COVID-19 Urgency of surgery categorisation

Most specialty societies in surgery have made recommendations as to what constitutes essential surgery – Cat 1 (urgent within 30 days) and Cat 2a (condition likely to progress/deteriorate and become Cat 1 or emergency within a few weeks). These recommendations can be found on the RACS and other College websites in their Covid-19 Information hub under Elective surgery recommendations from the specialty societies (see reference list below).

As there can be some challenges with interpretation, or conflicts of interest with decision making, we recommend establishing local scrutiny of categorisation and urgency, using senior oversight and a methodology that is independent, fair and transparent. For example, establishing a panel to ensure consistency and equity. This might involve one or more independent senior surgeons, charge nurse and anaesthetist, with or without discussion with CMO. As the covid-19 pandemic progresses there may need to be further rationalisation as to what procedures can be performed with the staff and resources available.

For cases with cancer, decision making, and timing of surgery or other modalities of treatment may be best determined by a multidisciplinary team that takes into account local resources and stage of the pandemic.

A one table summary of current recommendations is in the table below, prepared by the RACS Victorian Regional Committee in consultation with the Perioperative Expert Working Group and Victorian Perioperative Consultative Council. The table will be updated according to what stage of the COVID-19 pandemic Victoria is facing.

The RACS is promoting the following principles regarding elective surgery which we endorse:

1Review all scheduled elective procedures in consultation with the Director Medical Services, Chief Medical Office and Clinical Institute as needed (or a panel as suggested above).

2 Where you must conduct elective surgery, triage patients to ensure that the most urgent Category 1 patients are done first. (These typically include cancer, cardiovascular and other cases with progressive symptoms).

3 When conducting elective surgery, consider whether patients will need ICU beds and advise ICU early.

4 Minimise use of essential items needed to care for patients, including but not limited to, ICU beds, personal protective equipment, terminal cleaning supplies, and ventilators.

It is not possible to define the medical urgency of a case solely on whether a case is on an elective surgery schedule. While some cases can be postponed indefinitely, the vast majority of the cases performed are associated with progressive disease (such has cancer, vascular disease and organ failure) that will continue to progress at variable, disease-specific rates. As these conditions persist, and in many cases, advance in the absence of surgical intervention, it is important to recognize that the

decision to cancel or perform a surgical procedure must be made in the context of numerous considerations, both medical and logistical.

Speciality	Procedure	Indications	Organisation
Cardiothoracic	Bronchoscopy Congenital cardiac defects Coronary artery bypass grafting Heart valve surgery Lobectormy, wedge resections, pneumonectomy Pleurodesis		ANZCTS
Dentistry	Non aerosol generating procedures or where treatments generating aerosols are limited to: Endodontic treatment under rubber dam Extraction	Acute dental pain Management of significantly damaged upper front teeth Soft tissue pathology e.g. ulcers Swelling of the face, neck or mouth Dental trauma causing change in the position of teeth, soft tissue damage and/or significant pain Significant bleeding Difficulty opening the jaw and/or swallowing Management of complex medically compromised patients with dental concerns which may compromise their systemic disease Management of those at a higher risk of rapid progression of dental disease due to socioeconomic or cultural factors Management of patients referred by a medical practitioner for medically necessary dental care	ADA
ENT Facio- Maxillary		Cancer Threatened airway Bleeding Some fractures	ASOHNS
General Surgery			
Breast		Clip all new cancers sent for biopsy, in case their surgery may be delayed Consider neoadjuvant endocrine therapy for ER+ve cancers if surgery needs to be delayed Limit complexity of surgery – consider deferral of immediate reconstruction, contralateral risk reducing mastectomy Deferral of all risk reducing surgery	BreastSurgANZ
Endocrine		TATA intermediate or high risk thyroid cancer or suspected cancer Severe Graves' disease that is medically uncontrollable Goitre with significant and symptomatic airway compromise Hyperparathyroidism with severe hypercalcemia >3.0 Hyperparathyroidism in pregnancy Adrenocortical cancer or highly suspected adrenocortical cancer, Pheochromocytoma or paraganglioma* Cushing's syndrome with significant symptoms*	ANZES
Endoscopy	Colonoscopy	PR bleeding not haemorrhoids Acute colonic obstruction New IBD Possible malignancy	GESA, CSSANZ
	Gastroscopy	Upper GI bleeding	CSSANZ

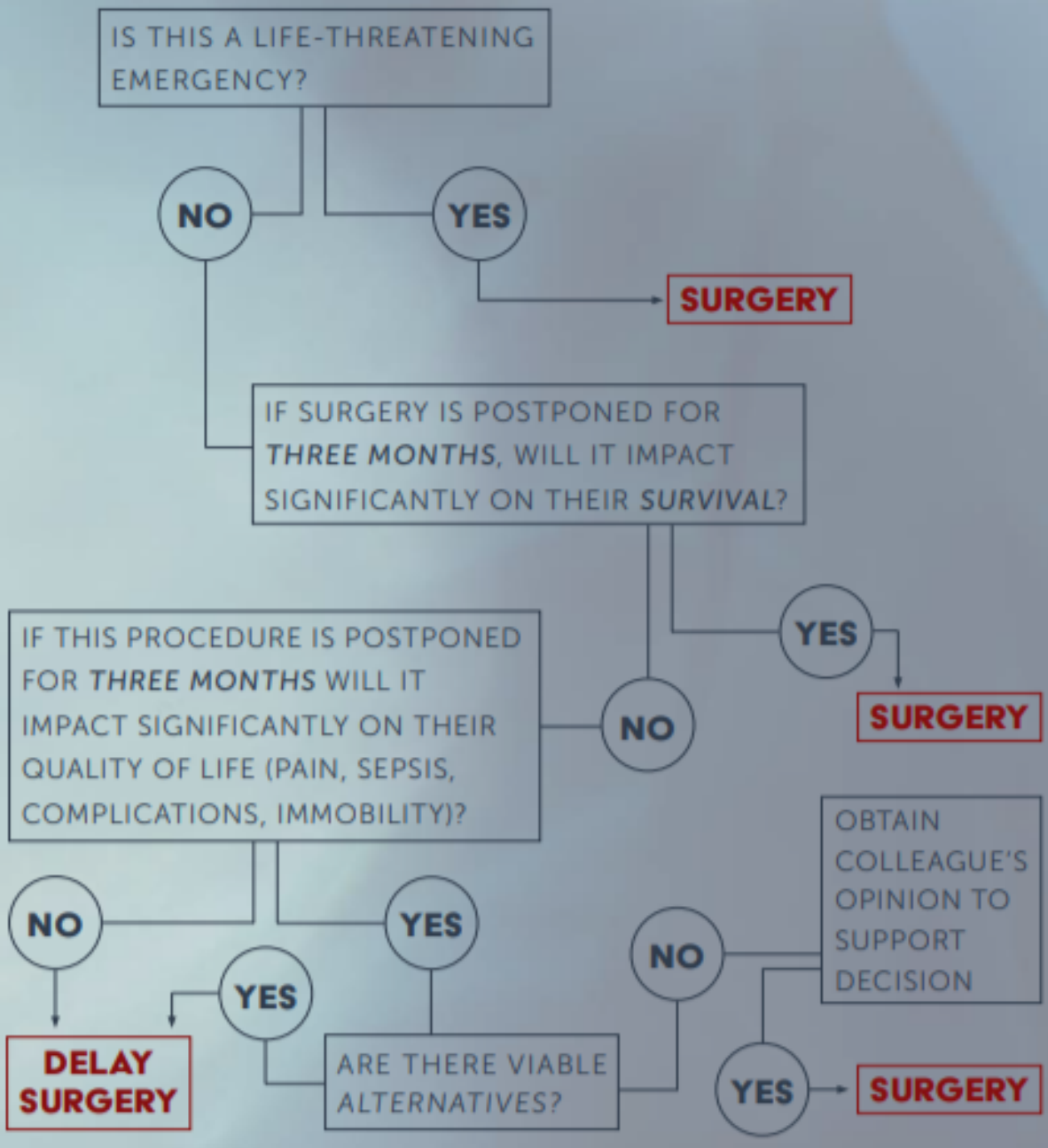
		Dysphagia Suspected cancer Upper GI obstruction incl food bolus	GESA
	Laparoscopy	Appendicitis, Acute cholecystitis, Cancer resections Management of intra-abdominal infections and adhesions Acute abdomen.	GSA, CSSANZ
HPB	ERCP Pancreatectomy Liver resection Cholecystectomy Gastrostomy Splenectomy	ERCP Malignancy Malignancy Symptomatic cholelithiasis If required for discharge ITP/ haematological malignancy	
Upper GI/Bariatric		Bleeding ulcer or varices* Internal hernia post bypass Complications of bariatric surgery with ischemia, septicaemia or inability to maintain nutrition Ruptured oesophagus Perforated Gastric/Duodenal Ulcer* Strangulated Hiatus Hernia/Gastric Volvulus* Blocked feeding tubes** (consider formal jejunostomy) Strictures requiring dilatation** Treatment of Upper GI Cancer following completed CRT Bleeding or ruptured GIST Staging of Upper GI Cancer potentially curative on imaging * If endoscopic or radiological intervention fails and patient unstable ** If dependent upon for nutrition	ANZGOSA/ANZMOSS
Gynaecology		Assessment and treatment associated with suspected or proven gynaecological cancers Acute haemorrhage not responsive to medical treatment Early pregnancy assessment for risk of miscarriage and ectopic pregnancy Timely access to abortion services, both medical and surgical Acute pelvic pain e.g. suspected ovarian torsion, cyst accident, acute pelvic abscess, Bartholin's abscess causing severe pain Acute on chronic pelvic pain following failed medical management and after multidisciplinary team assessment	RANZCOG
Hand Surgery		Tendon ruptures or lacerations Severe carpal tunnel compression with constant numbness, muscle wasting or unable to sleep Locked trigger fingers Joint instability due to ligament disruption Fingertip lacerations-consider cleaning and debridement under local anaesthetic and dressings (e.g.IV3000)	AHSS
Neurosurgery		Head injury Intracranial haemorrhage Depressed fractures Malignancy	NSA

		Infection Spinal cord compression Blocked shunts	
Ophthamology	Retinal surgery Vitrectomy Management of injuries	Glaucoma surgery Cataract with high IOP Retinal detachment Corneal injury/infection Sight restoring cataract for legal blindness	RANZCO
Orthopaedics		Fractures Dislocations Cauda equina Sepsis	AOTS
		Sepsis Knee tumours Painful locking knee Patella tendon rupture Dislocations	AKS AOF&A SESA
		Unstable fractures Tumours Cauda equina Infection Severe pain	SSA
Paediatrics	Cancer surgery Portoenterostomy for biliary atresia with jaundice Abscess incision and drainage Resection or diversion for acute exacerbation of inflammatory bowel disease not responsive to medical management Vascular access device insertion Repair of symptomatic inguinal hernia		ANZPS refers to ACS Paediatric Guidelines
Plastics		Limiting all non-essential planned surgeries and procedures, until further notice	
Urology	Orchidectomy/RPLND Radical prostatectomy Cystectomy Nephrectomy Surveillance cystoscopy Cystoscopy Prostate biopsy TURP/HoLEP Stone surgery Emergency surgery	Testicular cancer Select high risk prostate cancer MIBC, consider neoadjuvant chemo Tumours >7cm & upper tract tumours, IVC thrombus G3 Ta/1 TCC bladder, CIS +ve cytology/ abnormal imaging/ macroscopic haematuria Palpable lesion/PIRADS 4/5 on MP-MRI Retention (can't ISC/tolerate IDC) Symptomatic stones/stent in situ Trauma/torsion/obstructed system (consider nephrostomy/ in situ lithotripsy)	USANZ
Vascular		>7cm or imminent rupture AAA Threatened limbs and limb salvage Symptomatic carotid surgery Asymptomatic carotid surgery and surgery for claudication not to be done	Vascular Society
Other procedures performed in theatre			
Psychiatry	ECT	Catatonia Severe Depression	

IMPACT OF COVID-19: *GENERAL SURGERY*

DECISION TREE FOR SURGEONS

In the current context where only emergency or urgent procedures should be performed, we must take into consideration two separate patient groups. The delivery of emergency/urgent surgery for COVID-19 +ve patients and COVID-19 –ve patients. Our decisions need to deliver services equally to both groups.



References:
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2 RANZCOG COVID-19 information hub
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3 RANZCO COVID-19 information hub
https://ranzco.edu/wp-content/uploads/2020/04/RANZCO-triage-NZ-modification-level-4.pdf

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https://www.generalsurgeons.com.au/media/files/News/DOC%202020-04-08%20Impact%20of%20COVID-19%20-%20General%20Surgery%20Decision%20Tree.pdf