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EDITORIAL

A special edition of the *Journal of Visceral Surgery* on COVID-19: What problems, dangers and solutions have been identified?

All surgical specialties have seen their practices modified and destructured by the Acute Respiratory Syndrome (SARS-CoV-2) pandemic. Many learned societies have published recommendations and advice for surgery during the COVID-19 pandemic [1,2].

We all, whatever our modes and places of practice, walk the tightrope of what is possible amidst dangers on all sides. Of course, depending on our respective situations, this balancing act will be perceived differently. So, how will cancer surgery go forward? And this perception will evolve over time depending on the progression and the phases of the pandemic.

Yes, it would be desirable to continue operating on cancers, even if we perhaps should restrict certain indications. YES, but at what price and confronting what dangers?

Is it reasonable that surgery for localized colon cancer to be delayed for a few weeks? Yes! For a month or two? Not so sure! For three or four months? No! Where is this pandemic likely to lead us?

Some feel that the global intraoperative risk is increased and poorly controlled during a pandemic period and therefore surgery for a patient with an asymptomatic limited colon cancer should be deferred. While the patient must undergo curative surgery, this excess risk does not seem acceptable. This is partly explained in the article by Tuech et al. published here [3]. The intraoperative risk linked to COVID-19 was initially reported in a single Chinese publication on four cases, not a very significant sample. But a second publication describing 30 cases is much more worrisome, with a 44% rate of hospitalization in intensive care and an overall mortality of 20% [4]. So, you will surely read with interest about the cases of nosocomial infection by COVID-19 and the future of these patients in the very short term reported here by two Parisian surgical teams [5]. The risk is certainly not zero.

There are others who are not persuaded by this notion of excess-risk and anticipate, with good reason, a massive influx of surgical cases in a few weeks. Based on this analysis, these colleagues believe that it is therefore necessary to continue to operate on patients with cancer if that is possible. Operating at all costs, trying to adapt and be inventive — this is the point of view defended by one of our colleagues who works in an area heavily affected by the SARS epidemic [6].

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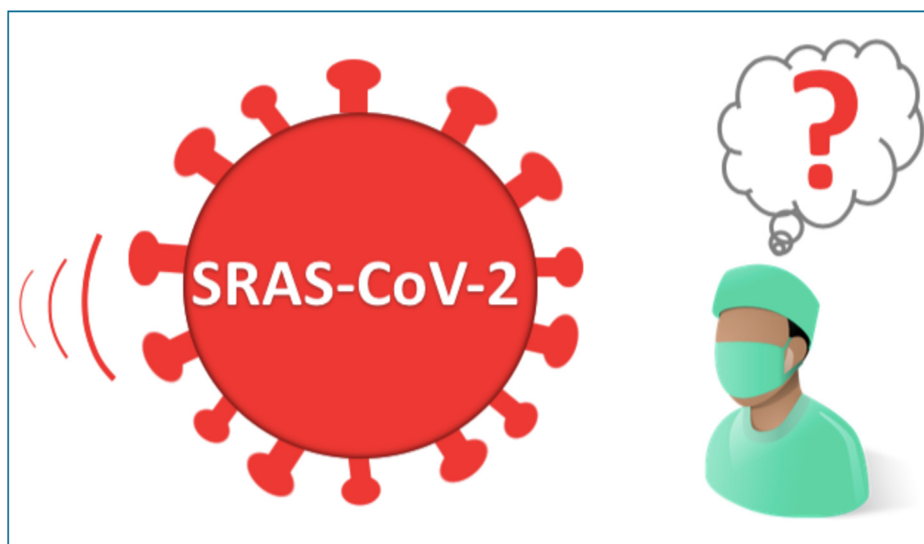

Figure 1. Vigilance.

How can we best manage risks about which we still know so little? Because, yes! The risks are multiple. Thus, if in France tomorrow a Regional Health Agency (ARS) should require a surgical team to move to a COVID-19-negative center in order to perform cancer surgery, should this be seen as an element of progress and finally an organization that transcends the divides between public and private medicine? Is there a positive effect of this crisis? Yes, unless this leads to cancer surgery being performed in a Level I center that lacks the authorization (by this same ARS) to operate on cancers. However, cancer surgery must meet quality criteria, and these criteria are not exclusively linked to the surgeon. If the center does not meet the quality criteria for anesthesia, resuscitation and pathology because of too little oncologic activity — where do we go next? Are we going to deliver uncertain or sub-optimal cancer treatments to patients in order to fill in boxes in an Excel spreadsheet? There is also risk that in the aftermath of COVID-19, we will no longer be able to tell these Level 1 centers that they must not operate on cancers. Will the result be poor patient care and the loss of years of progress in health care organization?

So, we must already reflect on and manage post-crisis care, and you will read with interest here the reflections and recommendations of the French Society of Endoscopic Surgery (SFCE) [7]. Yes, we need to anticipate and plan for what could have been foreseen.

We still must face up to the pandemic, the deadly quiet of idle operating rooms, the exhaustion of our anesthetist colleagues in heavily affected regions, who must also take call for the Emergency Rooms (ER). Yes, emergencies continue to occur and present to ER's although they are, largely forgotten by organizational systems that only consider the number of beds, new beds, free beds, beds for resuscitation of COVID-19 patients. The nature of emergency presentations has changed; they have decreased in number but increased in severity; is it because the sick are afraid to go to the hospital? This induces complex situations in ER's and this is highlighted in two texts of this special issue [8,9]. The clinical symptoms of a patient with COVID-19 infection may be predominantly gastrointestinal or full-blown respiratory symptoms, as the mini-review will tell you [10].

We must be vigilant in case of appendicitis, vigilant for the diagnosis and proceed with a CT scan that includes the lungs. Such a case is presented in this issue [11] (Fig. 1). But also, return, if you are still master of this technique, to open appendectomy via the McBurney incision because laparoscopy entails risks of virus aerosolization in the laparoscopic gases (a mini review will explain this) [12]. Finally, if you no longer have access to the operating room, you, the surgeon, and not the medical doctor, should assume the responsibility for instituting medical treatment of this appendicitis; such medical management is exposed to you in this issue [13]. But hold out! Keep an operating room available for emergencies, despite the formal demands of the ARS whose injunctions have incredible force in view of the number of dead and despite the temptation to open yet another bed to our anesthetist-resuscitators swept along by the avalanche of cases and facing increasingly difficult choices. Hold out, because it is probably there, in the emergency room, that our skills as surgeons will be most useful during this appalling turmoil and where we will be able to save lives. Because, with or without the virus, peritonitis also kills.

Disclosure of interest

The author declares that he has no competing interest.

References

[1] Akladios C, Azais H, Ballester M, et al. Recommendations for the surgical management of gynecological cancers during the COVID-19 pandemic — FRANCOGYN group for the CNGOF. J Gynecol Obstet Hum Reprod 2020.

[2] https://isspp.org/covid-19-pandemia-isspp-recommendation-for-therapy-of-patients-with-peritoneal-and-pleural-metastasis/.

[3] Tuech JJ, Gangloff A, Di Fiore F, Michel P, Brigand C, Slim K, et al. Strategy for the practice of digestive and oncological surgery during the Covid-19 epidemic. J Visc Surg 2020, http://dx.doi.org/10.1016/j.jviscsurg.2020 [pii: S1878-7886(20)30070-9, Online ahead of print].

[4] Lei S, Jiang F, Su W, et al. Clinical characteristics and outcomes of patients undergoing surgeries during the incubation period of COVID-19 infection. EClinicalMedicine 2020, http://dx.doi.org/10.1016/j.eclinm.2020.100331 [Epub ahead of print].

[5] Luong-Nguyen M, Hermand H, Abdalla S, et al. Nosocomial infection with SARS-Cov-2 in the Digestive Surgery departments. J Visc Surg 2020, http://dx.doi.org/10.1016/j.jviscsurg.2020.04.016 [Online ahead of print].
[6] Pessaux P. Re: strategy for the practice of digestive and oncological surgery during the Covid-19 epidemic. J Visc Surg 2020, http://dx.doi.org/10.1016/j.jviscsurg.2020.04.005 [Online ahead of print].
[7] Baud G, Brunaud L, Lifante JC, et al. Endocrine surgery during and after the Covid-19 epidemic: expert guidelines in France. J Visc Surg 2020 [DOI].
[8] Slim K, Veziant J. Urgent digestive surgery, a collateral victim of the Covid-19 crisis? J Visc Surg 2020, http://dx.doi.org/10.1016/j.jviscsurg.2020.04.001 [Online ahead of print].
[9] Canis M. Re: strategy for the practice of digestive and oncological surgery during the Covid-19 epidemic. J Visc Surg 2020, http://dx.doi.org/10.1016/j.jviscsurg.2020.04.007 [Online ahead of print].
[10] Gornet JM, Tran Minh ML, Leleu F, Hassid D. What surgeons need to know about digestive disorders and paraclinical abnormalities induced by COVID-19? J Visc Surg 2020, http://dx.doi.org/10.1016/j.jviscsurg.2020.04.017 [Online ahead of print].
[11] Pautrat K, Chergui N. SARS-CoV-2 infection may result in appendicular syndrome: chest CT scan before appendectomy. J Visc Surg 2020, http://dx.doi.org/10.1016/j.jviscsurg.2020.04.007 [Online ahead of print].
[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, http://dx.doi.org/10.1016/j.jviscsurg.2020.04.010 [Online ahead of print].
[13] Collard M, Lefevre JH, Maggiori L. Health crisis related to COVID-19: treatment modalities of acute uncomplicated appendicitis in adults managed by antibiotics alone as an alternative to appendectomy. J Visc Surg 2020 [Online ahead of print. DOI].

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