



European Colorectal Congress

29 November – 2 December 2020, St.Gallen, Switzerland

MASTERCLASS

Handling large rectal adenoma and malignant polyps

Do and don't in taTME surgery – a decade of experience explained

Prehabilitation, patient blood management, frailty index – welcome addition or resource wasting?

What your pathologist can do for you: from standard margins recommendations to molecular pathology/liquid biopsies and the microbiome

All techniques to avoid staple line intersections in colorectal surgery

Myths and facts about oral antibiotics, bowel preparation, and timing of iv antibiotics to reduce surgical site infection

Selective use of neoadjuvant and adjuvant radiotherapy for rectal cancer

Management of colorectal GIST – all you should know from diagnosis to handling recurrences

Management of pelvic sepsis after colorectal / coloanal anastomosis and oncological outcomes of the GRECCAR 5 trial

Best practices in colostomy construction and repair of parastomal hernia

The EBSQ Coloproctology Examination

COURSE OF PROCTOLOGY SCIENTIFIC PROGRAMME

Complex pelvic fistula revisited: established wisdom and innovative approaches

Anorectal trauma and foreign bodies

Sexually transmitted diseases in proctology

The painful bottom – Proctalgia beyond the classical abscess, fissures, and hemorrhoids

Fecal incontinence: investigations and conservative treatment

Fecal incontinence: neuromodulation and surgical options

The pelvic floor revealed: investigations and conservative management

The pelvic floor revealed: transperineal / transvaginal / transanal repairs explained

Obstructed defecation and IBS: investigations and differential diagnosis

Obstructed defecation: surgical options

Obstretical trauma: assessment, timing and options to repair

Mind and bottom reunited – from abuse to psychoproctology

Urogenital dysfunction in patients treated for rectal cancer – what do we know and what can we do?

Strategies and outcomes for obstructive cancers of the colon and rectum

The septic abdomen: getting out of misery and closing the case

Lars Pahlman lecture: Extending the limits of liver surgery

Do resection of the mesentery in Crohn's & appendectomy in ulcerative colitis alter the course of disease

Anal pain and emergency proctology: what every surgeon should know & do

Ventral rectopexy: indications, tricks of the trade, and long-term results

Randomized trial evaluating chemotherapy followed by pelvic reirradiation vs chemotherapy alone as preoperative treatment for locally recurrent rectal cancer (GRECCAR 15)

Kono S anastomosis and over the valve stricturoplasties: hope for better outcomes

Ethical considerations in crisis – lessons from Covid-19

Hemorrhoids – new options and time-tested solutions Multimodal approaches to colorectal liver metastases

Timeline of surgery following neoadjuvant radiotherapy – balancing morbidity and efficacy

Management pearls for early rectal cancer

Lessons learned along the robotic learning curve: a video guide for colorectal surgeons

Place and outcome of total colectomy in the surgical armamentarium

Total neoadjuvant therapy for colon and rectum cancers

Enhanced recovery pathways reloaded – a practical guide to success



EAES presidential lecture: Strategies for lifelong learning and implementation of new technologies

Is cancer an infectious disease: role of the microbiome

All you need to know about anorectal fistula

New drugs, old fears: state of the art management of IBD patients

A journey in global surgery – why getting out of the comfort zone

Anastomotic leak in colorectal surgery: insights, perspectives, and practical strategies

Management strategies for patients with advanced colorectal cancers

Cancer at the extremes of age: are there any differences in handling youngsters and seniors

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Correspondence

Therapeutic options for emergency gastrointestinal malignancy in COVID19 pandemic. The role of operative endoscopy

Editor

The concept that medical facilities and health workers might be an important contamination route in the pandemic has brought to consequences and attitudes for the population as well for legislators. In the pandemic period, most of the patients requiring intervention for gastrointestinal malignancy are in emergency, no-deferrable conditions. We reviewed the results of operative endoscopy to treat emergencies secondary to gastrointestinal

malignancy during the lock down period in Italy, from March 11th to April 28th. The study was approved by the Ethical Board of the University. All patients gave written informed consent. Endoscopy for no COVID 19 patients was performed in a dedicated room. COVID 19 and no COVID 19 patients had completely different routes. Protections were those suggested by the WHO^{1,2,3}. Seventy patients underwent emergent endoscopic operative procedures. There was no operative mortality and no major complication. Out of the 70 operative procedures, 21 were performed for malignancy-related emergencies (Table 1). Retrospective review by the surgical team considered

that in usual times, 10 of those patients might have had open or laparoscopic surgery. During the same period 199 patients underwent diagnostic operative endoscopy; eight patients were COVID19 positive. At a mean follow-up of 1 month from the procedure, all the health workers and the initially negative COVID19 patients were asymptomatic and COVID19 negative. In the pandemic surgeons have postponed or cancelled many elective treatments, reserving admission to the hospital only to patients with malignancy which could pose a threat to survival. Even patients with malignancy try to avoid medical facilities if possible. There is a general attitude to prefer therapeutic schema


Table 1 Endoscopic operative procedure during COVID 19 pandemic in patients with malignancy-related emergencies. Percutaneous Endoscopic Gastrostomy (PEG); Endoscopic Retrograde Cholangio- Pancreatography (ERCP); Self-Expandable Metallic Stent (SEMS); Endoscopic Variceal Band Ligation (EVBL); Argon Plasma Coagulation (APC) laser

Procedure	Age	Sex	Indications	General Conditions	Complications	SARS-CoV-2
SEMS Positioning	80	F	Antro-pyloric cancer	Serious but stable clinical conditions	Vomiting in the 3 days following the procedure	Negative
	51	F	Colonic cancer	Serious but stable clinical conditions	No complications	Negative
	66	F	Antro-pyloric cancer	Serious but stable clinical conditions	No complications	Negative
	67	M	Rectal cancer	Serious but stable clinical conditions	No complications	Negative
	60	M	Colonic cancer	Serious but stable clinical conditions	No complications	Negative
ERCP (with metallic biliary prosthesis positioning SEMS)	44	F	Carcinoma of the head of the pancreas	Fair clinical conditions	Hyperamylasemia and hyperlipasemia	Negative
	68	M		Serious but stable clinical conditions	No complications	Negative
	57	M		Fair clinical conditions	No complications	Negative
	70	M		Serious but stable clinical conditions	No complications	Negative
	74	M		Serious but stable clinical conditions	No complications	Negative
	66	F		Fair clinical conditions	No complications	Negative
	47	M		Fair clinical conditions	Hyperamylasemia and hyperlipasemia	Negative
EMR (carcinoma in situ-T1)	52	M	Faecal occult blood +	Fair clinical conditions	No complications	Negative
	67	M	Faecal occult blood +	Fair clinical conditions	No complications	Negative
Polipectomy (Carcinoma in Situ)	75	M	Polyps of the colon	Fair clinical conditions	No complications	Negative
	65	F	Faecal occult blood +	Fair clinical conditions	No complications	Negative
	60	M	Anemia	Fair clinical conditions	No complications	Negative
	63	F	Rectal bleeding	Fair clinical conditions	No complications	Negative
	69	M	Rectal bleeding	Fair clinical conditions	No complications	Negative
	79	M	Anemia, Faecal occult blood +	Fair clinical conditions	No complications	Positive

which imply reduced risk for complications and hospital admission^{4,5}. Visits from relatives are not allowed, so that the patient undergoing major surgery should expect a significant isolation time with inevitable negative psychological consequences. Cancer and cancer-related treatments frequently cause immune suppression, and patients with cancer have excess mortality risk from severe acute respiratory syndrome. General anesthesia with endo-tracheal intubation, postoperative pain, Intensive Care Unit permanence are some of the most common risk factors for postoperative pulmonary complications. Operative endoscopy generally requires shorter operative time, no general anesthesia and tracheal intubation, and less organizational efforts. Hospital stay is shorter. Pulmonary complications and infection-related complications are lower after operative endoscopy. A smaller number of health workers is involved, intensive care unit is rarely required. Operative endoscopy should be evaluated in the pandemic differently than in usual times. Endoscopic procedures which have the same results of standard surgery, or even a marginal less effective result, should be preferred. The possibility to defer the standard, more effective surgical operation at later times, after having resolved the emergency situation by a less risky endoscopic procedures, is a reasonable clinical perspective. Placement of self-expandable metal

stents to relieve malignant colorectal or gastric obstruction represents a valid temporary choice, deferring definitive surgery, if required in more convenient times. Malignant obstructive jaundice, associated or not with gastric outlet obstruction, can be relieved by stent placement. The endoscopic removal of a bleeding small colorectal cancer (Carcinoma in situ-T1-T2) may represent a valid choice, deferring any major resection if any during the follow-up period.

The appropriate therapeutic approach to patients should be tailored considering also the capability of the local health care system to meet existing and projected needs after surgery, including level and phase of the pandemic and local facilities inevitably limits. In the pandemic period operative endoscopy may represent a valid alternative (definitive or temporary) to generally accepted standard surgical solutions. Each patient should be evaluated in his/her specificity considering clinical conditions, expectations, personal needs and level and stage of the pandemic.

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DOI: 10.1002/bjs.11846

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