

Triage Guidelines for Elective Colorectal Cancer Surgery during COVID-19 Crisis (v2 – 3/4/20)

It is important that surgeons assess the capacity of their hospital to deliver operative and post-operative care to patients undergoing colorectal surgery at this time. It should be noted that capacity may vary between hospitals due to local outbreaks or staffing shortages. The risks and consequences of post-operative complications; the risk of COVID acquisition in hospital; and the possible restorative and non-restorative surgical options should all be considered and discussed with patients as part of the consent process. The colorectal MDT should be involved in all pre- and post-operative decision-making, irrespective of the setting of the patient's care. This particularly applies if surgery in a non-cancer centre is proposed. These guidelines do not replace the clinical judgement of expert colorectal surgeons.

Phase I. Semi-urgent setting (preparation phase)

Few COVID-19 patients, hospital resources not exhausted, institution still has ICU ventilator capacity and COVID-19 trajectory not in rapid escalation phase.

Cases that need to be done as soon as feasible (recognising that the status of each hospital likely to evolve over next week or two):

- Nearly obstructing colon
- Nearly obstructing rectal cancer
- Cancers requiring frequent transfusions
- Asymptomatic colon cancers
- Rectal cancers after neoadjuvant chemoradiation with no response to therapy
- Cancers with concern about local perforation and sepsis
- Early stage rectal cancers where adjuvant therapy not appropriate

Diagnoses that could be deferred 3 months:

- Malignant polyps, either with or without prior endoscopic resection
- Prophylactic indications for hereditary conditions
- Large, benign appearing asymptomatic polyps
- Small, asymptomatic colon carcinoids
- Small, asymptomatic rectal carcinoids

Alternative treatment approaches to delay surgery that can be considered by the MDT:

- Locally advanced resectable colon cancer

- o Neoadjuvant chemotherapy for 2-3 months followed by surgery
 - Rectal cancer cases with clear and early evidence of downstaging from neoadjuvant chemoradiation.
 - o Where additional wait time is safe
 - o Where additional chemotherapy can be administered
 - Locally advanced rectal cancers or recurrent rectal cancers requiring exenterative surgery
 - o Where additional chemotherapy can be administered
 - Oligometastatic disease where effective systemic therapy is available

Phase II. Urgent setting

Many COVID-19 patients, ICU and ventilator capacity limited, theatre supplies limited

Cases that need to be done as soon as feasible (recognising status of hospital likely to progress over next few days):

- Nearly obstructing colon cancer where stenting is not an option
- Nearly obstructing rectal cancer (should be diverted)
- Cancers with high (inpatient) transfusion requirements
- Cancers with pending evidence of local perforation and sepsis

Cases that should be deferred:

- All colorectal procedures typically scheduled as routine

Alternative treatment approaches:

- Transfer patients to hospital with capacity
- Consider neoadjuvant therapy for colon and rectal cancer
- Consider more local endoluminal therapies for early colon and rectal cancers when safe.

Phase III. Surge setting

Hospital resources are all routed to COVID 19 patients, no ventilator or ICU capacity, OR supplies exhausted. Patients in whom death is likely within hours if surgery deferred.



Cases that need to be done as soon as feasible (status of hospital likely to progress in hours)

- Perforated, obstructed, or actively bleeding (inpatient transfusion dependent) cancers
- Cases with sepsis

All other cases deferred

Alternate treatment recommended

- Transfer patients to hospital with capacity
- Diverting stomas
- Chemotherapy
- Radiation

Version 2, issued 3/4/20:

Stakeholder Consultation with surgeon members of NCCP Rectal Cancer Lead Clinicians Group. Reference and Acknowledgement: "COVID 19: Elective Case Triage Guidelines for Surgical Care. Colorectal Cancer Surgery." American College of Surgeons. Released March 24, 2020.