Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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EDITORIAL

Urgent digestive surgery, a collateral victim of the COVID-19 crisis?

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For some weeks now we have been experiencing an unprecedented COVID-19 pandemic that has had a profound impact on our routine surgical activities. No-one contests the importance of giving priority care to patients with life-threatening COVID-19 infections.

All French surgery teams in all branches have adjusted their activity, curtailing outpatient surgery and deferring scheduled operations as much as possible, in particular major cancer surgery, so as to free medical and paramedical staff to take care of patients admitted with COVID-19.

However, after several weeks under the French government's contingency plan for hospitals, and after some two weeks of confinement for the population, we are beginning to glimpse collateral damage arising from the epidemic.

Collateral effects of the epidemic and confinement

Already outside the field of surgery, two weeks of confinement have seen an observed increase of 30% in domestic violence [1].

Owing to prolonged confinement, some patients are presenting late to emergency services (''so as not to take up their time'', according to an article in the newspaper *Le Monde* dated 31 March 2020 [2]). In this way, an initially uncomplicated case of appendicitis can turn into localized appendicular peritonitis. Some patients with COVID-19 also complain of gastro-intestinal symptoms such as diarrhoea, vomiting and abdominal pain [3]. Patients have accordingly presented to emergency services with digestive symptoms, been sent on for COVID-19 testing, found to be uninfected, and only then been referred for surgery, after several hours delay.

Urgent surgery, a collateral victim

Collard M et al. [4] have emphasised the place of non-surgical treatment as an alternative treatment for adult uncomplicated acute appendicitis during the COVID-19 crisis. However, given the pressure of activity linked to Covid-19 with its attendant restricted access to operating rooms and staff redeployment, there might be a temptation to extrapolate this recommendation to borderline cases of appendicitis (diameter just above the limit, doubt about a peritoneal effusion, etc.) that would in principle qualify for emergency surgery. Likewise, there might be a temptation to treat uncomplicated acute cholecystitis medically to defer surgery until after the Covid-19 crisis has passed, or to opt for a colonic stent for an obstructive tumour rather than immediate surgery.

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These three simple situations (we could cite others) raise an ethical question. Do the current critical circumstances permit us to make exceptions to the rules of good practice? In the examples given, the right course would be appendectomy when a patient does not strictly meet the conditions for non-surgical treatment [5], emergency cholecystectomy [6], and first-line surgery for an occlusive colonic tumour [7]. The answer must be no. We cannot let proper management of surgical emergencies be a collateral victim of the COVID-19 crisis.

What solutions?

What can be done? The simplest solution would be to transfer the patients to hospitals (public or private) that are not under pressure from COVID-19. It might be judicious to have separate COVID-19 and non-COVID-19 medical teams. It would also be appropriate to deliver a clear message to the general public that urgent surgery will not be neglected, and that confinement will not impede emergency consultations.

It is essential that we do not degrade the quality of our surgical practice because of the COVID-19 emergency. Urgent surgery is still urgent and demands diligent care. If provided in safe conditions, such surgery can be performed in an out-patient care or enhanced recovery programme. If no operating room or post-operative recovery room is available, non-surgical treatment must be considered only in cases where it is justified by strong evidences.

Disclosure of interest

KS declares an interest in the companies Sanofi, MSD, FSK, B-Braun, and Baxter.

JV declares that he has no competing interest.

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