECT guideline for hallux valgus repair surgery*: a systematic review and procedure-specific postoperative pain management recommendations.[6] According to these recommendations, interventions that improved postoperative pain relief included paracetamol and non-steroidal anti-inflammatory drugs or cyclo-oxygenase-2 selective inhibitors, systemic steroids, ankle block, and local anesthetic wound infiltration. Included in this ESRA Updates issue is a reference paper explaining how to perform an ankle block.[7]

Take care, be safe and enjoy this ESRA Newsletter !

1. Clinical characteristics of 138 hospitalized patients with 2019 novel coronavirus-infected pneumonia in Wuhan, China. JAMA. 2020; 323: 1061-1069

2. Characteristics of and important lessons from the coronavirus disease 2019 (COVID-19) outbreak in China: summary of a report of 72314 cases from the Chinese Center for Disease Control and Prevention. JAMA. 2020 Feb 24; *https://doi.org/10.1001/jama.2020.2648*

3. *https://doi.org/10.1016/j.jhin.2020.07.020*

4. *https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(20)30644-9.pdf*

5. *https://doi.org/10.1111/anae.15170*

6. Korwin-Kochanowska K, Potié A, El-Boghdadly K the PROSPECT / ESRA Working Group Collaboration, et al. PROSPECT guideline for hallux valgus repair surgery: a systematic review and procedure-specific postoperative pain management recommendations
Regional Anesthesia & Pain Medicine 2020; 45: 702-708

7. Delbos A, Philippe M, Clément C, Olivier R, Coppens S. Ultrasound-guided ankle block. History revisited. Best Pract Res Clin Anaesthesiol [Internet]. 2019;33(1):79–93. Available from: http://www.sciencedirect.com/science/article/pii/S152168961930014X
https://doi.org/10.1016/j.bpa.2019.05.002