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References

- 1 Joint Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) and European Association for Endoscopic Surgery (EAES) Guidelines (29/03/20). <https://www.sages.org/recommendations-surgical-response-covid-19/> (accessed 31 March 2020).
- 2 Recommendations of the Spanish Association of Surgeons (Asociación Española de Cirujanos, AEC) (31/03/20). https://www.aecirujanos.es/Documentos-de-posicionamiento-y-recomendaciones-de-la-AEC-en-relacion-con-la-cirugia-y-COVID19_es_1_152.html (accessed 31 March 2020).
- 3 Recommendations of the Spanish Association of Coloproctology (Asociación Española de Coloproctología, AACP) (31/03/20). <https://aesp-es.org/index.php/recomendaciones> (accessed 31 March 2020).
- 4 Canadian Association of General Surgeons – statement from the CAGS Committee re: Laparoscopy and the risk of aerosolization (24/03/2020). <https://cags-accg.ca/wp-content/uploads/2020/03/Laparoscopy-and-the-risk-of-aerosolization.pdf> (accessed March 2020).
- 5 Spinelli A, Pellino G. COVID-19 pandemic: perspectives on an unfolding crisis. *Br J Surg* 2020. [Epub ahead of print]. <https://doi.org/10.1002/bjs.11627>
- 6 Di Saverio S, Pata F, Gallo G *et al.* Coronavirus pandemic and colorectal surgery: practical advice based on the Italian experience. *Colorectal Dis* 2020; **22**: 625–34.

Supporting Information

The video may be found in the online version of this article and also on the Colorectal Disease Journal YouTube and Vimeo channels:

Video S1. How to manage smoke evacuation and filter pneumoperitoneum during laparoscopy.

Ambulatory management of perianal Crohn's disease during the COVID-19 pandemic

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Dear Editor,

Since the outbreak of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) almost all surgical services have been shut down in the newly reorganized COVID-19 hospitals. In particular, all day-case procedures, such as exploration under anaesthesia (EUA) for anal fistula, have been postponed.

Symptomatic anal fistula in patients with Crohn's disease (CD) requires proper and timely treatment in order to avoid perianal sepsis and allow prompt initiation of anti-TNF-alpha treatment [1]. Guidelines and clinical recommendations specific for this period of global crisis for inflammatory bowel disease (IBD) suggest that IBD is treated as usual and recommend that any therapy should be administered while minimizing exposure of people and potential transmission [2]. EUA is the accepted gold standard for diagnosis and treatment of anal fistula in CD patients [3]. This operation is generally offered under narcosis in operating theatres but is currently not available in order to try and prevent the exhaustion of resources.

Since 2016, we have offered our CD patients under regular follow-up with symptomatic anal fistula an ambulatory exploration of the anal canal and rectum (outpatient exploration, OE) in order to reduce waiting times for surgical exploration. OE consists of an examination of the anal canal and lower rectum (proctoscopy) followed by fistula probing, seton insertion and drainage of small abscesses. We have reported a high rate of

feasibility (also in complex fistulas) and very high acceptance of the procedure amongst our CD patients [4]. During these past few weeks, we have adopted extra precautions, avoiding the use of electrocautery for the (albeit low) risk of transmission of SARS-CoV-2 in the aerosols generated during cauterization and using full personal protective equipment. Furthermore, it has to be said that OE can be accomplished by one surgeon alone, therefore preventing the risk of infection from other healthcare professionals. However, we perform this procedure with the aid of an experienced nurse who provides tremendous help, also reducing most of the patient's stress.

OE is carried out by a colorectal surgeon with a specific interest in IBD surgery, thus offering our patients not only the chance for timely treatment but also the opportunity to remain in their IBD referral centre and be treated by appropriate specialists instead of receiving suboptimal treatment by a general surgeon in a peripheral but COVID-free hospital [5]. As for the risk of contagion, OE has specific advantages over EUA, achieved through two mechanisms: (i) minimizing the number of medical personnel required and (ii) avoiding the high-risk anaesthetic manoeuvres needed for EUA.

While the procedure has already been shown to be feasible and well-tolerated, the present circumstances have further enhanced both its usefulness and acceptance by patients. We believe that during the COVID-19 pandemic, OE may represent the best if not the only surgical approach to anal fistulas in CD patients.

A word of caution is needed to emphasize that this procedure has to be implemented in expert, high-volume IBD centres as this is the only context in which its use would be safe and appropriate.

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Conflicts of interest

The authors negate any conflicts of interest.

Author contributions

All authors have contributed to drafting the work or revising it critically for important intellectual content; approved the final version to be published; agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of

any part of the work are appropriately investigated and resolved. DA has performed all operations during the COVID-19 pandemic and contributed to design. SB has had a major role in conception of the work. GS developed and pioneered the technique used in this work and contributed to conception and design of the present work.

Ethics approval

Ethics approval was not requested.

Patient consent

Informed consent was obtained from all patients.

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The paper does not reproduce material from other sources.

Clinical trial registration

No registration was obtained.

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References

- 1 Lee MJ, Freer C, Adegbola S *et al.* Patients with perianal Crohn's fistulas experience delays in accessing anti-TNF therapy due to slow recognition, diagnosis and integration of specialist services: lessons learned from three referral centres. *Color Dis* 2018; 1–7.
- 2 Mao R, Liang J, Shen J *et al.* Implications of COVID-19 for patients with pre-existing digestive diseases. *Lancet Gastroenterol Hepatol* 2020; 5: 426–8.
- 3 Sica GS, Di CS, Tema G *et al.* Treatment of peri-anal fistula in Crohn's disease. *World J Gastroenterol* 2014; 20: 13205–10.
- 4 Sibio S, Di Giorgio A, Campanelli M *et al.* Ambulatory surgery for perianal Crohn's disease: study of feasibility. *Gastroenterol Res Pract* 2018; 2018: 1–7.
- 5 Keller GPDS, Angriman GMSI, Celentano MCV. Inflammatory bowel disease position statement of the Italian Society of Colorectal Surgery (SICCR): Crohn's disease. *Tech Coloproctol* 2020; 24: 421–48.