



PSCRS Guidelines for Colorectal Surgeries during COVID-19

April 17, 2020

As the situation of the COVID-19 pandemic continues to evolve, the Philippine Society of Colon and Rectal Surgeons (PSCRS) stands by its commitment in providing comprehensive and expert management to patients with colon and rectal diseases. Our aim in developing these guidelines is to ensure that essential colorectal surgical care amidst the pandemic continues in a timely manner without compromising the safety of everyone.

Numerous guidelines from different surgical societies recommend that emergency procedures or “essential surgeries” are the priorities during the pandemic¹, or at least during the Enhanced Community Quarantine period. “Essential surgeries” are those procedures which are not immediate emergencies but which, after full risk assessment on a case-by-case basis, are judged necessary during this stringent quarantine period. However, in a non-emergent setting, a decision to cancel or delay a surgical procedure should be taken in the context of a number of considerations, such as the patient’s clinical presentation, disease severity, associated co-morbidities, and the risk of possibly exposing the patient to COVID-19 in the hospital setting.

The PSCRS regularly monitors the colorectal care landscape and updates recommendations as the needs arise. After careful review of the present situation, we recommend the following guidelines in the management of patient with colon and rectal diseases during the period of Enhanced Community Quarantine:

1. Postpone all non-urgent in-person office visits. For urgent matters, consider telephone or video calls.
2. Surgical intervention must be deferred or delayed for colorectal conditions which are non-emergent and which can be reasonably managed non-operatively. The need for a given colorectal procedure in these non-emergent cases should be determined by a surgeon with expertise in colorectal surgery.
3. The actual risk of proceeding with surgery against the actual risk of delaying the colorectal procedure should be clearly discussed with the patient and the family when obtaining consent for surgery.

4. Colorectal surgery cases that are expected to require prolonged hospital stay or have a high risk of peri-operative complications potentially requiring valuable ICU care should be considered for delay if possible.
5. All patients for essential surgery should be tested for COVID-19 and should have a CT scan of the chest before any colorectal surgical procedure.⁷
6. In case of positive COVID-19 findings, defer surgery if possible.
7. For COVID-19 negative patients, either open or minimally invasive surgical approach is appropriate. For COVID-19 positive patients, we recommend an open approach for emergency colorectal operations. Minimally invasive surgical procedures may be considered in highly selected patients where the benefit of laparoscopy significantly outweighs the risk of COVID-19 transmission through aerosolization. It is recommended that it must be performed by an expert in an ideal operating room set-up. A full guidance on laparoscopic surgery by PALES is currently available at <https://www.pales.ph>.
8. Multidisciplinary Team meetings should continue and held virtually as much as possible, as it is critical to the treatment planning for colorectal cancer patients.

General Management Strategy for Colorectal Surgery during the Enhanced Community Quarantine Period, recognizing the status of each hospital which may evolve over the next few days or weeks.

A. Colorectal cases that need to be done as soon as possible

- Symptomatic colon cancer (bleeding requiring multiple transfusions, obstruction, perforation) should undergo colostomy with definitive oncologic surgery, if possible.
- Symptomatic rectal cancer (bleeding requiring multiple transfusions, obstruction, perforation) should undergo placement of a diverting stoma followed by neoadjuvant therapy.
- Benign colorectal and anorectal emergencies (diffuse peritonitis in colonic diverticulitis or intestinal perforation, volvulus with compromised bowel, fulminant colitis, and anorectal sepsis) should undergo surgery.
- Anorectal abscesses. Incision and drainage under local anesthesia in the out-patient setting is recommended.

B. Cases that should be deferred, if possible :

Benign

- Surgery for hereditary syndromes
- Definitive surgery for complicated diverticular disease
- Definitive surgery for inflammatory bowel disease
- Closure of stomas
- Surgery for pelvic floor dysfunctions
- Hemorrhoids
- Anal fissures
- Endoanal/endorectal ultrasound and anorectal manometry
- Lower gastrointestinal endoscopy.

Malignant

- Asymptomatic, early stage (T1 and T2) colon and rectal cancer
- Asymptomatic, locally advanced, resectable colon cancer.
 - options:
 - neoadjuvant chemotherapy for 2 - 3 months followed by surgery.
 - transfer patients to hospital with capacity.
- Asymptomatic, locally advanced, resectable rectal cancer.
 - options:
 - neoadjuvant long course chemoradiotherapy
- Rectal cancer with clear and early evidence of downstaging from neoadjuvant chemoradiotherapy
 - options:
 - additional wait time of 12-16 weeks.
 - additional chemotherapy
- Locally advanced or recurrent rectal cancers requiring pelvic exenteration
 - options:
 - additional chemotherapy
 - expanded pre-rehabilitation
- Stage IV colorectal cancer/Oligometastatic disease
 - options:
 - symptomatic: palliate
 - asymptomatic: chemotherapy

These recommendations are temporizing strategies while the nation is on Enhanced Community Quarantine, and as hospitals prepare to reallocate resources to be ready for the COVID-19 peak, the exact time of which is hard to predict. Again, *the decision to defer colorectal surgery procedures may be justified based on the anticipated COVID-19 surge and critical straining on institutional resources*, The PSCRS will update these recommendations when the Enhanced Community Quarantine has been officially eased.

At present, we are hopeful that elective colorectal cancer surgery can be provided in COVID-19-free hospitals. If these hospitals are not available, essential colorectal cancer surgery may be offered by hospitals with COVID-19 patients provided COVID 19-positive and COVID-19 negative patients are located in clearly separate areas (e.g. wards, operating rooms, ICUs, radiology, and endoscopy units), with dedicated personnel for each, where an expert surgical team is available, and operating room/PPE resources and ICU beds/ventilators are not threatened should a pandemic surge occur. Below are the different phases of the hospitals in terms of healthcare in this COVID-19 pandemic. We recommend each and every surgeon be aware with the status of every hospital in their area.

Covid-19 PHASE of Hospital or Healthcare System:

- Phase 0. Unaffected – no COVID-19 patients, hospital operating as normal
- Phase I. Semi-Urgent Setting (Preparation Phase) — few COVID-19 patients, hospital resources not exhausted, institution still has ICU ventilator capacity and COVID-19 trajectory not in rapid escalation phase
- Phase II. Urgent Setting — many COVID-19 patients, ICU and ventilator capacity limited, operating room supplies limited
- Phase III. Hospital resources are all routed to COVID-19 patients, no ventilator or ICU capacity, operating room supplies exhausted; patients in whom death is likely within hours if surgery is deferred

References:

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4. Updated General Surgery Guidance on COVID-19 from the Association of Coloproctology in Great Britain and Ireland 5 April 2020
5. Lewis R (2020) Early GI Symptoms in COVID-19 may indicate fecal transmission. Gastroenterology
6. Ai T, Yang Z, Hou H et al (2020) Correlation of chest CT and RT-pcr testing in coronavirus disease 2019 (COVID-19) in China: a report of 1014 cases. Radiology