ANZHPBA Guidelines for Management of HPB Surgery during the COVID-19 pandemic

Introduction

Multiple guidelines are emerging with recommendations on management of surgical conditions as the risk of the spread of COVID-19 infection impacts our communities. Most of you will have already seen many of these and links to selected ones are provided below.

Any guideline produced today will undoubtedly require review as the realities of the pandemic evolve. Recommendations not only need to take into consideration measures to contain spread of COVID-19 infection amongst patients and healthcare workers, but also, as has become apparent in Spain, Italy and even the USA, the likelihood that resource limitations may begin to impact on our usual approach to management of specific HPB conditions.

The recommendations in this guideline are by necessity brief and generic. A number of your Association members are already working on more detailed guidelines concerning specific HPB clinical scenarios. These will be released as they become available.

Recommendations for clinical consultation

All new referrals require appropriate triage. Where the conditions are considered non-urgent, some form of telephone or video consultation is recommended initially, and face-to-face review should be deferred until considered appropriate.

If possible, all follow-up consultations and reviews should be deferred, or some form of telephone or video consultation utilised.

Urgent consultations with acute or potentially life-threatening conditions are more likely to require face-to-face assessment. Such assessment requires completion of an appropriate questionnaire prior to consultation to screen for potential COVID-19 infection and appropriate PPE should be utilised if there is clinical concern.

Recommendations for Clinical Meetings, MDTs and ward rounds

It is no longer appropriate to hold clinical meetings with multiple healthcare practitioners present in a confined space. All such meetings should be held using a videoconferencing platform such as Zoom, Microsoft Teams, Go-To-Meeting etc. Ward rounds should be carried out with the bare minimum of personnel with attention to appropriate social distancing, hand hygiene and utilisation of PPE as appropriate.

Recommendations for Surgical and Endoscopic Procedures

Non-urgent surgery has been suspended in both Australia and New Zealand in an attempt to both conserve resources (including PPE and surgical supplies), ensure capacity as the number of COVID-19 infected patients increase as well as protect both patients and staff from the risk of COVID-19 infection.

Accepting that non-urgent procedures will likely remain deferred for the present time, the following guidelines refer specifically to emergency and urgent or semi-urgent HPB surgery and HPB endoscopy.

All such patients require completion of an appropriate questionnaire prior to any procedure to assess the risk of current COVID-19 infection. For semi-elective procedures, this must be repeated in the 24 hours prior to surgery.

Every case needs to be considered on its merits, but in consideration of the possibility or presence of COVID infection our management choices should aim for resolution of disease morbidity with reasonable life expectancy and return to function. This should be achieved with as short a stay in hospital as possible and a minimal risk of complications. Consideration must be given to medical, hospital and equipment resources, especially, precious critical care resources. The risk of transmission of COVID-19 infection to healthcare workers must be minimal.

For upper GI endoscopy, ERCP and EUS procedures we recommend members follow the GESA guidelines (as linked below). However, members should note that while both ERCP and EUS are commonly used tools for HPB intervention and diagnosis, with the increased aerosolization risk associated with these procedures, alternative percutaneous or operative interventions may have a greater role.

In the operating theatre the number of personnel must be kept to a minimum. Surgical personnel should not be in the operating room during patient intubation and extubation when aerosolization may occur. Surgical procedures should be led by a surgical consultant rather than a trainee or registrar. Where there is suspected or actual COVID-19 infectious risk, PPE must be appropriate (N95 mask, eye protection, full hair cover, impervious gown, double gloves, negative pressure theatre if possible, etc., as guided by local practice). Some procedures carry higher risk of aerosolization. Surgical plumes from diathermy or other energy devices require appropriate filtered venting. Laparoscopic and robotic procedures have been reported as carrying higher risk and care must be taken with use of appropriate filters and extraction systems. Currently we do **not** believe minimally invasive approaches should be avoided but appropriate care must be taken. For a balanced view of this members are referred to Associate Professor David Cavallucci's review, Optimal surgical approach during the COVID-19 pandemic.

Links to other current guidelines

RACS guidelines for the management of surgical patients during the COVID-19 pandemic

GSA Covid-19 Guidelines for General Surgery

Updated Intercollegiate General Surgery Guidance on COVID-19; 27 March 2020

ACS: COVID 19 and Surgery – Elective Case Triage Guidelines for Surgical Care

Statement from AUGIS re Hepatobiliary and Pancreas Cancer Patients

GESA Considerations for Australian Endoscopy Units during the COVID-19 pandemic