The Editors welcome topical correspondence from readers relating to articles published in the Journal. Letters should be submitted electronically via the BJS submission site (mc.manuscriptcentral.com/bjs). All correspondence will be reviewed and, if approved, appear in the Journal. Correspondence must be no more than 300 words in length.

The show must go on

Editor

The COVID-19 pandemic adds multiple layers of uncertainty to the already challenging practice of surgery. In a recent publication[1], key disruptors to surgical workflow were identified and recommendations were given to mitigate these impacts. At the outbreak of COVID-19, general surgery and related subspecialties at Singapore General Hospital were divided into two different groups: 'hot' and 'cold'. The two groups further sub-compartmentalized into small, consultant-led subspecialty teams, functioning independently of one another to maintain social distancing. The 'hot' group, also known as enhanced acute care surgery (e-ACS), is composed of five independent teams each of which goes on one 24-h call every 5 days. The 'cold' group includes subspecialty teams that carry on with elective work. The benefit of dedicated COVID-19 staff is unclear, and patients are not always tested for COVID-19 in time[2] so compartmentalization into small teams helps mitigate the risk of cross-infection should there be virus transmission to a staff member.

Given the rising demand to treat COVID-positive patients, it seems counterintuitive to shift more manpower to acute care surgery; however we note a similar trend in Italy where it was required[2]. Although the number of acute cases was almost the same, we noticed a reduced length of stay from 4·8 days in February 2019 to 3·1 days in February 2020. This was a 35·4 per cent reduction in bed-days per emergency surgical patient, which translates into an annual saving of 7911 bed-days. As of 16 April 2020, there are more than 4400 confirmed cases of COVID-19 in Singapore, which is over 750 cases per million people, the highest in the Asia Pacific region[3]. Although we willingly answer the call to 're-direct [our] energies and works outside of [our] comfort zone'[4], our unique and irreplaceable role in caring for acutely ill surgical patients must meet the demands and challenges of this pandemic.

T. K. Nguyen, D. Chua, N. B. Shannon, J. C. F. Ng and H. K. Tan

Division of Surgery and Surgical Oncology, Singapore General Hospital and National Cancer Centre, Singapore

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1 COVIDSurg Collaboration. Global guidance for surgical care during the COVID-19 pandemic. *Br J Surg* 2020; https://doi.org/10.1002/bjs.11646 [Epub ahead of print].

2 Spinelli A, Pellino G. COVID-19 pandemic: perspectives on an unfolding crisis. *Br J Surg* 2020; https://doi.org/10.1002/bjs.11627 [Epub ahead of print].

3 Roser M, Ritchie H, Ortiz-Ospina E, Hasell J. (2020) - *Coronavirus Pandemic (COVID-19)*. https://ourworldindata.org/coronavirus [accessed 16 April 2020].

4 Ives J, Huxtable R. Surgical ethics during a pandemic: moving into the unknown? *Br J Surg* 2020; https://doi.org/10.1002/bjs.11638 [Epub ahead of print].