



Updated General Surgery Guidance on COVID-19 - 30th May 2020

- With the UK peak in COVID-19 admissions reportedly past, some of the steps in our previous guidance might now be modified, depending on local circumstances. Key local factors will be background infection rate, maintaining cold sites for elective surgery, availability of PPE, testing capabilities and ability to stream patients. The [Associations](#), Colleges and NHS have produced [guidance](#) on re-[starting](#) surgery which is available on their websites.
- Data are emerging to guide us about postoperative risks. When major surgery is carried out in COVID-positive patients, whether diagnosed peri-operatively or post-operatively, the risks appear to be [substantial](#).
- On the other hand, early reports suggest that elective major surgery may be carried out with acceptable risks in selected groups of self-isolated and swab negative cancer patients with perioperative care taking place in a COVID-cold environment. These apparent early successes come from areas with separate elective hospitals. Best practice in maintaining relatively COVID-cold sites has yet to be precisely defined. It is likely that staff and patient testing, good bed management, attention to patient flow and footfall, and allocation of staff, where feasible, to either hot or cold sites will all play a role.
- Two streams of patients are emerging and must be separated on basis of potential infection risk:
 1. Elective patients (isolated for 14 days, screened with questionnaire and tested by throat swab within 72 hours of surgery) undergoing surgery in a COVID-cold site.
 2. Acute patients whose status is unknown and who are therefore a potential risk to themselves and others. In EGS patients undergoing CT abdomen and pelvis for diagnostic purposes, assessment should include CT chest unless equally reliable and rapid alternative testing methods are locally available.
- The need persists for us to consider safety of all healthcare personnel, resource priorities, and infection rates in addition to the outcome of the individual patient.
- The risks of viral infection and dissemination from [surgical smoke plume](#) are unknown but there is concern about uncontrolled release of pressurised gas in laparoscopic surgery and use of electrocautery and other devices in open surgery. Proponents of [laparoscopy](#) during COVID-19 highlight potential risks and need for [risk mitigation](#) strategies including use of technological protection and enhanced PPE.

- Units have cautiously re-established laparoscopy where all criteria are met, theatre teams are satisfied with safety and skill set and most importantly, where the team consider that the benefits outweigh the risks in their local set up.
- A [recent review](#) indicates that greater caution continues to be needed with emergency surgery in terms of safety, diagnosis, and optimal treatment choices.
- As we progress through the phases of the COVID-19 pandemic, further information will continue to emerge and inform practice. The continued use of adequate PPE remains essential.

Association of Surgeons of Great Britain & Ireland

Association of Coloproctology of Great Britain & Ireland

Association of Upper Gastrointestinal Surgery

Royal College of Surgeons of Edinburgh

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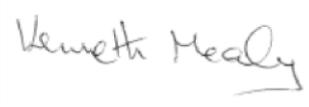
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