



Reply to Facing COVID-19 in Ophthalmology Department

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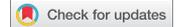


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LETTER



Reply to Facing COVID-19 in Ophthalmology Department

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A recent article by Romano et al.¹ outlined the recommended protocols for an Ophthalmology department facing COVID-19. Ophthalmology may not seem to be in the frontline, but as doctors we face this coronavirus pandemic together. Ophthalmologists continue to play a key role in caring for emergency cases. COVID-19 is highly contagious and potentially fatal; ophthalmologists are a high-risk category. As Romano et al.¹ articulates, we have close contact during the examination with exposure to conjunctival, tear and aerosol secretions. Despite efforts to minimize clinics and patient exposure, our emergency lists maintain high daily volumes. A wealth of literature is emerging and guidelines to tackle this evolving outbreak. A challenge faces each department to abide by advice using the personal protective equipment (PPE) that we have. We outline simple measures to ensure compliance and optical quality, striving for safety yet not involving any further cost or instrumentation.

The article references using a surgical face mask that meets a minimal protection level according to the American Society for Testing and Materials.² This classification of mask performance is based on particulate filtration efficiency, differential pressure and resistance to penetration; not on the design or breathability properties. There is no 'one-size-fits-all' personal protective equipment (PPE). We cannot wait for the perfect solution; even the 'right' mask worn incorrectly can put you at risk. We need the best protection for ourselves and patients against COVID-19; yet our specialty also demands the best optical clarity.

Can we complain of seemingly trivial nuisances during a global crisis? Goggles and eye protection can mist up while wearing a face mask. Fogging reduces vision – causing either non-compliance or a hazard to patient safety.^{3,4} Perhaps not an issue for less visually demanding specialties, this annoying phenomenon is more than a minor issue when it becomes optically imperfect for our work. It can be potentially dangerous if there is reduced clarity and binocularity while removing a foreign body at the slit lamp or doing an intra-vitreous injection. Studies have been done to compare materials; advanced coatings, anti-fogging properties, clarity and protection.⁵ In current times, we need to be creative and practical. We would like to draw our reader's attention to a simple method to prevent this: wash goggles and lenses with soapy water. This creates a thin surfactant film that reduces

surface tension, causing the water molecules to spread out evenly into a transparent layer, reducing misting.⁶

This 'fogging' phenomenon is doubled by patients wearing their recommended face-masks, self-affixed and ill-fitting. Conventional tying of a standard face-mask seems to be so the two ties lie above and below the ear, in a parallel appearance. This creates venting at the superior part of the face-mask – fogging the lens in an outstretched hand. The examination and potentially the exposure time, is prolonged. A better technique for patients and doctors is knotting the superior tie first with it lying directly below the ear, the inferior tie is brought up in front of the ear and knotted over the top of the head.⁷ This forms a criss-cross of the ties, creating two lateral 'vents' allowing exhaled air to escape.

To look after our patients we need to look after ourselves. Re-tying our face-masks and de-fogging goggles are simple methods that do not require any additional cost or materials. We can minimize exposure for patient and physician while maintaining standards with clear optics.

Declaration of Interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

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