ANZGOSA and ANZMOSS Guidelines for Triaging Upper GI and Bariatric Surgery during the COVID-19 pandemic

Version	2
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Approved by	ANGOSA and ANZMOSS

Purpose and Scope

In response to the COVID-19 pandemic non-urgent surgery is being 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 surge as well as protect both patients and staff from the risk of COVID-19 infection.

These guidelines were developed by the ANZGOSA & ANZMOSS Boards as a general guide to assist our members and medical directors when making decisions around what is reasonably deemed "urgent" Upper GI and Bariatric surgery during this unprecedented crisis.

The recommendations are divided into emergency and urgent elective procedures which have been defined as:

1. Emergency - conditions requiring urgent surgical intervention as the condition is life threatening or will cause permanent organ damage. Emergency cases are further subclassified according to the immediacy of care required.
2. Urgent and semi-urgent elective surgery – Usually these patients are outpatients. These categories include conditions requiring at least semi-urgent surgical intervention as the condition has the potential to deteriorate quickly to the point where the patient's situation may become an emergency.

This guide is not intended to be exhaustive, and it is recommended that each case is considered on it's merits, directing care to those most likely to have long term survivorship, and the available local resources. Emergency conditions that are common to all general surgical interventions (for example gallstone disease, post-operative haemorrhage, sepsis, necrotising skin infections) are not considered in the scope of this document. We recommend members follow the GESA guidelines for upper GI endoscopy (reference at end of document).

The evolving nature of the COVID-19 pandemic necessitates that these guidelines will be regularly reviewed.

Conditions requiring emergency care

Priority 1 – requires care in 1-4 hours

- Bleeding marginal ulcer following gastrectomy and gastric bypass* where the patient is haemodynamically unstable.
- Acute small bowel obstruction post gastric bypass or other Upper GI surgery particularly when suspecting internal hernia with potential ischaemia
- Gastric band perforation
- Gastric band acute prolapse with suspected gastric ischaemia
- Acute gastric band infection or erosion with septicaemia
- Ruptured oesophagus (iatrogenic or spontaneous)
- Bleeding Gastric/Duodenal Ulcer or varices unable to be controlled endoscopically or with embolization
- Perforated Gastric/Duodenal Ulcer that cannot be managed conservatively
- Strangulated Hiatus Hernia/Gastric Volvulus unable to be decompressed with NG/endoscopy

Priority 2 – requires care 4-12 hours (noting that these may be Priority 1 if the patient septic or in shock)

- Anastomotic or staple-line leak post oesophagectomy, gastrectomy, sleeve gastrectomy or gastric bypass
- Perforated marginal ulcer post gastric bypass*
- Gastric band prolapse without ischemia
- Gastric volvulus that has been decompressed with NG/endoscopy then re-obstructs. Surgery should be deferred if patients are stable and able to drink, even if serial NG tubes are required

Priority 3 – requires care 12-24 hours

- PEG/NJ/NG feeding tubes for patients with obstructing oesophageal cancer, strictures or leaks following bariatric and upper GI surgery that are dependent on the tube for nutrition. Consider formal feeding jejunostomy to avoid instrumentation of the naso-pharynx and minise risk.
- Upper GI obstruction
- Staple line leaks post sleeve gastrectomy or gastric bypass* where the patient is stable

Urgent and semi-urgent elective procedures

Category 1 - conditions needing treatment within 30 days. Has the potential to deteriorate quickly to the point where the patient's situation may become an emergency

- Oesophageal cancer and Gastric cancer where neo-adjuvant therapies have been completed if ICU is available. If ICU is not available consider continuing neo-adjuvant therapy.
- Staging of new Oesophageal and Gastric cancers where there is no metastatic disease on imaging and curative treatment is planned and the staging will change management *(please see guidelines on management of oesophageal and gastric cancer during coronavirus pandemic)*
- Diagnosis of suspected upper GI malignancy where patient management will be altered
- Blocked PEG/NJ/NG feeding tubes for patients with obstructing oesophageal cancer, strictures or leaks following bariatric and upper GI surgery that are dependent on the tube for nutrition
- Bleeding gastric cancers still regarded as potentially curative. Consider the role of Radiotherapy as a bridge to surgery

- Excision of GIST lesions which are bleeding despite maximal PPI therapy or have stigmata suggestive of poor outcome. The use of Imatinib or radiotherapy should be considered as a bridge to surgery
- Slipped Gastric Band with obstructive symptoms and empty band
- Eroded Gastric Band with acute symptoms (pain, fever, port swelling)
- Symptoms suggestive of internal hernia post gastric bypass

Category 2 – needing treatment within 90 days. Their condition causes pain, dysfunction or disability. Unlikely to deteriorate quickly and less likely to become an emergency

Note: Only cases that would be marked as high category 2 under normal circumstances would be considered in this category and prioritised for surgery at this time

- Incarcerated hiatus hernia with obstructive symptoms, pain and anaemia proven to be due to Cameron's lesions that cannot be managed conservatively with dietary modification and iron supplementation
- Prolapsed Gastric Band managing with fluid out of band but unable to maintain nutritional requirements on a liquid diet
- Eroded gastric band with abdominal pain
- Anastomotic strictures requiring dilatation to maintain nutritional requirements
- Gastric sleeve narrowing requiring dilatation to maintain nutritional requirements

Other relevant guidelines

Members are directed to these other relevant guidelines that may help support decision making:

GESA	https://www.gesa.org.au/public/13/files/COVID-19/Triage_Guide_Endoscopic_Procedure_26032020.pdf
American College of Surgeons	https://www.facs.org/covid-19/clinical-guidance/elective-case/thoracic-cancer
	https://www.facs.org/covid-19/clinical-guidance/elective-case/metabolic-bariatric
GSA	https://www.generalsurgeons.com.au/media/files/News/DOC%202020-03-29%20COVID-19%20Guidelines%20for%20General%20Surgery_FINAL.pdf
ISDEA	https://isde.net/covid19-guidance

Notes

*Gastric Bypass in this document refers to both Roux-en-Y Gastric Bypass and One Anastomosis Gastric Bypass