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COVID 19: Elective Case Triage Guidelines for Surgical Care

Cancer Surgery

Introduction

During the current COVID-19 pandemic, hospital leadership and individual providers are facing increasingly difficult decisions about how to conserve critical resources, such as hospital and ICU beds, respirators, transfusion capacity as well as protective gear (e.g. PPE) that is vital for protecting patients and staff from unnecessary exposure and intra-hospital transmission. While nothing will replace sound medical judgement and local adjudication, it has generally been advised that hospitals discontinue elective surgery, and guidance on the triage of non-emergent surgical procedures during the pandemic has been made available on the American College of Surgeons website. Guidance on the triage of elective surgery is based on an Elective Surgery Acuity Scale provided by Sameer Siddiqui, MD, FACS of St Louis University. Triage guidelines contained within this document below, specifically add another level of specificity on triage of elective cancer surgery patients during the COVID-19 pandemic. This information is intended to help institutions and providers who are facing a rising burden of hospitalized COVID-19 patients and a higher prevalence of community infection. Not all cancer conditions can be outlined, accordingly, this document will focus on how to manage the more common cancer types during the pandemic.

Guiding Principles for Cancer Care Triage

Resource Considerations

Individual provider decisions about proceeding with elective surgeries should not be made in isolation, but rather should take into consideration what is known about the availability of local institutional resources. Local authorities responsible for the preparedness of their facility for managing coronavirus patients should be sharing information frequently about local resource constraints, especially protective gear for providers and patients. This will allow providers to understand the potential impact each decision may have on limiting the hospitals capacity to respond to the pandemic. For elective cases with a high likelihood of postoperative ICU or respirator utilization, it will be more imperative that the risk of delay to the individual patient is balanced against the imminent availability of these resources for patients with COVID-19. These kinds of cases may need to be adjudicated on a frequent basis as the impact of COVID-19 on communities grows exponentially, with different baselines for different communities. This guidance document does not cover the management of patients who test positive for coronavirus, which is a different aspect of managing the pandemic and is covered elsewhere.

Cancer Care coordination

The basic tenets of cancer care coordination should be followed as much as possible using virtual technologies. Institutions with Tumor Boards may find it helpful to virtually gather their multi-disciplinary experts in order to consider either individual cases or for institutions with high case volumes to establish triage criteria based on local circumstances, COVID-19 prevalence and/or the availability of alternative, non-surgical therapies. As much as possible, we encourage shared decision making. Further, we highly recommend multidisciplinary virtual discussions regarding priority for non-urgent cancer surgery. At a minimum, patients should be informed that decisions regarding non-urgent cancer surgery are consensus-

based, and based on local and projected resources and disease prevalence as well as and tumor characteristics and expected outcomes from delays.

General Comments Regarding Cancer Care Triage

Recognizing that the COVID-19 situation may be highly variable and fluid in different communities across the country, we have organized decision-making into three phases that describe the acuity of the local COVID-19 situation. Hospitals will likely progress through these phases over the next several weeks to months, and then will also de-escalate thereafter. It is important that decisions regarding provision of cancer care are made in the context of these phases and that leaders of the cancer care team are updated regularly and frequently by hospital leadership to understand their particular environment at any given time during the crisis.

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