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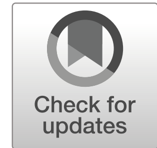

LETTER TO THE EDITOR

Letter to the Editor RE: "COVID-19 Impact on Colorectal Daily Practice—How Long Will It Take to Catch Up?"

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Dear Editor,

We read with interest the article regarding the impact of COVID-19 to colorectal practice and the longer term consequences this will have to our patients.[1] As in the USA, NHS England halted all elective surgery on the 15 April 2020 to free up anaesthetic resources. In reality, many hospitals, particularly those close to London where the COVID-19 peak preceded other parts of the country, postponed all non-urgent surgery some time before this. This was to allow operating theatres and post-operative departments to be transformed into intensive care facilities to manage the anticipated demand from ventilated patients. Also as in the USA,[2] senior surgical faculty were reorganized either being seconded to critical care units themselves or doubling up on emergency on-call rotas compensating for the redeployment of junior colleagues.

Modelling has estimated that across the country, 43,000 operations were cancelled per week.[3] As elective surgical activity has increased over the last few weeks, the issue of prioritization has become increasingly relevant. National guidelines exist,[4] but these do not account for the nuances of individual patients. Surgeons are experienced at "fighting the corner" of patients under their direct care; we have to do this regularly, for example, when competing for shared access to emergency theatres. Post-COVID prioritization is an evolving situation, and understandably patients with cancer were at the front of the queue when elective surgery restarted. However, not all cancer patients will suffer poorer outcomes as a result of having their cancer surgery delayed by a few months,[5] and some may, in fact, benefit from further delay until a time exists when the added risk of undergoing surgery is reduced. Perhaps more challenging still is how we prioritize benign procedures and maintain a level playing field across different surgical specialities competing for access to theatres or specialist equipment such as robotics. National guidelines continue to evolve for elective surgery in the current climate and have relaxed initial approaches such as avoiding laparoscopic surgery and the routine use for CT chest imaging prior to surgery.[6] At our hospitals, a multi-specialty prioritization committee has been established acting as content experts to review indications for surgery prior to patients being offered dates for their surgery.

In time, we will need to investigate the impact of postponing surgery at this level. Fortunately, in the UK, we did not reach a critical capacity for intensive beds during the initial COVID peak, as was seen in other countries. However, we may never appreciate the actual cost of creating this state of "COVID-readiness" to our non-COVID patients. Non-operative strategies for some surgical pathologies such as appendicitis were considered, and such an approach was used in isolated patients, though in the main we elected to continue operative management, albeit with open surgery during the initial COVID peak, as we believed the hospital to be a dangerous place for patients to be and surgery to be the safest route to early discharge.

Understanding the population-level downstream consequences of surgical decisions made during the pandemic, and guidelines that were often theoretical given the lack of available evidence,[7] is vital so that we will be better prepared should we encounter further peaks or experience such a pandemic again in the future.

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