

COVID-19 was first identified in Wuhan, China, in December 2019, and recognized as a global pandemic on 11 March 2020. Consequent to the COVID-19 pandemic, scientific societies have published countless guidelines. These are not unequivocal and are not evidence based. In spite of this, IANS has proposed some guidelines on the use of HRA in anal cancer and its precursors.

Even if high-grade anal intraepithelial neoplasia (AIN) is the direct precursor to anal cancer, the rate of progression to invasive carcinoma is between 1.3% and 3.2% at 5 years [2,3]. The meta-analysis performed by Machalek reported that rates of progression from AIN III to anal cancer are approximately 1 in 600 per year in HIV-positive men who have sex with men (MSM) and one in 4000 per year in HIV-negative MSM patients [2]. Moreover, the benefits of screening programmes targeting high-risk populations are still controversial, and due to the low rate of progression screening is unlikely to be cost-effective. Furthermore, anal screening tests are not designed to detect anal cancer.

Nyitray and Coll [4] have shown that digital ano-rectal examination (DARE) has a high sensitivity for detection of anal neoplasms, as does self-anal examination for singles or partner anal examination for couples. Concordance between clinicians' result and participants was 91.2%. Neoplasms of  $\geq 3$  mm may be detectable by the clinician or self- or partner palpation.

Guidelines from the Italian Society of Colo-Rectal Surgery (SICCR) suggest that the grade of recommendation for the use of HRA in screening for AIN is weak based on moderate-quality evidence (2B) [5].

An additional factor is that SARS-CoV-2 viral RNA has been isolated from stools [1]. Whilst oro-faecal spread is not thought to be a major factor in the epidemic, HRA practitioners need to be aware of it as a potential source of infection.

Considering all these aspects it is our opinion that HRA should be avoided during the COVID-19 pandemic. HRA is a time-consuming examination when adequately performed; it is very expensive, especially if performed with personal protective equipment; and it includes the potential risk of infection for personnel involved in the procedure.

Considering the costs of dealing with the problems posed by COVID-19, the shortage of healthcare professionals and the lack of worldwide consensus evidence for HRA, this examination cannot be considered mandatory during the COVID-19 pandemic.

The low risk of progression of AIN to invasive carcinoma, even in high-risk patients, and the long time from diagnosis of AIN and progression do not justify the use of HRA and a screening programme during the COVID-19 pandemic.

DARE with biopsy of suspicious palpable lesions of symptomatic patients could be considered sufficient during this period. A latency of 6–12 months is probably reasonable for these patients without affecting the natural history of AIN.

## Conflicts of interest

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

## M. Mistrangelo\*, G. Naldini† and M. Morino\*

\*Surgical Science Department, Città della Salute e della Scienza di Torino, University of Turin, Turin, Italy, and †STI Proctological and Perineal Surgical Unit, Cisanello University Hospital, Pisa, Italy  
E-mails: mmistrangelo3@cittadellasalute.to.it and mistrangelo@katamail.com

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## COVID-19 and the treatment of acute appendicitis in Ireland: a new era or short-term pivot?

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Dear Editor,

COVID-19 (SARS-CoV-2) has caused major disruption to healthcare practices globally. The reality of a pandemic rapidly overwhelming healthcare systems has been alarming, and countries earlier in their curves have sought to implement the lessons from others'

experiences. Surgery is among the many services impacted by restructuring to provide surge capacity in Ireland. Since the commencement of our national mitigation phase in March 2020, with subsequent escalation to lockdown on 17 March, elective care has been reduced to only those most time-sensitive (e.g. oncological care). There has also been a push to manage surgical emergencies non-operatively due to safety concerns regarding general anaesthesia in patients with occult COVID-19 infection and the risks of aerosol generating procedures (especially perhaps laparoscopy) to staff [1,2].

Acute appendicitis is the most common acute surgical presentation [3]. While some groups and recent guidelines advocate conservative care [4,5] which is based on large cohort and randomized controlled trials that have suggested short-term outcomes equivalent to surgery [6,7], in Ireland operative intervention had remained the predominant strategy before the pandemic [8]. Our surgical community held concerns over the seemingly high rates of failure with a conservative approach, and the risk of increasing overall hospital stay coupled with our lack in widespread availability of CT. We have examined how national practice preferences have changed over the last 6 weeks including analysis at patient experience level at our own institution, a major urban tertiary unit.

To assess current national practice, we surveyed 161 surgeons and senior surgical trainees obtaining a 59% response rate (95/161). Seventy-six per cent of participants have modified their practice to a predominant conservative approach with the majority (74%,  $n = 71$ ) obtaining CT at presentation. Interestingly, 83% ( $n = 79$ ) stated that they would return to operative management after the COVID-19 crisis.

Similar to other units, we also adjusted practices from the beginning of March 2020. Between then and now (24 April 2020), 18 patients have been admitted with clinical acute appendicitis with 11 (61%) having non-operative management. Interestingly, their median length of stay *vs* those undergoing appendectomy in the same period was 3.5 *vs* 2 days. On follow-up phone review at 1-week post-discharge, 54% of those in the conservative care group had ongoing discomfort (although none had reattended the emergency department or their family physician). 63% ( $n = 7$ ) would choose up-front appendectomy if they could decide again, and 45% ( $n = 5$ ) are interested in interval appendectomy.

From these results, it is apparent that the COVID-19 pandemic has impacted our national practice but perhaps not our psyche regarding acute appendicitis. As our infection curves flatten and international professional societies update guidance to support the re-

introduction of normal surgery (with the added protection of personal protection equipment and use of antiviral filters), we will be resuming our prior practice. While one should 'never waste a crisis', it seems likely our national preference remains 'to solve a problem by removing the cause, not the symptom'.

## Conflicts of interest

All authors declare no conflict of interest.

## Author contributions

All authors have seen, edited and approved the final version of this paper.

## M. E. Kelly, E. Murphy, J. C. Bolger and R. A. Cahill

Department of Surgery, Mater Misericordiae University Hospital, Dublin, Ireland  
E-mail: Kellym11@tcd.ie

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