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

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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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Resumption of elective colorectal surgery during COVID-19 and risk of death

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Dear Editor,

The Association of Coloproctology of Great Britain and Ireland has recently released recommendations for re-starting elective colorectal surgery to address the concerns that significant numbers of patients worldwide have been deferred during this pandemic [1]. It is a credit to the speciality that most units have managed to continue with urgent cancer surgery through the pandemic, with leading units undertaking four to five urgent cases per week. Despite this there is now a need to accommodate other patient groups who need colorectal surgery, such as those with inflammatory bowel disease and others with benign colorectal conditions who have been placed on hold. Patients are anxious about timely widening of services to reduce waiting time, and there is a backlog for surgeons trying to serve this need in an already bulging set of waiting lists; meanwhile, stakeholders are concerned about the reduction in clinical activity.

We report here on nosocomial or hospital-acquired infection with COVID-19 [2]. Our study included 1564 patients from 11 hospital sites throughout the UK and one in Italy, and collected outcomes up to 28 April 2020. The overall in-hospital mortality rate for patients with COVID-19 was 27.2% (425/1564). Of the COVID-19 cases, a conservative estimate for the nosocomial infection rate was at least 12.5%. The median age of patients with nosocomial COVID-19 was 80 years [interquartile range (IQR) 71.5–86.5 years] compared with 73 years (IQR 60–82 years) for patients admitted with community-acquired COVID-19 infection. Nosocomial COVID-19 patients were also frailer than those in the community-acquired COVID-19 group; the respective median levels of frailty being moderate [Clinical Frailty Scale (CFS) = 6] versus vulnerable (CFS = 4). It is reassuring that the risk of developing COVID-19 as a nosocomial infection after elective

surgery is no higher than for other hospital-acquired infections [3]. It was also found that patients with nosocomial infection had a modest reduction in risk of mortality, which may be attributed to timely care.

However, the biggest issue is the significantly increased risk of death in this group for patients undergoing routine procedures in the midst of a pandemic. When we consider that the National Bowel Cancer Audit reports a < 2% risk of death with elective colorectal surgery for cancer [4], a figure of 27% would be unacceptably high. Similarly, data from CovidSurg in *The Lancet* reports that 30-day postoperative mortality worldwide was 23.8% (268 of 1128) in COVID-19 patients rising to 38.0% (219 of 577) for those with pulmonary complications [5].

The decision-making regarding the harm patients may come to by having their surgery delayed needs to be urgently weighed up against the high death rates seen in those who develop nosocomial COVID-19. Units such as Salford Royal have devised risk prediction tools that may be of use in prioritization of patients according to vulnerability to COVID-19 [6].

It is hoped that the risk of nosocomial COVID-19 infection has now reduced as the first wave of the pandemic has lessened. We feel that a special approach is required for frail patients who require elective surgery at this time. Innovative alternatives may be reported as a bridge to managing certain groups as having long-term conditions rather than ‘curing’ them with surgery – antibiotics [7] and stents for acute appendicitis for example. We would recommend a multidisciplinary discussion between patient, carer, surgeon and geriatrician with regard to delaying surgery longer than previously anticipated. Ahead of the second wave of COVID-19 predicted for the winter, we would urge that patients who are 80 years and older undergo an urgent frailty assessment with their GP in order to optimize their medical and functional status.

Data availability statement

Data available on request from the authors.

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