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Editorial

Reopening Our Practice and the Woes of the Pandemic

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For most of us, the Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) is the first and worst pandemic we have ever faced. From its beginnings in Wuhan, China in December 2019; it has exploded; now affecting 213 countries and 10.27 million people worldwide. Claiming 505,071 lives so far; this deadly virus is raging still [1]. A large number of health workers have fallen prey to this virus, which plummeted most of the world into lockdown. As we ophthalmologists were forced to limit our practices to urgent cases only; questions now arise on how to keep ourselves' and our patients' safe; as the lockdown eases.

SARS-CoV-2 is highly contagious with an average reproductive number (Ro) of 3.28, which signifies a self-sustaining contagion; unless stopped. It spreads mainly through droplets, but can also spread via bodily secretions including tears. With no treatment and no vaccine, the most we can do is flatten the curve by precautionary measures [2,3].

There are recommendations both by the American Academy of Ophthalmology and the Royal College of Ophthalmologists on how to resume our practices, safely and we should all develop a protocol for our own setup, as we deem suitable. Everyone should be considered a suspect, unless proved otherwise. We should wear at least a surgical mask, goggles and gloves. Some may prefer personal protective equipment (PPE). Meticulous hand hygiene should be implemented after each patient [4-6].

The general rule is to enable patients who need the most care; like emergencies, trauma, surgical or glaucoma cases to come to the clinic wearing masks, limiting the number of attendants in the hospital, and limiting only one person or attendant in the room. Sanitizer should be available for all. Temperature checks at the entrance are needed at every hospital. Patients should be allowed in the clinic only if no exposure to coronavirus, no travel history within 14 days, or no symptoms. Social distancing at the waiting room should be done. For the non-urgent patients, telephonic or video consultations should be utilised [4-6].

Disinfection should be done in the clinic, after every patient with ≥70% ethanol or bleach (sodium hypochlorite 0.1%). Slit lamps should have plastic shields between the doctor and patient. Non-contact tonometry has been considered microaerosol generating and should be aborted for now.

Coronavirus testing for every patient who is to undergo any surgical procedure is mandatory. Aerosol generating procedures (AGVs) include general anesthesia with intubation, lacrimal surgery, phacoemulsification and vitrectomy as well. It is recommended that surgeons may use Filtering Face Piece 3 (FFP3) respirators and protective eye shields [7].

As health workers, it is not easy to wear masks all the time, which can cause trouble breathing, nasal congestion and skin irritation. The possible air transmission of this virus through Heating, Ventilation and Air Conditioning Systems (HVAC) of hospitals have caused authorities to shut them down; proving to be even more difficult for us to work in the heat. Goggles not only cause bothersome astigmatism, fog easily especially in the summer, and impair image quality at the slit lamp. It is important to take breaks at work and to relax; to prevent this pandemic from overwhelming even the most resilient [8].

Most of us are used to hard work and do not like staying at home. On a more positive note, this lockdown provided us an opportunity for a long needed vacation, even though at home only; to contemplate, to relax, to enjoy our hobbies, to be with our families, to take a break, to attend webinars, to read, and also to write.

In these uncertain times, as we reopen our practices, I am positive that being patient, taking the necessary precautions and following the recommended guidelines, we will be able to beat this virus and help our patients; as all of us have vowed to do. We are all in this together.

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