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Editorial

Position statement of the Surgery-AEC-COVID Working Group of the Spanish Association of Surgeons on the Planning of Surgical Activity during the second wave of the SARS-CoV-2 pandemic: Surgery must continue☆

Posicionamiento del Grupo de Trabajo «Cirugía-AEC-COVID» de la Asociación Española de Cirujanos sobre la planificación de la actividad quirúrgica durante la segunda ola de la pandemia por SARS-COV-2: la cirugía debe continuar

Our country, like many in our setting, is experiencing a second wave of the SARS-CoV-2 virus pandemic, although the circumstances we face now are different and once again require deep analysis. Like at the beginning of the pandemic, there is currently an exponential increase in the number of registered cases, occupation of hospitalization beds and intensive care units, and patients who have died from COVID-19[1]. This has led to a new declaration of a state of alarm throughout the national territory[2]. During the first peak of the pandemic, there was practically complete ignorance and little scientific evidence about the management of this type of patients. In addition, it was difficult to establish appropriate organizational circuits both in hospitals and in primary care centers, and there was also a shortage of the required diagnostic tests. The need to provide a healthcare response to an unprecedented situation in our health care system made it necessary to adopt a series of drastic measures that fundamentally included redistribution and prioritization of both human and material resources to treat patients affected by COVID-19.

This redistribution of resources, which was *a priori* logical and necessary, had a great impact on the scheduled and urgent activity of practically all surgery services in Spain. In some cases, scheduled surgical activity was completely suspended[3,4]. We also witnessed the phenomenon of an initial decrease in the number of urgent surgeries due to a lower influx of patients because of fear of infection, coupled with a delay in patients seeking treatment at hospitals, which subsequently led to the need to operate on patients with more advanced disease.

Although the curve was flattened and the consequences of the pandemic were minimized in terms of mortality and sequelae in infected patients, this decrease in programmed surgical activity resulted in delays in many procedures[5], which, in some cases, led to performing surgeries in more advanced disease states. This has greatly impacted cancer patients, but it has also undoubtedly had an impact on benign pathologies requiring early attention due to the danger of developing more advanced symptoms, yet this is more difficult to measure and determine[6–8]. Thus, surgical patients are an important part of the ''secondary victims of the pandemic'' group, without forgetting, on the other hand, the diagnostic delays of these patients due to the global slowdown of the healthcare system.

Several scientific societies made decisive contributions and published various recommendations and clinical practice guidelines[9], with various objectives: to establish the behavioral guidelines of healthcare professionals, to try to help

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optimize the distribution of available resources within our healthcare system, to create specific organizational circuits within hospitals that facilitate the management of the situation, and to facilitate decision-making for the prioritization of patients. These documents established different scenarios within the pandemic depending on the use of resources, designing scales for the prioritization of patients based on their underlying disease, local incidence of the pandemic, risks associated with a possible SARS-CoV-2 co-infection and complexity of the procedure[10,11]. These tools, some generated by the AEC itself and validated by other societies[12], have provided for the safe and efficient restart of surgical activity in our country. The recommendations made have always had a dynamic character and were designed to adapt to different epidemiological contexts and healthcare pressure. They provide a model to regulate surgical activity in proportion to the available resources, both human and material. For these reasons, we believe that these parameters should continue to be followed to guide decision-making, especially in situations with a growing incidence of new COVID-19 cases in order to continue with surgical treatments to the greatest extent possible, without being unilaterally suspended or minimized.

This second wave of the pandemic has arrived with somewhat more evidence (although still very limited), but we at least have learned lessons that we must put into practice. Undoubtedly, the situation will again generate massive exposure of medical professionals to the virus. We must be extremely careful to maintain protection measures in our hospitals to avoid contamination between colleagues and patients, as well as to be very alert to our responsibility in our behavior socially to avoid becoming vectors of hospital transmission. Likewise, we must make a call to the population so that patients and relatives follow the basic rules of behavior and protection within hospitals to avoid infection and the development of nosocomial infections. We currently have more data and resources to detect asymptomatic patients who are carriers of the virus, and their identification is key given the associated increase in morbidity and mortality as a consequence of the surgical trauma itself in pauci-symptomatic or asymptomatic patients[13].

In the same manner as at the beginning of the pandemic, from the AEC we insist on the irrefutable need to have personal protection equipment (PPE) as well as tools for the systematic screening of patients and healthcare professionals. This latest upwards swing brings with it new challenges, such as: determining the cost/effectiveness of the enormous diversity of PPE used so far (without being able to determine that the bulkiest are superior to the most comfortable), obtaining faster and more accurate diagnostic tests, determining the optimal time of the intervention in patients with past infection or in asymptomatic patients with positive previous screening tests, or determining the preoperative confinement period. What is evident is that we must insist on the patient's need to minimize preoperative contacts. Unequivocal screening criteria should be established, including patients who underwent emergency surgery and those previously admitted who will require an initially unforeseen intervention.

From the COVID-19 Working Group, as well as from the ACS itself, we believe that, although the pandemic will again require careful planning and an extraordinary response from healthcare professionals, neither society as a whole nor the scientific-medical community itself would understand if this response were the same as during the first wave of the pandemic. We must manage to stop COVID-19 without again paralyzing other activities, especially surgery and the circuits to diagnose potentially curable entities. If not, the consequences will be even worse than those caused by the virus itself. In the same way as in the first phase, all surgeons will once again be available to our healthcare system, once again providing all the skills of a multi-purpose specialty like ours and the undeniable vocation of service that defines our profession.

Appendix A. Members of the Surgery Working Group-AEC-COVID

Josep M. Badia, Inés Rubio Pérez, Esteban Martín Antona, Sandra García Botella, Mario Álvarez Gallego, Elena Martín Pérez, Sagrario Martínez Cortijo, Isabel Pascual Miguelañez, Lola Pérez Díaz, Jose Luis Ramos Rodriguez, Eloy Espin Basany, Raquel Sánchez Santos and Victoriano Soria Aledo.

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◇The names of the components of the *Cirugía*-AEC-COVID Working Group may be consulted in Appendix A.

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