

COVIDTrach; the outcomes of mechanically ventilated COVID-19 patients undergoing tracheostomy in the UK: Interim Report

Acknowledgments

COVIDTrach collaborative (see appendix)

Editor

COVIDTrach is a UK multidisciplinary collaborative project that evaluates the outcomes of tracheostomy in patients diagnosed with COVID-19 who are receiving invasive mechanical ventilation. In parallel, data is collected on the use of personal protective equipment (PPE) and rates of COVID-19 infection amongst operators. Between 6th April and 11th May 2020, data was received on 564 tracheostomies from 78 UK NHS hospitals. Results are given in brackets as a fraction of results received (n=results/number of results received).

The majority of patients were male (n=405/563, 72%) and BMI ranged from 18.5 to <25 (22%), 25 to <30 (35%), 30 to <40 (35%) and >40 (8%) (data available in 426 cases). The number of days from intubation (day 0) to tracheostomy ranged from 0-35 (median 16, IQR 13, 22) (data available in 543 cases). Prior to tracheostomy, the median FiO₂ was 40% (IQR 30, 45) (data available in 555 cases) and the median PEEP was 8 (IQR 6, 10) (data available in 539 cases). An open method of tracheostomy was used in 58% of cases (n=323/560), a percutaneous method in 39% (n=217/560) and a hybrid method was used in 3% (n=20/560). A negative pressure environment was used in 10% of cases (n=55/530).

Fifty-two percent (n=219/465) of COVID-19 patients who had undergone tracheostomy and were still alive had been weaned from mechanical ventilation at the point of completing the survey (Table 1). At the point of survey, 38% (n=169/450) of patients who had undergone a tracheostomy had been discharged from intensive care. The all-cause in-hospital mortality following tracheostomy in COVID-19 patients was 12% (n=62/530) with two deaths attributed to post-operative tracheostomy complications and the other 60 (97%) recorded as "COVID-19 related". As many of the patients are yet to complete their critical care, the mortality and weaning rates are likely to change with time. The success in tracheostomy decannulation and discharge from hospital will be evaluated in future reports.

Adequate PPE should be viewed as mandatory for tracheostomy in COVID-19 patients due to the significant potential for aerosol generation.^{1,2} In all cases (n=545/545), operators used either an FFP3 mask or Powered Air Purifying Respirator (PAPR). Additional PPE used involved either a face visor or hood with face shield in 99% of cases (n=538/545), a disposable gown in 97% (n=527/545) and double gloves in 90% (n=490/545). The question "Did any of the operators test positive for COVID-19 within

two weeks of the procedure”, was answered by 71% (n=400/564) and all confirmed that no operators had become COVID-19 test positive within two weeks of the procedure. Whilst this finding is reassuring, it is open to potential reporting bias and does not account for the remaining cases that are yet to reach the two-week time point.

The number of COVID-19 PCR tests performed prior to tracheostomy ranged from 1 to 12 (median 1, IQR 1,2). The COVID-19 test was positive in 86% (n=443/503) of patients prior to tracheostomy with the length of time from the last test to the day of surgery recorded as median 14 days (IQR 7,19). The role of identifying PCR test status in COVID-19 patients ahead of tracheostomy is unclear. ICU patients can remain test positive for several weeks after the onset of symptoms,^{3,4} and whether the detection of viral RNA by PCR predicts risk of infectivity to operators and other health care professionals is uncertain. Delaying tracheostomy to achieve negative tests is likely to prolong endotracheal ventilation and thus defer the potential benefits of tracheostomy whilst increasing the risk of complications relating to endotracheal intubation.

References

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Ethics committee approval

COVIDTrach is classed as a service evaluation and collects de-identified anonymised data only. Using the UKRI & HRA decision tool (<http://www.hra-decisiontools.org.uk/research/>), ethical approval was not required for this project.

Data collection

Study data were collected and managed using REDCap electronic data capture tools hosted at University College London. REDCap (Research Electronic Data Capture) is a secure, web-based application designed to support data capture for research studies, providing: 1) an intuitive interface for validated data entry; 2) audit trails for tracking data manipulation and export procedures; 3)

Conflicts of interests

No conflicts to declare.

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