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CORRESPONDENCE

RE: RE: Strategy for the practice of digestive and oncologic surgery in the COVID-19 epidemic situation



The article [1] we published gave rise to numerous thought-provoking commentaries [2–6], for which we thank the authors. Like other authors [7–9], we attempted to provide surgeons with avenues for reflection allowing them to adapt to the unprecedented situation with which we had (and still have to) cope, namely the “COVID-19” pandemic. These articles proposed lines of adaptation to the initial phases of the pandemic, before or during the peak(s), when our health care system ran the risk of being overwhelmed. And now, as soon as feasible [3,10], it matters that optimal treatments be proposed to patients in a secure and controlled environment. While the duration of phase 3 is impossible to accurately foresee, it is likely to last several weeks or months, a prediction that seems confirmed by the occurrence in European countries of new epidemic peaks. Even taken alone, uncertain duration justifies adaptations of our health care system. Over the course of phase 3, we will be called upon to manage infected patients, immunized patients, and patients who apparently have not been infected by the virus, some of whom may paradoxically be infected, even though they remain asymptomatic. In this context, M. Zizzo et al. [5] have underlined the interest of screening as a means of avoiding not only operation of an infected patient and the increased risk of mortality induced by the infection [11], but also the contamination of the medical team. The utilization of laparoscopy and the risk of aerosolization inherent to this technique have raised numerous questions in the surgical community [12]. While the laparoscopy precautions to be taken during the period of epidemic outbreak have been detailed [1,2,6], M. Canis et al. [2] have pointed out that for the sake of future patients, the attendant reflexes will need to be conserved and transmitted. While F Drissi et al. [6] have drawn attention to the scarcity of data in the literature on contamination by the virus of the peritoneal liquid, other authors [13] have stated that when all precautions are observed, the risk of contamination might be lower with laparoscopy than with laparotomy.

Risk assessment is an exercise familiar to surgeons, who are used to weighing a risk in the medium term, such as the evolution of a pathology, against a risk in the short term, such as that entailed by a surgical procedure. In the present-day situation, it will behoove us to adjust our risk assessment, taking into account the risk of waiting before operating as opposed to the risk of not being able to apply our usual safety and quality criteria, before undertaking surgery. We now know, as has been verified in numerous countries, that lockdown and the initial phase of the epidemic occasioned delays in consultations and radiological

or endoscopic diagnostics, delays leading to unduly belated consultations and more advanced stages of diseases. These observations underscore the relevance of surgery-related publications detailing the history of a given illness and providing an evaluation of the time that is or is not available [1]. A second assessment of the risk/benefit balance will come from intensive care doctors, who will be called upon to provide perspective on the health care resources to be allocated to COVID patients and to those awaiting surgery, whether the operation be obviously risky (cancer, transplantation...) or eventually risky (morbid obesity...). Exchanges between our diversified specialties will assume major importance, taking place site by site, as local constraints will be at the forefront of discussions and decisions.

While we have adapted to the new constraints imposed on us by the circulation of a virus unknown to us a year ago, the reflections and adjustments already carried out will need to endure and develop, some examples being adaptation of teleconsultation and remote teaching, which avoid travel, fatigue... and excessive CO² consumption. Were the coronavirus crisis to make us forget the combat to be waged against global warming, it would be unfortunate [14].

Indeed, during the weeks and months of lockdown, our planet breathed better; that said, the economic repercussions could be incalculable...

To conclude, some solutions have been found and others will arise from our collective intelligence as we pool the resources of our health care system, the objective being to have it evolve into a system that resists and perseveres.

Disclosure of interest

The authors declare that they have no competing interest.

References

- [1] Tuech J-J, Gangloff A, Di Fiore F, Michel P, Brigand C, Slim K, et al. Strategy for the practice of digestive and oncologic surgery in COVID-19 epidemic situation. *J Visc Surg* 2020;157:S6–12.
- [2] Canis M, Bourdel N, Botchorishvili R. Surgery and the COVID-19 epidemic: Some additional precautions. Re: “Strategy for the practice of digestive and oncological surgery during the COVID-19 epidemic”. *J Visc Surg* 2020;157(3 Suppl 1):S65.
- [3] Pessaux P. Re: “Strategy for the practice of digestive and oncological surgery during the COVID-19 epidemic”. *J Visc Surg* 2020;157(3 Suppl 1):S67–8.
- [4] Rao AR. Re: Strategy for the practice of digestive and oncological surgery during the Covid-19 epidemic. *J Visc Surg* 2020;157(4):363.
- [5] Zizzo M, Bollino R, Annessi V. Pre- and post-operative screening in limited-term elective cancer surgery patients during the COVID-19 pandemic. *J Visc Surg* 2020;157(3 Suppl 1):S69–70.
- [6] Drissi F, Frey S, Abet, E. Commentaires de l'article... *JCIRV* 20 00178R1.
- [7] Glehen O, Kepenekian V, Bouché O, Gladieff L, Honore C. RENAPE-BIG-RENAPE Treatment of primary and metastatic

- peritoneal tumors in the Covid-19 pandemic. Proposals for prioritization from the RENAPE and BIG-RENAPE groups. *J Visc Surg* 2020;157(3S1):S25–31.
- [8] Baud G, Brunaud L, Lifante JC, Tresallet C, Sebag F, Bizard JP, et al. Endocrine surgery during and after the COVID-19 epidemic: Expert guidelines from AFCE. *J Visc Surg* 2020;157(3S1):S43–9.
- [9] Collard M, Lakkis Z, Loriau J, Mege D, Sabbagh C, Lefevre JH, et al. Antibiotics alone as an alternative to appendectomy for uncomplicated acute appendicitis in adults: Changes in treatment modalities related to the COVID-19 health crisis. *J Visc Surg* 2020;157(3S1):S33–42.
- [10] Tuech JJ, Gangloff A, Di Fiore F, Benyoucef A, Michel P, Schwarz L. The Day after Tomorrow: How Should We Address Health System Organization to Treat Cancer Patients after the Peak of the COVID-19 Epidemic? *Oncology* 2020;1–9, <http://dx.doi.org/10.1159/000509650> [Online ahead of print].
- [11] Besnier E, Tuech JJ, Schwarz L. We Asked the Experts: Covid-19 Outbreak: Is There Still a Place for Scheduled Surgery? "Reflection from Pathophysiological Data". *World J Surg* 2020;44(6):1695–8.
- [12] Veziant J, Bourdel N, Slim K. Risks of viral contamination in healthcare professionals during laparoscopy in the Covid-19 pandemic. *J Visc Surg* 2020;157(3S1):S59–62.
- [13] Mintz Y, Arezzo A, Boni L, Baldari L, Cassinotti E, Brodie R, et al. The risk of COVID-19 transmission by laparoscopic smoke may be lower than for laparotomy: a narrative review. *Surg Endosc* 2020;34(8):3298–305.
- [14] Tuech JJ. Surgeons must get on the train by reducing greenhouse gas emissions in their operating theatres, their hospitals and their universities. *J Visc Surg* 2020;157(4):265–7.

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