

## COVID-19 pandemic: new rules of engagement in endocrine surgery

Editor

SARS-CoV-2 is sweeping across the world triggering a nation-by-nation upscaling of emergency strategies to tackle its outbreak<sup>1</sup>. The adoption of strict prevention and control measures in addition to tactical reallocation of hospital resources and manpower are required to respond to a surge in patient care demand<sup>2</sup>. Guidance on prioritization strategies to address surgical practice in these dire straits is required to reduce the burden on healthcare systems and support institutions and providers<sup>3</sup>. Some guidance is available concerning the management of patients needing surgery for endocrine conditions during the COVID-19 pandemic<sup>4</sup>; patients with the following endocrine conditions requiring hospitalization within 30 days that are included in the priority class of the waiting list are scheduled.


Priority is given to: thyroid cancers that are life-threatening or have serious morbidity such as those with aggressive biology; severely symptomatic Graves' disease that cannot be controlled with medical management (agranulocytosis represents a rare adverse reaction of methimazole that occurs in about 0.2–0.5 per cent of cases and may mimic COVID-19 symptoms); highly symptomatic goitre; paediatric neoplasia; hyperparathyroidism unresponsive to medical therapy; confirmed adrenocortical cancer or suspicious lesions; pheochromocytoma or paraganglioma unable to be safely controlled medically; highly symptomatic Cushing's syndrome unable to be managed on medication; endocrine disorders in pregnant patients that are threatening the health of the mother or foetus that cannot be controlled with medical management.

All scheduled patients are called beforehand by administrative staff and screened for symptoms of fever, cough, or shortness of breath in the

previous 2 weeks or close contact with COVID-19 patients<sup>5</sup>. Patients with symptoms or contact/travel history or active COVID-19 are deferred.

Once admitted to the hospital, all patients are tested for COVID-19 (nasopharyngeal swab) before surgery. A preoperative chest X-ray is also performed. Suspected cases are isolated and chest CT is performed. An accurate medical history of the patient is obtained. Detailed informed consent is provided, including the current increased risk of COVID-19 exposure and the potential adverse perioperative outcomes. Surgical masks are provided and must be worn by each patient. Patient allocation to nurse and specialist surgeon (consultant) is recorded on the hospital management software to track contacts and limit the number of team members entering patient rooms. Designated non-COVID routes are adopted for intra-hospital patient transport. Early discharge strategies are adopted (PTH assay as early predictor of hypocalcaemia allowing a preventive control is performed).

Strategies to minimize physical follow-up are observed with patient education, email, phone and telemedicine consultations<sup>6</sup>. Shifting to a community-centred care involves new ethical and moral issues, new aims, new outcomes, and new uncertainties that arise from a new perspective<sup>7</sup>. Concerns about short-term and long-term oncological outcomes, tumour progression and deterioration of emotional state need to be addressed<sup>2,7</sup>. Postponing the entire diagnostic framework in terms of out-patient visits, screening tests, diagnostic imaging and oncologic follow-up may result in a diagnostic delay. The backlog constituted by delayed diagnosis and deferred operations will grow over time and may overwhelm healthcare systems as a 'second epidemic wave'<sup>8</sup>.

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