

COVID-19 in the UK- Experience from The Frontline

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Start of the pandemic

At the end of February, I was undertaking a mini fellowship on Trans-anal Total Meso-rectal Excision (TaTME) in Switzerland. The number of cases infected with corona virus disease (COVID-19) and deaths were rising exponentially in Italy. As the virus hit the UK, I was still able to complete 'Non-Technical Skills for Surgeons (NOTSS) for trainees' course at the deanery office at Fulbourn, Cambridge on the 13th of March 2020.[1]

Effect on personal life - self isolation

I had operating list on the 17th of March where an 81-year-old male having laparoscopic right hemicolectomy for cancer was listed. This patient was readmitted a week after being discharged from the hospital with collapse and it had become apparent that he acquired COVID-19 in the surgical ward. Fortunately, he recovered from this and remains well till date. The same day, my son had fever with some cough. I needed to self-isolate according to UK government guideline for two weeks as there was no facility for testing whether my son had contracted coronavirus or not. There were a lot of problems in getting food from the supermarket on the way back home as the shelves were empty, online food order

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was impossible but somehow, we managed with our friends delivering food for us at our front door.

Although I was self-isolating, I did all the work which was possible from home including Annual Review of Competence Progression (ARCP) for General Surgery Specialty Trainees and reorganization of the colorectal services at hospital. There were new updates coming from the Specialty Associations including Association of Surgeons of Great Britain and Ireland (ASGBI), Association of Colo proctologists of Great Britain and Ireland (ACPGBI), European Association of Endoscopic Surgeons (EAES) and British Association of Gastroenterology (BSG). The Advancement in Surgery (AIS) channel webinars organized in collaboration with Chinese panelists sharing their experience with surgeons from all over the world was very useful.[2] As the colonoscopy and laparoscopic surgery were supposed to be aerosol generating, there was massive fear about these techniques. At one stage, I thought the laparoscopic surgery was dead! There was a talk about negative pressure theatres which are not available in UK. Patients referred with suspected bowel cancer had to be diverted towards CT scan rather than colonoscopy for investigations. The number of COVID-19 cases kept on rising. Many people in Italy kept on dying which remained the country with most deaths in Europe for many weeks which was soon surpassed by UK.

Surgeries During Pandemic

We prepared colorectal service document for my hospital based on national guidelines during the pandemic.[3] The hospital complex had to be re-organized in red, yellow, and green areas. We continued with emergency surgeries but changed these to open and stopped laparoscopic surgery completely. Conservative management with antibiotics rather than surgery were tried for



appendicitis and cholecystitis. We gave stomas for all colon/rectal resections rather than anastomosis. We cancelled all benign elective general surgeries which continues to be paused to present time. There was a pause for elective cancer resections for three weeks at the height of pandemic in late March and early April. Then we restarted the colorectal cancer operations at clean area of the hospital. Initially open surgery with stoma rather than anastomosis was performed for these cases. As the number of cases plateaued and started declining, The Association of Laparoscopic Surgeons of Great Britain and Ireland (ALSGBI) issued position statement about laparoscopic surgery and there were good ways to mitigate risks of aerosolization during laparoscopic surgery.[4] In summary, the surgical pathway involves patients self-isolate for two weeks pre operatively (it was one week when we started), have COVID screening including PCR (Polymerase Chain Reaction) testing 48 hours before anticipated surgery (used to do chest CT initially but this was dropped as the national guideline stated it as '*not required*' in mid-May), surgery at clean operating theatres and green ward post operatively and self-isolation for two weeks after surgery. Full personal protective equipment (PPE) was worn during the surgery. Ideally, the staffs should have been tested periodically but it did not happen yet in our Hospital. The consent forms were revised to include additional complications of COVID-19. We were able to have no mortality so far amongst 15 elective cancer patients operated during the pandemic at my hospital. Two laparoscopic stacks were available in our Hospital - *Stryker Pneumoclear* and *Air Seal* both have capabilities of filtering aerosol sizes as small as 0.01 micron [5]. All emergency admissions were COVID-19 tested and we had re-introduced lap surgery for selected emergency operations in case by case basis if it was believed that the benefit of lap over open surgery was substantial.

Effect on referrals with suspected cancer

With lockdown, the patients were asked not to travel to hospital unless necessary. There was a huge reduction in referral for patients with suspected bowel cancer to 25% of what we generally get. Face to face consultations were replaced by telephonic and video consultations. In the primary care, more emphasis was placed in Fecal Immunochemical Testing (FIT) to triage patients with altered bowel habit – value more than 100 being significantly raised needing investigation as soon as possible. Although,

CT scans were used rather than colonoscopies for investigations at the height of pandemic, more and more colonoscopies were being performed with necessary precautions.[6]

Personal protective equipment (PPE)

I was on call for a week at the beginning of April. The FFP3 testing took quite a while for me to be fitted with FFP3, 3M 1873 mask. Also, further full protection such as face shield should be worn. I needed to do open ileo-caecal resection for ileo-caecal Crohn's as an emergency. As I tried to stop bleeding using diathermy there was production of visible smoke. Despite suction connected to this diathermy, some must have escaped and travelled to any staff present in the theatre including myself. The virus particles may travel to patient from staff in theatres some of whom may be virus carriers. There was FFP3 mask but there was no proper face shield. The visor provided was not good enough as the viral particles could easily travel to face via the side and top of the visor. I was immediately given face shield as I raised this issue with the chief executive and the infection control in the hospital.

COVID positive patient needing major surgery - dilemma whether to operate or not

I was asked to operate a 72-year-old male COVID-19 positive patient, who had acute severe colitis and was not responding well to medical treatment. As I approached him, I could hear his typical breathing which sounded to me as something was stuck in his throat. The decision to operate upon him was abandoned because it was believed that the risk of mortality is double for patients going to ward and four times if going to ICU (Intensive Care Unit) ventilated compared with current predicted mortality scores for COVID-19 positive patients undergoing surgery. The reported crude post-operative mortality rate remains 20-25% for COVID positive patients. [7,8] The patient succumbed to death later that night.

Present condition and future

As the number of COVID-19 cases plateaus and hopefully declines, the hospital and our surgical cases go up. Referrals with suspected cancer is going up as the lockdown is gradually released. The challenge now is to perform colonoscopy in all the patients who have been waiting for several months. We are managing the surgical cases for cancer who are in need of surgery. Careful case selection based

on priority of disease, vulnerability of the patient and environmental factors are key factors taken into account on case selection and operation.[9]

We are at the time of uncertainty. There is a fear that we may get another surge of cases in UK. It is worrying; the number of cases is going up in Nepal and nearly 10 patients have died at the time of writing (June 4, 2020). In the UK, the number of Nepalese who have died has already exceeded 50. Putting upon the emphasis of “test, trace and track” I hope will help to diagnose and contain the spread of virus thereby reducing the number of cases. I am of optimism that we will beat this pandemic. Let’s hope invention of a cure is not too far away!

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