

The Editors welcome topical correspondence from readers relating to articles published in the *Journal*. Letters should be submitted electronically via the *BJS* submission site (mc.manuscriptcentral.com/bjs). All correspondence will be reviewed and, if approved, appear in the *Journal*. Correspondence must be no more than 300 words in length.

COVID-19 and emergency surgery

Editor

We endeavour, as always, to provide the highest level of patient care within the framework of imposed constraints and to preserve the health of the surgical workforce providing this care.

There is minimal evidence regarding emergency surgical care in the COVID-19 era. The paradigm of committing a patient to an operative or nonoperative pathway for management of perforation, obstruction or intra-abdominal inflammation is crucial. Until we have sufficient prospective evidence (currently being accrued internationally), we must extrapolate guidance from experience in outcomes of elective surgical patients who contracted COVID-19 perioperatively.

The effects of perioperative physiological stress on predisposition to or recovery from COVID-19 are not known but it is assumed that relative immunocompromise after major surgical intervention worsens the

prognosis of those who either contract COVID-19 perioperatively or have been asymptomatic carriers prior to intervention. Infection with this virus can complicate the perioperative course and prove a significant diagnostic challenge with an unacceptably high fatality rate¹.

Prior to this global pandemic, all colleges were strongly advocating utilization of scoring systems for every emergency laparotomy^{2,3}. As caregivers, we are obliged⁴ to furnish patients with as robust figures as possible regarding morbidity and mortality to enable these individuals to decide on management strategies. If the (albeit imperfect) evidence available to us suggests that the presence of COVID-19 has an adverse impact on perioperative outcomes, we are compromising our patients' decision-making capacity by denying them preoperative screening (either radiological or by reverse transcriptase–polymerase chain reaction (RT–PCR)) where feasible.

The accuracy of RT–PCR in the postoperative setting remains unknown. Notably, in a recent series from China of over 1000 patients to assess the diagnostic accuracy of different tests, chest CT scan had sensitivity of 98 per cent compared with a RT–PCR sensitivity of only 71 per cent.

In light of this, we feel there is justification to issue a recommendation that every patient scheduled for emergency

surgical intervention be offered either a thorax CT or RT–PCR screening for COVID-19 prior to intervention⁵.

A. Hogan 
Galway University Hospitals, Galway,
Ireland

DOI: 10.1002/bjs.11640

- 1 Spinelli A, Pellino G. COVID-19 pandemic: perspectives on an unfolding crisis. *Br J Surg* 2020; <https://doi.org/10.1002/bjs.11627> [Epub ahead of print].
- 2 COVIDSurg Collaborative. Global guidance for surgical care during the COVID-19 pandemic. *Br J Surg* 2020; <https://doi.org/10.1002/bjs.11646> [Epub ahead of print].
- 3 Søreide K, Hallett J, Matthews JB, Schnitzbauer AA, Line PD, Lai PBS. Immediate and long-term impact of the COVID-19 pandemic on delivery of surgical services. *Br J Surg* 2020; <https://doi.org/10.1002/bjs.11670> [Epub ahead of print].
- 4 *Montgomery v Lanarkshire Health Board* [2015] SC 11 [2015] 1 AC 1430.
- 5 Ai T, Yang Z, Hou H, Zhan C, Chen C, Lv W *et al*. Correlation of chest CT and RT-PCR testing in coronavirus disease 2019 (COVID-19) in China: a report of 1014 cases. *Radiology* 2020; 200642. <https://doi.org/10.1148/radiol.20200642> [Epub ahead of print].