** Indian Association of Surgical Gastroenterology **

 **[A Section of the Association of Surgeons of India (ASI)]**

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***IASG Covid-19 Advisory***

The current COVID 19 pandemic has led to widespread disruption of health services across affected countries. In the time of lockdown, there is a universal cessation of elective surgeries; however emergency surgeries are being carried out. There is a considerable grey zone between what constitutes an emergency and what can wait. It is also unclear in the current scenario what is the duration of the wait and what is the solution after that period as resources will not allow immediate handling of all patients even after resumption of routine service.

No guideline can appropriately address each procedure carried out by GI Surgeons in every centre. The broad principles can be laid down for practice taking into account the protection of patients as well as medical staff.

This would include:

1. Risk benefit ratio to the patient in delaying a procedure versus risk of long hospital stay in the current scenario with a risk of contracting an infection in hospital
2. Availability of adequate protective supplies as well as manpower to carry out the procedure and to deal with probable complications
3. Shortage of available hospital beds, ICU beds and ventilators in view of the allocation for COVID 19 patients.
4. Shortage of blood and blood products owing to shortage of blood donors.
5. Difficulty of transport of patients and relatives to the hospital and for appropriate follow up.

It is clear that the above factors vary widely from area to area within our country and from centre to centre.

Cases should be managed as a multidisciplinary approach in consultation with medical gastroenterologist, interventional radiology and oncology colleagues by video conference. Second opinions too should be sought by this route.

Broad principles that must be followed are:

1. Emergency procedures which is life threatening and have no alternatives, e.g. bowel perforation, gangrene and unresolved obstruction which need immediate surgery.
2. If a non-surgical alternative can defer an emergency procedure, e.g. percutaneous drainage of empyema or infected peripancreatic collection, this should be considered looking at the rate of success and potential risk of prolonged hospital stay versus the benefit of delay of surgery.

Procedures that do not resolve a threat to life like cholecystectomy for biliary colic, Frey’s procedure for chronic pancreatitis may be deferred till the situation settles.

Surgeries for GI cancer having a high chance of cure and low complication rate and shorter hospital stay e.g. colectomy should not be deferred too long.

The role of alternate approaches to GI cancer such as NACT or RT in this setting to defer surgery should be discussed in a multi-disciplinary team meeting (preferably by tele/video link) understanding that chemotherapy is immune suppressive and multiple hospital visits increase exposure risks to patients and may not be logistically feasible in this time.

Surgery should be performed to minimize hospital stay and complication risk, e.g. a low threshold for stoma creation.

Laparoscopy should be avoided.

Covid 19 testing

Surgery which can be deferred and should ideally be performed after testing and the patient to be COVID 19 negative.

If the test is positive or the viral status of the patient is unknown all staff including surgeon, anesthetist, scrub nurse and OT attendant must have access to appropriate personal protective equipment (PPE) or refer patients to centers where this is available. Due to the relative lack of familiarity in workflow in the theatre, an OR coordinator can be assigned to each team at least in the initial period.

Patient consultation

Patient counseling is of utmost importance and tele consultation facilities should be set up for this purpose to allay irrational fears and for follow up of patients. Government guidelines for tele consultation are available on the Ministry of Health and Family Welfare website. Many software solutions are available for this. Scans may be shared by the patient or scan centre uploading DICOM images on a cloud app such as Google drive and the link may be shared with the treating clinician. Clinicians should maintain an electronic record of all such communications for medico legal purposes.

Staff management

To ensure continued care, staff in larger hospitals should work in teams with a one week on one week off rota to ensure that in case of an unfortunate COVID 19 exposure and quarantining of a team, patient care is maintained. High risk individuals (older members or those with severe co-morbid conditions) in the team may be requested to not be in direct patient contact and share their vast experience by teleconferencing and managing follow up on telemedicine and taking over the administrative load.

They key for IASG members is for themselves to stay safe at this time along with their patients so that they may continue to keep giving exemplary care till this crisis resolves.

IASG Secretariat

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