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Readaptation of surgical practice during COVID-19 outbreak: what has been done, what is missing and what to expect

Editor

COVID-19 is challenging healthcare systems worldwide, with confirmed cases approaching 2 500 000 patients and more than 165 000 deaths¹. Italy was one of the first western countries to report COVID-19 cases, and is suffering most from this outbreak, forcing the government to undertake extraordinary measures in the form of a nationwide lockdown². Furthermore, hospitals have had to reallocate resources to deal with the rapid increase in infections, with diseases other than COVID-19 being suddenly put to one side, eventually leading to unintentional collateral damage.

Hospital infrastructures and personnel have been reallocated to containment of the infection and management of COVID-19 patients³. Our surgical practice has moved to considering only cancer patients. The waiting list has been reworked and the significant reduction in the number of ICU beds has strongly influenced treatment allocation. As an institutional policy, we have improved patient selection to limit the need for postoperative intensive care management. We have maintained standard numbers of high-risk operations; lately selecting more surgically fit patients. Consequently, fewer patients have been admitted to the ICU, avoiding further pressure on resources. Our policy was pursued in an effort to prioritize patients by cancer prognosis, as

malignancies requiring high-risk surgical interventions (i.e. liver metastases, cholangiocarcinoma, pancreatic adenocarcinoma, sarcoma) generally have a worse prognosis and are more likely to be affected by delays in treatment.

Patients with cancer might suffer at multiple levels as the reduction in outpatient clinics and limitations in diagnostic modalities hamper rapid referral. The healthcare system should manage to find a solution to this primary screening issue, eventually avoiding even longer delays in care⁴. Medical and surgical oncology societies have recently published guidelines on the management of cancer patients during the COVID-19 pandemic, mostly calling for a delay in surgery; we strongly believe that multidisciplinary meetings should be reworked to consider patients with cancer in the COVID-19 era, taking into account the limited resources and an uncertain future. Care should be offered depending on institutional practice and resources, reviewing and discussing each type of cancer differently, and case by case, in an effort to minimize loss of patients due to disease progression.

Cancer patients are more susceptible to COVID-19 infections and have a 20 per cent mortality rate following surgery⁵. Nasopharyngeal swabs for all patients admitted to surgery are necessary to contain spread of the disease and avoid complications. Furthermore, evidence is required concerning the management of COVID-19-positive patients with cancer, as treatment allocation influences prognosis.

Surgeons worldwide have standardized the use of personal protective equipment during minimally invasive procedures to limit transmission of the disease. However, further evidence is needed as this is still of low quality and limited to laparoscopy; nothing has been disclosed concerning open surgery.

The COVID-19 outbreak will generate a gap in recovery that has to be

considered in the near future. Surgical delay should not affect prognosis in order to minimize future repercussions. In the coming months, an inverse trend should be encouraged, re-enforcing diagnostic steps and treatment possibilities to counteract the delays we have accumulated to date. International cooperation is required during this reallocation of resources to better tackle the future emergency.

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DOI: 10.1002/bjs.11698

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