

COVID-19 pandemic: perspectives on an unfolding crisis

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COVID-19 has been declared a pandemic by the World Health Organisation (WHO) as confirmed cases approach 200 000 patients with what will exceed 8000 deaths across over 160 countries¹. After the initial description in Wuhan and China, Italy was hit first in Europe and the impact has been immense². The virus spread very rapidly such that 2 weeks from the first cases diagnosed 1000 patients tested positive. One week later the number of positive cases exceeded 4600, reaching over 30 000 patients and 2500 deaths on the 18 March 2020^{1,3}. The region of Lombardy was the most profoundly affected, with local institutions forced to reset the entire healthcare system to face the challenges, while the Italian government ordered a nationwide lockdown⁴. Other nations followed, for example, Spain declared the state of emergency on 14 March and announced similar measures to be taken⁵.

Outpatient clinics

Most outpatient clinics have been suspended, and scheduled patients are called beforehand by hospital administration, asking for specific symptoms in the previous two weeks (for example, fever or cough), or direct exposure to COVID-19-positive individuals. In such cases, the patient is asked not to come to the hospital and the visit is postponed. Check-points were set up to assess patients for symptoms and to provide each individual with surgical masks before

entering hospitals. No visitors or accompanying persons are allowed in the hospital and all shops, restaurants, and facilities remain closed (including vending machines).

Elective surgery

Non-urgent, non-cancer procedures were stopped to reallocate the nurses and anaesthetists to face the COVID-19 emergency. This measure freed ventilators for patients with COVID-19 and converted surgical theatres into additional intensive care unit beds as needed. Patients with cancer were prioritized by clinical priority and availability of resources: patients in probable need of postoperative intensive care were corralled into specific, government-defined centres to free resources elsewhere. It is foreseeable that there will be a significant number of patients with benign conditions needing surgery after the surge in patients with acute viral illness falls. This will require extra resources to catch up on the backlog.

Emergency surgery

The need to care for patients with emergency presentation still continues during a pandemic. Therefore, surgical staff and the available units have been modified to balance service provision, reducing infection risk, and specialist care. Most centres have reduced the number of consultant/attending surgeons on the ward, down to one or two with similar trainee

numbers per day, with larger teams being used for covering emergency and accident services. This policy reduces the number of working units attending the hospitals and limits unnecessary exposure of patients and healthcare providers. Indications for surgery in patients tested positive for COVID-19 should not differ from those who have tested negative in emergency conditions. Some colleagues report a worse postoperative course after complications in elective COVID-19-positive patients, but data are lacking. There are some reports regarding patients with COVID-19 presenting with gastrointestinal symptoms that mimic surgical diseases, specifically a pancreatitis-like clinical presentation.

Considerations on safe practices

There is no agreement of whether a dedicated COVID-19 staff should be allocated to infected patients needing surgery. Patients are not being tested for COVID-19 routinely as yet, especially if they are asymptomatic. Theoretically, this would imply that there should be the highest level of personal protection attire for surgical staff in every case. Due to the shortage of protection equipment hospital management tend to recommend use only in known COVID-19-positive cases even though this stresses individuals⁶. Some professional bodies state that the evidence for guidelines is limited, recommending no more than standard surgical

protection for the scrub team⁶. This policy differs from that followed in many afflicted zone centres where the highest protective measures are being taken. There are no agreed policies about testing staff routinely but it is intuitive that it would be desirable to test all patients and staff in a pandemic. It is not clear whether the virus can be found in circulating CO₂ used for laparoscopic surgery or aerosol generating procedures. Some allow the use of laparoscopy but question transanal minimally invasive procedures, due to the increased risk of exposure to aerosolized biological fluids with the latter⁷. Laparoscopy may reduce intraoperative exposure to smoke compared with open surgery and devices for smoke evacuation and cleansing are recommended where feasible. Some suggested using the closed circuit of the pressurized intraperitoneal aerosol chemotherapy (PIPAC) if available, but cheaper and more readily available alternatives to reduce the contamination from aerosol from CO₂ during laparoscopy have been proposed, such as connecting one of the laparoscopic ports to a water seal created with a sealed container by means of extension lines (<https://www.escp.eu.com/covid19escp>). Special attention should be paid to evacuating residual CO₂ from the container and the abdominal cavity before removing the trocars. The Spanish Association of Coloproctology suggested that intracorporeal should be favoured over extracorporeal anastomosis to avoid contamination with a faecal aerosol⁸.

Considerations on the impact of COVID-19 on patients

The shortage in resources and the increased need for facilities are jeopardizing the usual high standards of elective care to patients². The International Organisation for the Study

of Inflammatory Bowel Diseases (IOIBD) provided updated evidence on COVID-19 in patients with inflammatory bowel diseases (<https://www.ioibd.org/ioibd-update-on-covid19-for-patients-with-crohns-disease-and-ulcerative-colitis/>). According to the Global Cancer Observatory of the WHO⁹, in Europe, every year approximately 500 000 patients are diagnosed with colorectal cancer and four million with any type of cancer. This would mean that – assuming that the crisis lasts 2 months – a diagnosis would be delayed in approximately 83 000 patients with colorectal cancer and more than 660 000 patients with any cancer. This estimate does not include the time needed to restore activity and catch up on the backlog so it is likely much higher. The COVID-19 outbreak made it necessary to suspend or reduce the number of multidisciplinary meetings. In the dramatic scenario of intensive care bed scarcity, patients with cancer may need non-invasive options as a compromise (for example, radiotherapy, chemotherapy, or both) yet there may be treatment delays due to the pandemic. The potential disease progression, which is associated with quality of life and costs of care implications¹⁰, has a knock-on effect that may happen with benign disorders too¹¹.

What can we learn?

Telemedicine may reduce the need for physical attendance in outpatient clinics¹², thereby minimizing contact exposure where possible. Perhaps this was a good idea whose time has come in the clinical arena but are we ready to embrace the technology for academic meetings? Many events have been cancelled already this year. Virtual meetings have advantages including a better environmental profile, lower costs, and on-demand streaming. None of us was prepared to face a

pandemic. Patients, relatives, and the community need to be provided with understandable information to limit the inevitable psychological burden. Surgeons and our health-care colleagues facing psychological challenges with risk of burnout need support services. A joint international effort is advisable to face the COVID-19 fallout and establish pathways for crisis management.

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In this IAES literature update we are taking the unusual step of not bringing attention to an endocrine surgical paper. Most endocrine surgeons are currently being redeployed to non endocrine surgical tasks or facing the dilemma of knowing how to manage urgent endocrine surgical patients in the context of the COVID-19 pandemic.

This article describes how after the disease initially presented in Wuhan, China the disease has spread to all continents with a rapidly increasing mortality. The paper describes how Italy was the first European country to be affected and has become the source of information on to and how not to manage surgical patients in the crisis.

The COVID 19 emergency is is an unfolding situation but this article describes the situation from a surgical perspective and forms essential reading.

Paper reviewer: Prof Fausto Palazzo, Department of Endocrine Surgery, Hammersmith Hospital & Imperial College London.