Updated Intercollegiate General Surgery Guidance on COVID-19 25th March 2020

Surgeons will continue to care for patients in the current crisis, especially emergencies. Patient care will be affected if surgeons become sick and leave work. This current document updates recent guidance as further information has now emerged from government, Italy and China. We must follow guidelines and also apply common sense to at risk clinical environments. Consider COVID-19 infection possible in every patient. While priorities may change as rapid testing becomes available, these are our combined updated guidelines:

1. Acute patients are our priority. COVID-19 should be sought in any patient needing emergency surgery by history, COVID-19 testing, recent CT chest (last 24h) or failing that CXR. Any patient undergoing abdominal CT scan must also have CT chest.

2. Any patient currently prioritised to undergo urgent **planned surgery** must be assessed for COVID-19 as above and the current greater risks of adverse outcomes factored into planning and consent. Consider stoma formation rather than anastomosis to reduce need for unplanned post-operative critical care for complications.

3. Full Personal Protective Equipment (PPE) should be used for laparotomy except perhaps when the patient is convincingly negative for COVID-19, but note that current tests maybe false negative. Full PPE includes wearing visors or eye protection. It is imperative to practise donning and doffing PPE in advance.

4. **Laparoscopy should generally not be used** as it risks aerosol formation and infection. Chinese and Italian experience reflects this. SAGES have offered guidance. Advocated safety mechanisms (filters, traps, careful deflating) are difficult to implement. Consider laparoscopy **only** in extremely selected cases where the mortality benefit is substantially beyond doubt in the current situation.
   - Use appropriate non-operative treatment of appendicitis or open appendicectomy.
   - Treat acute biliary disease conservatively for now or with cholecystostomy.

5. **In theatre:**
   - Minimum number of staff in theatre
   - Full protective PPE including visors for all staff in theatre
   - Stop positive ventilation in theatre during procedure and for at least 20 minutes after the patient has left theatre
   - Smoke evacuation for diathermy / other energy sources
   - Patients are intubated and extubated in theatre – staff immediately present should be at a minimum.

6. Risk situations in surgery also include:
    - Approaching a coughing patient, for example, even if COVID-19 has not been diagnosed. Protection including eye shield is needed.
    - Naso-gastric tube placement is an aerosol generating procedure (AGP). AGPSs are high risk. Full PPE is needed. Consider carrying out in a specified location.

7. **Only emergency endoscopic** procedures should be performed . No diagnostic work to be done and BSG guidance followed. Upper GI procedures are high risk AGPs and full PPE must be used.

Association of Surgeons of Great Britain & Ireland

Association of Coloproctology of Great Britain & Ireland

Association of Upper Gastrointestinal Surgeons

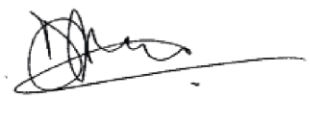
Royal College of Surgeons of Edinburgh

Royal College of Surgeons of England

Royal College of Physicians and Surgeons of Glasgow

Royal College of Surgeons in Ireland

Professor S Michael Griffin
President
Royal College of Surgeons of Edinburgh



Professor Derek Alderson
President
Royal College of Surgeons of England

Professor Jackie Taylor
President
Royal College of Physicians and Surgeons of Glasgow

Mr Kenneth Mealy MD FRCSI
President
Royal College of Surgeons in Ireland

We acknowledge the help of Professor Iain Anderson, Miss Nicola Fearnhead and Professor Giles Toogood in the production of this guidance.