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## Do we really need guidelines for high resolution anoscopy during the COVID-19 pandemic? – Response

doi:10.1111/codi.15203

*Dear Editor,*

We appreciate Mistrangelo *et al.* [1] bringing to our attention the use of high resolution anoscopy (HRA) in the era of the COVID-19 pandemic. However, the authors focus on the role of HRA in ‘screening’, and make a suggestion that HRA is ‘mandatory’. We believe that their perspectives are potentially misleading, as neither of these points is mentioned in the original guidelines [2].

The International Anal Neoplasia Society (IANS) guidelines were first published on 8 April 2020, in response to multiple enquiries from our members and others, at a time of great confusion and anxiety amongst practitioners from many different jurisdictions around the world. They drew on the latest available evidence at the time and received input from a wide range of experts in the field.

Many organizations have issued guidelines regarding the management of cancer in the era of COVID-19 [3]. In England, for example, a new diagnosis of anal cancer would clearly be allocated a ‘priority level 1’, as curative therapy has a high (> 50%) chance of successful treatment [4]. Newly diagnosed anal cancers have better outcomes when diagnosed early [5], with increasing evidence that chemoradiotherapy may be avoided in smaller cancers such as superficially invasive squamous cell cancers [6].

Whilst digital anal rectal examination (DARE) is an important first step in the evaluation of all symptomatic patients, this unfortunately has a very limited evidence base and may have significant false-negative rates [7]. In centres with highly trained practitioners, subject to robust quality assurance measures [8], HRA offers the unique ability, like colonoscopy, to detect cancers at an order of magnitude greater than those by palpation at DARE [6]. Furthermore, although high grade

squamous intraepithelial lesions are not usually palpable by DARE, experienced HRA practitioners are able to identify a small subset of lesions that demonstrate neo-vascular changes indicating probable imminent progression to cancer.

We accept that centres without access to high quality HRA services may have to rely solely on DARE findings. However, where HRA expertise has already been developed, it has the ability to offer early, accurate, diagnosis of anal cancers and worrisome high grade squamous intraepithelial lesions, with the potential to substantially improve survival and quality of life of our patients. This remains true in the era of COVID-19.

The IANS is focused on the prevention and early diagnosis of anal cancers. Our patients are often drawn from the very vulnerable populations most at risk for COVID-19, such as the immunocompromised. It is becoming increasingly clear that many months or years will pass before the risk of COVID-19 is reduced to a level where these guidelines are no longer necessary. Progression to anal cancer is likely to occur in some patients during this period. The IANS guidelines, like others in similar fields, suggest a reasonable approach to care in these difficult times.

## Conflicts of interest

None of the authors have any conflicts of interest to declare.

## Author contributions

Richard Hillman, Tamzin Cuming, Naomi Jay, Stephen Goldstone, Michael Berry-Lawhorn, Luis Barroso, Mayura Nathan, Joel Palefsky: Substantial contributions to the conception or design of the work; or the acquisition, analysis or interpretation of data for the work; drafting the work or revising it critically for important intellectual content; final approval of the version to be published.

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Received 29 May 2020; accepted 30 May 2020; Accepted Article online 21 June 2020

In response to doi: <https://doi.org/10.1111/CODI.15116>

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## Reported outcome measures for colorectal cancer patients during the COVID-19 pandemic

doi:10.1111/codi.15236

Dear Sir,

The urgent reorganization of clinical services in response to the early stages of the COVID-19 pandemic has had a significant impact on the delivery of colorectal cancer (CRC) surgery. Both patients and surgeons had difficult decisions to make, including individual risk assessment, issues pertaining to informed consent and the safety of laparoscopic surgery.

We explored how our CRC patients felt they had been managed by way of a detailed postoperative telephone questionnaire. Patient-reported outcome measures (PROMs) were based on the validated Functional Assessment of Cancer Therapy – Colorectal Cancer

**Table 1** COVID-19 quality of life survey outcomes.

QOL score subscales	Median	Range
Physical (0–12)	9	4–11
Social (0–12)	12	6–12
Emotional (0–12)	7	3–10
Functional (0–12)	10	8–12
COVID-19: psychological impact (0–8)	4	0–8
COVID-19: practical impact (0–8)	6.5	4–8
Overall QOL score (0–64)	46.5	30–61

quality of life (QOL) survey [1,2], adapted to specifically address the COVID-19 situation. Patient details were accessed from the hospital's electronic database.

Over 9 weeks (17 March 2020 to 19 May 2020) we cautiously treated 21 CRC patients comprising 16 men and 5 women (median age 67.5 years, range 55–84 years). Nineteen patients underwent elective surgery (COVID-19 screened) and two had emergency surgery. Three patients (14%) were diagnosed with COVID-19 during admission, and there was one death. Overall median patient satisfaction score was 10/10 (range 3–10), but there was variation in QOL scoring dependent on the question subscale (Table 1).

This PROM has given us insight into the clinical reality that these patients faced. Whilst overall satisfaction scores were high, additional attention needs to be focused on the emotional and psychological well-being of future CRC patients should there be another wave of infection.

## Conflicts of interest

None of the authors have any conflicting interest to declare.

## Ethics and Service evaluation

No ethics committee review required.

## Consent

All patients consented to data collection, analysis and dissemination.

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Received 7 June 2020; accepted 16 June 2020; Accepted Article online 6 July 2020