Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Correspondence: Letter to the Editor

A dramatic reduction in surgical consults in a University Teaching Hospital during the COVID-19 pandemic

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To the Editor,

As the country slowly returns to normal activity, we reflect on the effects of the COVID-19 global pandemic on surgical activity. During the peak of the crisis, our entire critical care capacity was saturated with SARS-CoV-2 (COVID-19) patients requiring mechanical ventilation. Additional surge capacity was required, leading to the conversion of our postoperative recovery area, post operative acute care unit and some operating theatres into critical care ward space for patients. As a significant reduction elective surgeries scheduled and performed nationwide was observed, surgeons cross-skilled for re-deployment to other roles.[1–3] Additionally, we prepared for an unprecedented increase in surgical interventions to be performed on COVID-19 confirmed, medically-admitted patients which was based on anecdotal evidence from our colleagues in China and Italy.

Our institution distributes a daily secure surgical electronic handover to all members of the Department of Surgery.[4] This handover is written by the on call team and includes clinical details of all surgical referrals and consults. We compared our general surgical consult activity during the height of the COVID-19 pandemic (March 8th –May 10th 2020) to the corresponding time period in 2019 (March 10th-12th May 2019). During the pandemic study period, 58 consults (46.5% male, mean age 63.87 ± 16.94) were seen. This is a 96% decrease in referrals compared to 2019 (114 referrals, 37.7% male, mean age 63.45 ± 17.56).

Abdominal pain was the most common indication for the consults in both time periods (46.6% during the pandemic vs 40.4% in 2019). This was followed by gastrointestinal bleeding (12.1% vs 18.4%) and cutaneous abscesses including perianal abscesses (8.6% vs 9.6%). Other less common indications in both time periods were hernias, diarrhoea, anaemia and vomiting.

We consulted on 16 COVID-19 confirmed patients (56.2% male, mean age 59.43 ± 18.37, range 28.33–93.84 years). The reasons for consults were: 5 (31.3%) for undifferentiated abdominal pain, 4 (25%) for gastrointestinal bleeding, 3 (1.8%) for chest drain insertion or chest drain management and 1 (6.2%) each for diarrhea, jaundice, rectal prolapse and high nasogastric output.

Thus, the overall number of consults, particularly for COVID-19 patients was far lower than we had expected. We were particularly surprised at the low number of referrals for barotrauma requiring chest drain insertion. Abdominal pain and gastrointestinal bleeding continued to be the mainstay of the consults we performed. Considering the high numbers of COVID positive patients admitted to critical care and on the wards, only 16 who were admitted under other services required a surgical opinion. Similar to the general hospital population, the reason for the consult was most commonly for abdominal pain. Overall, there were less patients in the hospital in general as patients due to the reduction in elective surgical procedures (including orthopaedic, gynaecologic and urology procedures) and a public fear of contracting COVID-19 in hospital. However, this does not fully explain why we saw such a marked reduction in consults. Due the unprecedented nature of the COVID crisis and the paucity of evidence based guidelines, we hope our data help to inform future pandemic surgical planning and guidelines. This documented reduction in consults suggests that surgical staff could be potentially reallocated to other appropriate areas during future pandemics if needed.

Sincerely,

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