



## The Association of Coloproctology of Great Britain and Ireland

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# ACPGBI Guidance on Management of Patients with IBD requiring Surgical Intervention during COVID-19

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- Emergency & Urgent Surgery**
  - Emergency laparotomy
  - Colectomy for acute severe colitis
  - Perianal Crohn's abscess*must continue*
- Advocacy for optimised patients**
  - Intra-abdominal sepsis drained
  - Nutritional issues addressed
  - Immunosuppression weaned*theatre access*
- Compromises during COVID-19**
  - Defer surgery for quality of life
  - Open surgery more common
  - Stoma rates may be higher*patient discussion*

### Considerations

- Multidisciplinary IBD recommendations
- Shared decision-making with patient
- Assess vulnerability score of patient
- Preoperative COVID-19 testing & CT chest
- COVID-free operating site if available
- Assess excess risk of postoperative mortality
- Data collection for audit of outcomes

Patients with ulcerative colitis and Crohn's disease may be more susceptible to infection either due to the underlying disease or the immunosuppressive medications needed for disease control. Information and advice for patients with inflammatory bowel disease (IBD) during the COVID-19 global pandemic is available from the charity Crohn's and Colitis UK (CCUK):

<https://crohnsandcolitis.org.uk/news/coronavirus-covid-19-advice>. Guidance for clinical management has been provided by the British Society of Gastroenterology (BSG): <https://www.bsg.org.uk/covid-19-advice/bsg-advice-for-management-of-inflammatory-bowel-diseases-during-the-covid-19-pandemic/>

Surgery is recognised as the treatment of choice for some specific complications of IBD, in order to save lives and improve quality of life. Patients with IBD are often aware of the potential need for surgery in these situations, and possible need for surgery is a common concern. This concern is heightened now by the lack of certainty about the perioperative safety of any major surgery and reduced healthcare resources including access to urgent and elective surgical operating lists and critical care provision.

There is, now more than ever, real need for patient involvement in careful, integrated multi-disciplinary decision-making that balances the relative risks of surgery within a healthcare environment with constrained resources and high risk of COVID-19 exposure and infection.

Some important guiding principles, when considering surgery as a potential management option during COVID-19 are:

- Work together with gastroenterology, IBD specialist nurse, anaesthetics and critical care teams to assess and balance risks of resection against potentially immunosuppressive medical treatments if surgery is not mandated. Patient consultation (remotely) and involvement in shared decision-making is essential.
- The UK IBD COVID-19 working group has developed a specific tool to help clinical teams identify moderate and high-risk IBD patients. This is already available on the BSG and CCUK websites.
- Consider what is truly urgent and in absolute need of operative intervention. Emergency and urgent expedited surgery will still need to be performed.
- Integrated decision making and advocacy for IBD patients across colorectal departments is essential to ensure that urgent patients with IBD are not relegated in terms of surgical priority due to constraints on healthcare resource. Advocacy on a case-by-case basis will be essential for the IBD patient with previous septic

complications who is now optimised after drainage of sepsis by interventional radiology, weaning off immunosuppressants and nutritional support.

- Where facilities are available for “cold” (COVID-free) sites without an Emergency Department or in standalone separate COVID-free hospital wings, consideration may be given to a “safe zone” for surgical interventions in IBD patients.
- Preoperative screening questions and testing for COVID-19 should be undertaken whenever time allows. Emergency patients, especially those on immunosuppressants or who have symptoms, should have CT chest prior to emergency surgery. Given that COVID-19 testing may be false negative, repeat testing or CT chest may also be desirable in urgent or expedited cases.
- An important caveat when considering surgery is highly concerning preliminary data suggesting high postoperative critical care admission and mortality after general surgical operations due to exposure and postoperative infection during the COVID-19 surge. Consent for surgery should include discussion about the environmental risks of surgery during the pandemic.
- Vulnerability of the individual patient, given risk and consequences of acquiring COVID-19, should be considered. A vulnerability score of V1 indicates that a patient is unlikely to have excess mortality when compared to a fit individual < 70 years old in the event of COVID-19 infection. A score of V2 is ascribed to a patient who is likely to have significant excess mortality compared to a completely fit individual < 70 years old in the event of COVID-19 infection but would probably receive invasive ventilation if required and resources were available. A vulnerability score of V3 indicates that a patient would be extremely likely to succumb to COVID-19 as a hospital-acquired infection and would not currently receive invasive ventilation during the pandemic due to constrained resources and poor overall prognosis. More information about vulnerability scoring: [https://journals.lww.com/dcrjournal/Documents/Prioritizing\\_Access\\_to\\_Surgical\\_Care\\_During\\_the.99694.pdf](https://journals.lww.com/dcrjournal/Documents/Prioritizing_Access_to_Surgical_Care_During_the.99694.pdf).
- Given the COVID-19 environment and likely limitations on healthcare resources, full consideration must be given to the safety of both the operating theatre team delivering care and the patient’s safety in the event of developing postoperative complications such as anastomotic leak requiring further salvage surgery and critical care admission.

This will mean accepting, in the short term, a higher rate of open surgery & stoma formation when resectional surgery is required.

- Patients with surgical complications of perianal Crohn's disease should still be offered emergency drainage of abscesses. In the absence of a definite clinical abscess, patients with new onset pain may be temporised with antibiotics for symptomatic relief and urgent perineal MRI, where available, to exclude occult infection requiring urgent surgical drainage.
- Where surgical interventions are undertaken, data collection about perioperative outcomes is essential to inform future practice and so ACPGBI encourages inclusion of patient data in national and global prospective observational studies after appropriate local audit registration.

Prioritisation of surgical access for IBD patients during recovery phase in the aftermath of the COVID-19 pandemic should be:

1. Patients with IBD who would normally have been advised to have surgery in a standard healthcare environment but were considered high risk on vulnerability scoring. In the interim, these patients should be monitored closely by IBD teams and then offered surgery as soon as the environmental risk has subsided.
2. Patients who were considering surgery for quality of life purposes and wished to proceed should be the second priority for IBD surgery during recovery.
3. Patients who need restoration of bowel continuity.

All patients who have had care "temporised" during the COVID-19 crisis should have access to IBD specialist nursing advice as safety netting in the interim, and timely re-review at a combined IBD MDT when resources allow.

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