Updated Intercollegiate General Surgery Guidance on COVID-19 27th March 2020

This updated guidance will be subject to further amendment in the light of new national recommendations in relation to PPE and aerosol generating procedures. It should be noted that current advice from Public Health England in relation to positive flow ventilation in theatres should be followed and the previous text related to this issue has been removed.

Surgeons will continue to care for patients in the current crisis, especially emergencies. Patient care will be affected if staff become sick and leave work. This current document updates recent guidance for general surgery now further information has emerged from government, Italy and China. Consider COVID-19 infection possible in every patient. We must follow guidelines and also apply common sense to at risk clinical environments. Unfortunately, many patients will be disadvantaged by the current pandemic and increased risks apply to all patients. Teams will apply judgement based on local circumstances, resources and for some exceptional patients. While priorities may change as incidence increases and rapid testing becomes available, this is our current combined updated guidance for general surgery. This guidance is intended to aid development of consensus regarding regional and local approaches to treatment. It will be reviewed as regularly as possible but there will remain a great deal of uncertainty regarding the pandemic and you should update yourself from government and hospital resources also.

1. Acute patients are our priority. COVID-19 should be sought in any patient needing emergency surgery: use history, COVID-19 testing, recent CT chest (last 24h) or failing that CXR. Any patient undergoing abdominal CT scan should also have CT chest. Current tests for COVID-19 may be false negative.

2. Any patient currently prioritised to undergo urgent **planned surgery** must be assessed for COVID-19 as above and the current greater risks of adverse outcomes factored into planning and consent. Consider stoma formation rather than anastomosis to reduce need for unplanned post-operative critical care for complications.

3. All theatre staff should use PPE during all operations under general anaesthetic whether by laparoscopy or laparotomy and infection control practices should be followed, as determined by local and national protocol. Those protocols advise on levels of Personal Protective Equipment (PPE) based on risk from proximity to potential viral load. When COVID-19 status is positive or uncertain, international experience recommends Full Personal Protective Equipment (PPE) be used for laparotomy but shortages prevent this in most areas and stratification is necessitated with lesser measures for low-risk cases. Full PPE is advised for positive or suspected patients and includes double layers of disposable gloves and gown, eye protection and FFP3 mask. It is imperative to practise sterile donning and doffing of PPE in advance. Procedural tasks are slower and more difficult when wearing full PPE. In low risk patients it may be pragmatic currently to use appropriately reduced measures, including a type 2R fluid resistant mask with visor and disposable gown and gloves as a minimum.

4. Laparoscopy is considered to carry some risks of aerosol-type formation and infection and considerable caution is advised. The level of risk has not been clearly defined and it is likely that the level of PPE deployed may be important. Advocated safety mechanisms (filters, traps, careful deflating) are difficult to implement. Consider laparoscopy **only** in selected individual cases where clinical benefit to the patient substantially exceeds the risk of potential viral transmission in that particular situation.
    - Where non-operative management is possible (such as for early appendicitis and acute cholecystitis) this should be implemented. Appropriate non-operative treatment of appendicitis and open appendicectomy offer alternatives.

5. **In theatre:**
    - Minimum number of staff in theatre
    - Appropriate PPE for all staff in theatre depending on role and risk
    - Smoke evacuation for diathermy / other energy sources
    - Team changes will be needed for prolonged procedures in full PPE
    - Higher risk patients are intubated and extubated in theatre – staff immediately present should be at a minimum.

6. **Only emergency endoscopic** procedures should be performed. No diagnostic work to be done and BSG guidance followed. Upper GI procedures are high risk AGPs and full PPE must be used.

7. Consider the diagnosis and risk of COVID-19 in other situations in Emergency General Surgery settings and act accordingly. Presentations with intestinal symptoms occur and COVID-19 may present initially as an apparent post-operative complication. Naso-gastric tube placement may be an aerosol generating procedure (AGP). AGPSs are high risk and full PPE is needed. Consider carrying out in a specified location.

Association of Surgeons of Great Britain & Ireland

Association of Coloproctology of Great Britain & Ireland

Association of Upper Gastrointestinal Surgeons

Royal College of Surgeons of Edinburgh

Royal College of Surgeons of England

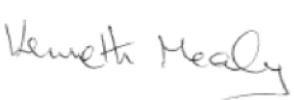
Royal College of Physicians and Surgeons of Glasgow

Royal College of Surgeons in Ireland

Professor S Michael Griffin
President
Royal College of Surgeons of Edinburgh

Professor Derek Alderson
President
Royal College of Surgeons of England

Professor Jackie Taylor
President
Royal College of Physicians and Surgeons of Glasgow



Mr Kenneth Mealy MD FRCSI
President
Royal College of Surgeons in Ireland

We acknowledge the help of Professor Iain Anderson, Miss Nicola Fearnhead and Professor Giles Toogood in the production of this guidance.