Peter Munk Cardiac Centre – COVID-19 pandemic planning initiatives.

1. **Decrease out-patient clinic volumes by 50% across the program.** All planned clinic out-patient visits are reviewed by staff physicians and their medical administrative assistants. Any cases that are deemed to be non-urgent are deferred. When possible, and when appropriate, patients are preferentially seen through the OTN, or contacted by phone. The possibility of using other communication platforms for patient interactions with health care providers (Skype, Zoom) is being considered.

2. **Decrease elective surgery volumes and cardiac cath lab procedures by 50% across the program.** Procedures that Cardiology, Cardiac Surgery and Vascular Surgery will cease to carry out, and those procedures they will continue to offer are described in below.

3. **Operating room and admission privileges at other Hospitals.** Vascular surgeons at UHN, St. Michael's Hospital and Sunnybrook now all have OR and admitting privileges at each of these hospitals. This was arranged so that cross-coverage was possible, in case surgeons at one hospital are unavailable, due to quarantine or illness. Cardiac Surgery is considering implementation of a similar cross-appointment arrangement.

4. **Cardiology.**

   Will stop doing:
   - Elective diagnostic angiography
   - Structural cases in non-urgent or stable patients
   - Percutaneous coronary interventions in patients with stable coronary artery disease
   - Patients who meet the primary indications criteria for implantable cardiac defibrillators
   - Elective permanent pacemakers

   Will continue doing:
   <u>Cardiac catheterization</u> for
   - Shock
   - Acute myocardial ischemia or infarction
   - Heart failure with hypotension, arrhythmia, chest pain, severe aortic stenosis or a new cardiac murmur
   - Patent foramen ovale or atrial septal defect with right to left shunt causing hypoxia
   - Severely symptomatic mitral stenosis
   - Pregnancy with any lesion that threatens mother and/or baby
   - Symptomatic complex adult congenital heart disease patients where the source of acute symptoms and therapeutic approach is unclear
   - Post-operative complications requiring repair for significant symptoms

   <u>Pericardiocentesis</u>
   - Tamponade

Electrophysiology

- Pulse generator replacement that for battery depletion
- Devices for ventricular tachycardia – secondary prevention
- Permanent pacemaker for heart block or those with temporary trans-venous pacing
- Urgent lead revision
- Catheter ablation for recurrent hemodynamically significant arrhythmias poorly controlled on medications

Cardiogenic shock interventions (selected patients, after Heart Team approval)

- Intra-aortic balloon pump
- Extracorporeal mechanical oxygenation
- Mechanical circulatory support

5. Cardiac Surgery

Will stop doing:

1. Asymptomatic mitral valve repair
2. CABG for noncritical CAD in patients with stable angina
3. AVR for asymptomatic severe AS
4. Myectomy for stable HOCM
5. Pericardiectomy
6. Cardiac tumours not causing embolic/obstructive symptoms
7. TAAA repair for aneurysms just meeting surgical criteria

Will continue doing: All other cardiac surgical procedures

6. Vascular Surgery

Will stop doing:

- Bypasses or endoluminal interventions for claudication
- Carotid endarterectomy for asymptomatic carotid stenosis
- Varicose vein procedures
- Dialysis access, except for acute thrombosis, sepsis or inability to place a percutaneous dialysis line

Will continue doing:

- Aortic aneurysm repair
  - EVAR, advanced and standard, or open repair when aneurysms meet size criteria
- Carotid endarterectomy for symptomatic carotid stenosis
- Critical limb ischemia - salvageable
  - Aorto-bifemoral bypass or endoluminal interventions
  - Lower extremity bypass: *in-situ*/composite/synthetic/endoluminal interventions
- Critical limb ischemia, unsalvageable or diabetic foot infection
- Major and minor amputations