Minimising the impact of COVID-19 on cancer surgery

Editor

The COVID-19 pandemic has significantly disrupted cancer treatment nationwide, despite NHS England urging Trusts to ensure cancer care continued[1]. Cautious clinical guidance[2] – avoiding anastomoses, reducing laparoscopy and deferring higher risk patients – coupled with the diversion of resources to manage the expected surge, caused UK cancer surgery numbers to plummet.

The major concern was unwittingly performing surgery on COVID positive patients or patients becoming infected post-operatively. Early data from Wuhan suggested a 20 per cent mortality for COVID-19 positive elective surgery patients[3]. Unnecessarily endangering staff and other patients was also a key concern. Additionally, the potential reduction in ITU capacity and the possibility of litigation were prominent considerations[4].

In Oxford, we confined COVID-19 positive cases to our acute site, designated the Churchill Hospital the 'clean' site and commissioned support from the independent hospital. Since UK lockdown on 23rd March, we have conducted over 400 cancer procedures and extended our services to support more severely affected Trusts.

We introduced 14 days preoperative shielding and minimised hospital visits using drive-through phlebotomy and swabbing services. CT chest was used for major procedures until routine pre-operative viral swab testing was available. All theatre staff used level II PPE and underwent robust simulation training.

We use enhanced recovery protocols and where possible, early discharge with intensive telephone follow-up. Monitoring of the cohort continues, but to date we have no reported peri-operative COVID-19 infections.

During the recovery phase, we must address the needs of patients whose treatment has been put on hold[5]. Firstly, we need to extend surgery to cancer patients with significant co-morbidities and patients with clinically urgent benign disease. Secondly, we must resume diagnostic services to avoid a peak of deaths due to delayed diagnoses.

Teamwork, agile decision making and above all, systematic testing of staff and patients is essential to restore workforce confidence, improve efficiency and resource utilisation.

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1 NHS England and NHS Improvement. Letter to chief executives of all NHS trusts and foundation trusts, CCG accountable officers, GP practices and primary care networks, and providers of community health services. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/urgent-next-steps-on-nhs-response-to-covid-19-letter-simon-stevens.pdf.

2 The Association of Coloproctology of Great Britain and Ireland. Considerations for Multidisciplinary Management of Patients with Colorectal Cancer during the COVID-19 Pandemic. https://www.acpgbi.org.uk/news/considerations-for-multidisciplinary-management-of-patients-with-colorectal-cancer-during-the-covid-19-pandemic/.

3 Lei S, Jiang F, Su W, Chen C, Chen J, Mei W *et al.* Clinical characteristics and outcomes of patients undergoing surgeries during the incubation period of COVID-19 infection. *EClinicalMedicine* 2020; https://doi.org/10.1016/j.eclinm.2020.100331 [Epub ahead of print].

4 Spinelli A, Pellino G. COVID-19 pandemic: perspectives on an unfolding crisis. *Br J Surg* 2020; **107**: 785–787.

5 COVIDSurg Collaborative. Elective surgery cancellations due to the COVID-19 pandemic: global predictive modelling to inform surgical recovery plans. *Br J Surg* 2020; https://doi.org/10.1002/bjs.11746 [Epub ahead of print].