

first observations suggest a high fatality rate even for operations usually associated with a very low morbidity [14]. Of course, it is imperative to guarantee a safe treatment. Adequate screening and preventive measures for the patients and staff should be adopted. The linear accelerators should be disinfected and cleaned by trained staff and a separation of the location of emergency from elective surgical operations should be assured. There is no need to delay treatment in uninfected patients. Patients should be informed about the risk of cross-contamination during treatment. This is expected to represent an opportunity to define a homogeneous multidisciplinary management in locally advanced rectal cancer patients. We should remain vigilant and share the basis on which important clinical decisions are made in this critical period.

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## Conflict of interest

There are no conflicts of interest.

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## Research disruptions and recovery

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Dear Sir,

With the COVID-19 pandemic the routine work of surgeons has been reduced to release resources to critical care and other functions. This is necessary and right in order to protect the health of our communities now. As a consequence, many of us who undertake clinical research have seen our work suspended. With a rich portfolio of colorectal research, this includes studies such as ROS-SINI2, PITSTOP and MASH, and has delayed the start of other important studies such as ELF 2 and Damascus. When we return to something akin to normality, we shall be looking to re-establish the studies in a timely manner. Funders have generally been flexible with regards to the disruption and have provided guidance on how the disruption might be managed [1]. There is no doubt that they may be asked to provide additional support for studies in progress, which may have an impact on future funding opportunities.


This disruption and pause in work might, however, provide an opportunity. In order to avoid drowning in

the deluge of extension requests that will arrive towards the end of the pandemic, the Health Research Authority (HRA) could allow currently approved studies to extend recruitment commensurate with lost time without the need for prior approval. The process of securing approvals to conduct even low-risk surgical research in the UK is Byzantine in complexity. Securing central approvals to a change in terms of this research as simple as adding a site can be a drawn-out affair. Many of our prior efforts to secure approvals are now at risk of ‘timing out’, and approvals will need to be sought to refresh or extend recruitment and follow-up periods from the central HRA.

If the HRA acts promptly, additional delays of months for studies which wish to resume recruitment in a period after they were due to have closed could be avoided. Such action would also allow resources to be moved to processing, with the expected surge in requests for new approvals as clinical practice redevelops momentum following the current crisis. In addition, attention could also turn to development of a streamlined process for the set up of low-risk studies (e.g. observational) to optimize the recovery of our vibrant research community.

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## How to manage smoke evacuation and filter pneumoperitoneum during laparoscopy to minimize potential viral spread: different methods from SoMe - a video vignette

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*Dear Editor,*

Even though previous studies on hepatitis B virus showed that it could be found in the intra-abdominal

gas, there is no evidence so far of the presence of SARS-CoV2 particles in the gas used during laparoscopy, but it is prudent to perform laparoscopy with safety strategies to avoid diffusion of potentially infected intra-abdominal aerosol into the operating room [1-6].

Appropriate personal protective equipment based on patient status and adequate precautions must be adopted, using ultrafiltration (smoke evacuators and/or filters) during the procedure and monitoring of smoke/gas evacuation and final exsufflation [1-6]. Trocar incisions should be minimized to avoid gas leakage around ports, with CO<sub>2</sub> insufflation and pneumoperitoneum at a minimum possible level [1,4]. Ports should be maintained closed during the procedure, evacuating all pneumoperitoneum via the filtering system before extracting the specimen and removing the trocars [1-4]. Commercially available closed filtration systems are recommended by the Canadian Association of General Surgeons, which discourages the use of nonfiltered devices [4].

Recently, surgeons have shared on social media (SoMe) various methods for filtering gas in laparoscopy during the COVID-19 pandemic, where other systems are not available.

In this video (Video S1) the authors propose a few strategies. Readers should be made aware that, due to the rapidly evolving scenario, it is recommended to check regularly for updates about the correct measures to adopt when performing laparoscopy during the COVID-19 pandemic. Hopefully, this trend towards a higher level of safety in surgery may result in a definitive adoption of the strategies described in the video.

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