Re: The Impact of COVID-19 on Interventional Radiology Services In the UK

Is There an Opportunity for Service Development in Interventional Oncology?

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Sir,

We read with great interest the data presented by Zhong et al. [1, 2] outlining an average 31% decrease in the volume of IR cases seen in the first 4 weeks of the COVID-19 lockdown in 6 centres in the UK. Our own experience at a different tertiary referral centre in the UK has been broadly in line with these findings. It is worth mentioning, however, that IR with its history of innovative, minimally invasive and effective treatments is optimally positioned to provide high-quality care for patients in this difficult time.

In our institution, thermal ablation of liver tumours is a well-established procedure for both primary and secondary malignancies. All procedures are performed under general anaesthesia with local anaesthetic infiltrated into the puncture site during the procedure. To facilitate access to anaesthetic support, ablation cases are booked onto a hepatobiliary surgical operating list, utilising that lists anaesthetic team. The patients are admitted overnight postprocedure for observation and pain management as required.

As the second wave of COVID-19 progressed across the UK, the pressure on both high dependency and intensive care beds increased dramatically. As a result of this, and along with a global reduction in operating list capacity, our surgical colleagues found themselves increasingly unable to offer liver resection to patients with potentially curative disease. We found a situation therefore where we were asked to evaluate whether we could do not only more ablation procedures than in previous years but also explore the option of daycase ablation given hospital pressures.

Review of the electronic medical records of the past 50 ablation patients (30 hepatocellular carcinoma, 16 colorectal liver metastases and 4 other metastatic lesions to the liver) was conducted with a focus on the visual analogue pain score (rated 0–10 with 0–3 classified as none/mild, 4–6 as moderate and > 6 as severe pain) at 6 h postprocedure.

In total, 47/50 (94%) of patients had a pain score of 0–3 of which 39 (83%) had no pain at all. Of the remaining 3 patients, one patient with moderate pain (score 5) had undergone a large ablation with multiple needle placements. One patient developed a low-grade fever postprocedure which was thought to be a postablation syndrome or low-grade infection and one patient developed a urinary tract infection postprocedure whilst in hospital and was admitted for 4 days.

In light of these data, and on review of results in the published literature [3], we have now begun to offer daycase ablation in selected patients. We feel that review of comorbidities, technical aspects of the procedure, and social circumstances are key areas of evaluation along with careful assessment of the patient postprocedure prior to discharge. To date we have had no complications or returns to hospital.

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Our experience highlights that as with any major shift in working conditions, new opportunities and alternative solutions will arise. We believe that interventional radiologists should actively be seeking methods to enhance availability of oncological treatments by means of discussion with clinical colleagues and ongoing critical evaluation of existing clinical pathways.

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Declarations

Conflict of interest The authors declare that they have no competing interests.

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