



Surgical Life

The Journal of the ASGBI

Number 57



Celebrating 100 years of ASGBI

A Message from the President

Professor Iain Anderson

Welcome to Surgical Life in the Centenary year of our Association. Our journal has a new name and structure as detailed by our editor, Professor Vassilios Papalois below. Thanks to Vassilios and guest editor Professor Susan Moug for putting this marvellous edition together: it encapsulates many of our recent challenges as well helping us celebrate our Centenary. A glance at the authorship will confirm the modern diversity of general surgeons in the UK at all levels, something which ASGBI actively embraces and supports. Thank you to all the authors – what a range of talent. How surgery and our own surgical lives have changed in the last 6 months, never mind 100 years.

Our Centenary? Reaching a Centenary is a proud moment for any voluntary organisation, especially one whose aims are furthering both the Art and Science of surgery and constructive fellowship between surgeons conducted with the aim of improving patient care. All these have been needed in this dramatic centenary year but

who would have thought it would be like this? We think first of surgical and other medical and allied professional colleagues who paid with their lives or suffered serious infection with COVID-19 doing their jobs. Lord Moynihan, founder of the Association, would have been all too familiar with diseases which were highly infectious, relied for diagnosis on history and clinical features, had no specific treatment and with which the health system could not really cope. But it was, I confess, a bit of a surprise to meet one in 2020. Instead of finalising plans for our celebratory Centenary meeting in Glasgow, our attention turned to clearing the hospitals and devising non-operative treatment plans given the real concern that intensive care units and hospitals would be overrun by COVID-19 patients and that blunt triage would be required. Our ethos broadened from being solely patient-centred to also considering staff and population safety in order to maintain core services. Some units and areas did indeed suffer very badly whereas others escaped more lightly but the pandemic and

Association of Surgeons of Great Britain and Ireland
35-43 Lincoln's Inn Fields, London WC2A 3PE | Tel: +44 (0) 207 973 0300

www.asgbi.org.uk



necessary responses have altered surgery and our practice enormously. Several articles in this Journal examine aspects of practice, training and research during COVID-19 and we would be very interested to hear your own reflections and views. Perhaps the Association could facilitate more practical peer support of colleagues in units struggling with future local lock-downs?

Much of our Centenary programme will be carried forward to our 2021 meeting which will now look forward to the next 100 years. Meantime our archivist Mr Mick Crumplin has provided interesting historical photos and we have put together a short historical video (view [here](#)). Sir Barry Jackson, President at our 75th Anniversary, looks back at some fascinating historical aspects of ASGBI. He was brave enough to anticipate the future then (page 24) with apparent success! Ongoing change in surgery and hence our Association is both inevitable and welcomed and we have much to look forward to. Some ask why we need a general surgical association when elective surgery is now so specialised. Recent events have highlighted the need as ASGBI provided and coordinated significant responses to COVID-19, working with Colleges and other Associations across and beyond surgery. Every branch of medicine is subspecialised and we need groupings to have a voice or communicate effectively. The Associations have more direct contact with practitioners in their disciplines and showed they could respond to practical problems quickly but structure and unity are needed. Without that we couldn't have achieved the input we had to improving the PPE issue, to producing urgent guidance on practice and then modifying it with others to try and prioritise for the recovery.

Our members (led by Gill Tierney and Susan Moug) led the national study in real time of the impact of the change in appendicectomy practice during COVID-19 in their COVID:Harem study and this Journal covers a number of research oriented pieces of interest. For example, please take a look at Ms Jen Law's article on patient perspectives on priorities in Emergency Laparotomy (page 37). Surely an under-researched area and all too pertinent as more of our patients become frail?

The pandemic has changed the way we communicate with patients and with each other. In the absence of a Congress we wished to ensure that trainees could present their research and we have been running "free paper" sessions on zoom. They are a great success and very enjoyable. The range of material is outstanding. Please do join one or more of the remaining sessions (view [here](#)). Also, look out for our educational webinar series in the autumn – more details soon. Web based communication has also allowed easier regional meetings too. Thanks to Ms Katie Cross in the Southwest for running a great local meeting with a top class lecture and an easy means for our members there to link up with each other. Her article is at page 85. It was a pleasure to join her meeting and I look forward to more regional meetings in the autumn. Please sign up for our ever-popular Emergency Surgery Day meeting on September 9th. It's virtual this year, free for members and as usual, has a fantastic speaker list and will tackle problems we all face.

Our annual Congresses have always been a highlight and will doubtless become so again as there's nothing quite like sharing experiences face to face (F2F!). Do come to our next meeting in Glasgow in May 2021. It will be all about change but in time, it will be fascinating to look back and see which recent changes have become permanent. Meantime, short virtual business meetings will surely stay. Virtual meetings remove barriers of cost and time bringing an unmatched opportunity for ASGBI to engage its members more and so become more balanced, more inclusive and better able to influence for the good. Please see Vassilios Papalois's Letter from the Editor for our interest groups initiative.

By September we will be establishing a series of new committees and interest groups on matters ranging from inclusivity, research, clinical standards, and teaching to environment and sustainability. Specific clinical topics are welcome too. Some will be executive-led but more will be led from the grass roots.

Please consider what input you would like to have to these groups to make ASGBI and general surgery more cohesive, more effective and more inclusive as we move into our second century.

In the ASGBI, Everyone Matters!

Best Wishes

Professor Iain Anderson
President, ASGBI





Contents of the Journal of the ASGBI

Number 57

1-13 FROM THE EXECUTIVE

- 1-2 A Message from the President
- 5-7 A Letter from the Editor
- 7-11 New Journal announced
- 12 Annual General Meeting Report
- 13 Update from the Director of Scientific Programme

14-25 100 YEARS - REFLECTIONS

- 14-19 The Association of Surgeons 1920 - 2020: A century of education and fellowship
- 20-23 Memories of running International Surgical Training Courses
- 24-25 Reflections on the past 25 years

26-29 UPDATES

- 26-27 Getting it right first time: Update and next steps
- 28-29 Young BHS

34-49 GUEST EDITOR

- 34 Guest Editor: Professor Susan Moug
- 35-36 Contributors
- 37-38 What patients want from emergency laps
- 39-40 Differential attainment and the changing surgical workforce
- 40-42 Personalising care for primary breast cancer in older women – an overview of work from Nottingham
- 43-44 The role of the trainee in emergency laparotomy cases
- 44-45 The death of the diagnostic laparoscopy in acute appendicitis?
- 45-49 References

50-81 EXPERIENCES OF COVID-19

- 50-52 Delivery of surgical services during the COVID-19 pandemic: A succinct review
- 53-54 Comments from ASGBI Regional Representatives on post- COVID19 surgery recovery July 2020
- 55-56 Impact of COVID-19 pandemic on surgeons and surgery
- 56-58 Is COVID the end or just the beginning of a new era of surgical training?
- 58-60 Impact of COVID-19: recruitment to surgical training and progression
- 60-61 Surgical practice during Covid-19 – an Audit by FY1's
- 62-65 BASO ~ The Association for Cancer Surgery presents the Cancer Surgeons "Surgical life" during the COVID-19 Pandemic
- 66-68 Colorectal Surgery in the Covid-19 era – An Italian interview
- 69-72 COVID-19 A pandemic during a pandemic. The impact on bariatric surgery
- 73-77 Surgical research in the COVID-19 pandemic
- 77-78 COVID-19, social media and education
- 78-81 The COVID-19 pandemic: Impact on ethnic minorities and gender disparities

82-85 FEATURES

- 82-84 Sustainability and the environment in surgery
- 85 Being the first ASGBI Social Media Editor
- 85 ASGBI Emergency General Surgery CPD

86-87 ART AND SURGERY

- 82-83 Curing Folly

88-90 PROUDLY PRESENTING OUR TEAM

- 88-90 Acute Care Surgery Team at Cork University Hospital - the whole store

92-95 EMERGENCY GENERAL SURGERY

- 92-93 ASGBI & NFAS present The Emergency General Surgery Symposium 2020
- 94 ASGBI Webinar Series

96-101 CORESS

- 96-101 CORESS Feedback

102 FEEDBACK

A Letter from the Editor

Professor Vassilios Papalois, ASGBI Director of Communications and Informatics



Dear Colleagues, Dear Friends,

We are delighted to offer you the summer 2020 issue of the ASGBI e-journal. This issue is the first where our e-journal is rebranded as **ASGBI Surgical Life**. There is a very happy reason for this change of brand. This summer, following consultation with our members, we are launching a second e-journal which would be clinically oriented. The new e-journal aims to attract short clinically oriented papers and its overall concept, aims, Editorial Board and review process are presented in the introduction to it that follows this article. Our traditional e-journal will focus on professional surgical matters (hence Surgical Life!) and the new one will have a clinically spin; we will soon announce a "competition" through our communication channels giving you the opportunity to give it the most suitable name (**ASGBI...**)! You would be delighted to know that, thanks to the preparatory work done by the Editorial Board, we have papers waiting to be formally submitted.

2020 is our hallmark centenary year and the most appropriate occasion to reflect on our past and plan our future. Although due to the COVID-19 pandemic we did not have a chance to celebrate "live" at our Congress, there is a special section with articles of memories and thoughtful reflections that set our course for the years ahead of us. We will continue with similar articles in the upcoming issues way into our 100+1 year!

One of the most successful sections of our e-journal is that of the **Guest Editor**. We select the Guest Editor through a very thorough process aiming for a Colleague with experience and expertise in hot topics and major challenges we face in day to day surgical life. The bar goes higher by each issue and this issue is no exception. **Professor Susan Moug** and a team of five most talented surgical trainees have put together some top-class articles related to research that addresses day to day surgical-professional matters. They have our warm congratulations and grateful thanks.

The summer 2020 issue of Surgical Life is published at a time when the surgical community in the UK and around the

world is recovering (or trying to recover...) from the COVID-19 pandemic. We have a **special section related to COVID-19** addressing the delivery of surgical services, challenges in clinical practice, training and education, impact on ethnic minorities and gender disparities as well as some views of our Regional Representatives reflecting regional challenges. It is a collection of 12 very well written articles that we hope you will find informative and helpful to pave the way for the weeks and months ahead of us.

You will also find many very interesting features and updates and we would like to express to all the authors our sincere gratitude for the great work and commitment to our e-journal.

There are some more exciting news from the world of ASGBI Communications.

The President's Ezine has a more dynamic character presenting more topical issues and being linked with our social media account. Please note that the e-zine is open for any communication that you would like us to include that could be of interest to the ASGBI members and beyond.

Our e-educational platform is gradually being populated. We will launch next week a new e-module in the field of colorectal surgery, and we have prepared three prize winning video presentations from previous ASGBI Congresses as complete educational entities; they will feature in the platform very soon. Furthermore, the webinars produced by the ASGBI are gradually being uploaded in the platform enhancing its educational value. I would like to emphasize that our e-platform is designed in a way that allows for all ASGBI members to contribute creatively and get the credit for that.

We have introduced the role of the **Social Media Editor (SME)** aiming to enhance the presence and influence of the ASGBI as well as constructive dialogue within the broader surgical community through the use of social media. The role of the SME will be to champion this cause for a period of 1-3 months on behalf of the ASGBI. The rotation in this role allows for each SME to focus on





the role on a relatively short period of time and introduce their own ideas and initiatives. Social Media, in particular Twitter, provide significant reach beyond the membership. The ASGBI have over 10,000 followers of @ASGBI on Twitter and wishes to generate more original content to appeal to those using social media for education/information. A lot of this material can feed into in our e-educational platform. We are most grateful that Ms Cleo Kennington who has kindly accepted to be our first SME. Ms Kennington is doing a really superb job through our corporate social media accounts. The role of SME will be taken over at the beginning of September by Mr Jonathan Epstein. Cleo and Jonathan have our grateful thanks. You are all encouraged to come forward and take on this role, lead our social media portfolio and enhance our educational material.

We have established the **ASGBI Medical Student Apprenticeships**. The ASGBI wishes to engage the medical students who are members of our Association aiming to keep them within our ranks during their training and consultant years and give them a chance to contribute actively (in a structured way that will be recognised) to the projects of the ASGBI currently and in the future. We can make the apprenticeship popular and generate much more interest for the ASGBI within the medical schools that will create a critical mass for potential future members of the ASGBI. Two students have already started their ASGBI apprenticeships and we wish to popularise the initiative among medical schools across the UK.

The ASGBI Women in Surgery initiative (content of discussion, surveys etc.) led by Ms Irene Bellini is going from strength to strength and has resulted in two publications in peer review journals under the ASGBI banner and was the basis for one book:

Changing the norm towards gender equity in surgery: the women in surgery working group of the Association of Surgeons of Great Britain and Ireland's perspective. Bellini MI, Adair A, Fotopoulou C, Graham Y, Hutson A, McNally S, Mohan H, Vig S, Parks R, Papalois V. J R Soc Med. 2019 Aug;112(8):325-329

A woman's place is in theatre: women's perceptions and experiences of working in surgery from the Association of Surgeons of

Great Britain and Ireland women in surgery working group. Bellini MI, Graham Y, Hayes C, Zakeri R, Parks R, Papalois V. BMJ Open. 2019 Jan 7;9(1): 024349.

"Gender Equity in the Medical Profession" I Bellini and V Papalois (eds) was published by IGI Global, August 2019

Such articles are discussed, cited and engage surgeons with the ASGBI. The plan is to convert into publications material coming from all our activities (debates in the EGS Symposium, surveys, debates on the topics addressed by the Guest Editors etc.) to promote the work of the ASGBI.

The successful examples of the ASGBI Women in Surgery Group (843 members on the Facebook group), ASGBI Emergency General Surgery Group (440 members on the Facebook group) and the more recent ASGBI Sustainability in Surgery Group (already 47 members on the Facebook group) are some characteristic examples of excellent and productive collaboration amongst our members and much beyond. Our founder Lord Moynihan set the noble cause of the ASGBI most clearly: "the advancement of the science and art of surgery and the promotion of friendship amongst surgeons". The most challenging experience of the COVID-19 pandemic made it clearer than ever the need to work together as colleagues and friends to deal with challenges in surgical practice and surgical life. In that regard, we have cordially invited our members to offer their ideas regarding **ASGBI interest groups** that they would like to lead or be part of; aiming to address those challenges in a collegiate and constructive way and achieving some palpable outcomes. The ASGBI has the resources to facilitate these groups across our web links, social media, collaboration and e-learning platforms allowing for strong engagement across the general surgical community. Our Association also has strong links to the highest levels within the profession that allows to raise the profile and influence of the work of the interest groups nationally. Some great proposals have come forward related to inclusivity, research, clinical standards, sustainability in surgery, and medico-legal matters. The invitation for ideas is still open so please come forward with your proposals!

Our aim is that ASGBI interest groups that **YOU** will propose and **YOUR** work in the groups will be recognised, will shape the future of our Association and influence day to day practice for surgeons across the UK and around the world.

I would like to express my sincere gratitude to all Colleagues who contributed to the publication of the summer 2020 issue of Surgical Life. My most special thanks to Ms Vicki Grant, our Communications and Events Manager, for her great work and exemplary professionalism and efficiency.

Have some rest in the summer!

Enjoy reading!



The ASGBI announces the establishment of the new clinically oriented e-Journal!

The ASGBI Executive has agreed to proceed with the establishment of a new clinically oriented e-journal for the Association based on a proposal by Professor Vassilios Papalois, ASGBI Director of Communications and Informatics. This will be in addition to the existing successful e-journal of the ASGBI that addresses mainly current professional matters.

Short articles could address:

- **Clinical Cases**
- **Audit Analysis**
- **Small Research Studies**
- **Clinical Innovations**
- **New Techniques**
- **Smaller Sites Studies**

There will be a robust, quick and efficient review process within 14 days.

Articles would be published on the Journal page on the ASGBI web site following the completion of the reviewing process. Articles will be cross referenced with the e-learning platform and will also be publicised via the ASGBI Social Media channels.

The members of the first Editorial Board are:

Editor: Vassilios Papalois

Members:

Anita Balakrishnan
Irene Bellini
Evangleos Efthimiou
Kim Gorissen
Chris Lewis
Siong Liau
Kamal Mahawar
Giovanni Tebala





ASSOCIATION OF SURGEONS OF GREAT BRITAIN AND IRELAND (ASGBI): NEW e-JOURNAL

JOURNAL NAME: ASGBI

Members are cordially invited to suggest the most suitable name!

SHORT CLINICAL PAPERS/LETTERS TO THE EDITOR

INSTRUCTIONS FOR AUTHORS

OVERVIEW

Authors should submit short papers/ letters to the editor that will enrich the existing literature by conveying:

- Clinical cases
- Unusual or underreported presentations
- A novel or innovative diagnostic treatment approach and its outcomes
- New surgical techniques or modifications of current techniques
- Cases highlighting a need for change in current practice
- Cases which are of educational value
- Audit analysis
- Small research studies
- Smaller sites studies

GENERAL FORMATTING GUIDANCE

Authors must consider the following when preparing manuscripts for submission:

	Text Word Limit	Abstract Word Limit	Reference Limit	Table, Figure, Photograph Limit*
Case Report	1000	100	15	3
Letter to the Editor	500	N/A	5	1

*Combined total of tables, figures and photograph

As case reports are published online, there are no printing charges for submission.

Language: All work must be submitted in English and written in a formal and academic style. Authors should aim to convey information clearly and concisely.

General Formatting:

- Manuscripts should be double spaced and typeface font should be 12-point. Arial and similar sans serif fonts are preferred.
- Page margins must be 2.5cm (1-inch) from the top/bottom and left/right.
- Image files must be uploaded in .tiff, .eps or high-resolution PDF format.
- Abbreviations should be avoided in the manuscript title and within the Abstract. The full term or short phrase for which an abbreviation stands must be delineated prior to its use in the text. Exceptions to this are standard units of measurement e.g. cm, mmHg etc.

MANUSCRIPT PREPARATION

Manuscripts must be structured under the following headings:

- Title Page
- Summary Page
- Text Pages
- References
- Tables
- Figures/ Photographs

TITLE PAGE

The Title Page must include:

- **Manuscript full title**
- **Authorship statement** (Complete list of authors, using their full names, name of institution and department in which the work was completed and author affiliations, details of corresponding author (full name, workplace address, telephone no. and e-mail address). The specific contribution of each author must be indicated. Further guidance can be found in the ICMJE Recommendations page <http://www.icmje.org/recommendations/browse/roles-and-responsibilities/defining-the-role-of-authors-and-contributors.html>.
- Funding, financial support, grants (including a quote of the sum(s))
- Consent and Ethics Approvals (if applicable)

SUMMARY PAGE

The Summary Page should include:

- **Abstract**
 - Word Limit (max. 100 words)
 - Structured, with the following headings; Background (the context, purpose and significance of the publication), Case Report (the principal, relevant clinical details), Conclusion. Abstracts must not include any references.
- **MeSH terms/ Keywords:** 3-10 words or short phrases, appearing after the Abstract.





TEXT PAGES

The main body of the case report should be structured under the following headings:

1. Background

This should outline the authors' rationale for presenting the case report, as well as a brief outline of the case and the wider medical/ surgical context.

2. Case Report

All patient information should protect the patient's anonymity and privacy. Any personal information disclosed must be clinically relevant e.g. age, gender, ethnicity (if relevant), the main medical problem, co-existing medical history, related drug history (generic name, dosage and route), diagnostic and therapeutic procedures undertaken. Report any significant treatment outcomes and highlight any adverse effects or complications.

3. Discussion

Authors must present their case report within the wider clinical context and in relation to existing literature in the relevant field. Authors should include an analysis of the case and of the possible implications for future practice, as well as any possible limitations identified.

4. Conclusion

Authors should summarise and re-iterate any salient didactic points or recommendations identified as a result of the case.

5. Acknowledgements

This section should acknowledge any contributors who are not included in the authors list e.g. writing/ technical assistants, head of department etc. Any financial support should also be disclosed and acknowledged in this section.

REFERENCES

Authors should select references that are up-to-date and accessible. Unpublished work cannot be cited.

The ASGBI uses AMA (American Medical Association) referencing format.

For example:

Doe J, Williams G, Jones H et al. Article Title. Journal Name 2016; 100:1198-1210

- References in the main text body must appear as superscripts
- References must be listed in the order in which they appear in the text
- A maximum number of 6 authors can be listed in a citation. If there are more than 6, the first 3 should be listed, followed by et al.
- The article title must be listed after the authors' names. This is followed by the name of the journal (this can be abbreviated, as accepted by the National Institute of Medicine).

Any references included in tables or figures should follow consecutively from the references embedded in the text.

TABLES, FIGURES & PHOTOGRAPHS

Tables

Each table must be included as a separate file and not as picture images. Tables should be named in the order with which they appear in the text. Table headings and captions should be brief and descriptive.

Figures & Photographs

File format: Each figure must be included as a separate file and not embedded within the main text. Acceptable file formats include .tiff, .eps and high-resolution PDFs. The following file formats are NOT acceptable; .pptx, .jpg and .png.

Color images must be saved in 'CMYK' color space and NOT 'RGB' colour space.

Colour & Resolution: Figures must be the highest resolution possible with a minimum of 300 dots per inch (DPI) or higher. The following exceptions apply:

- Monochromatic images must be of at least 1200 DPI or higher
- Figures containing both images and text must have a resolution of 600 DPI or higher.
- Figures/ photographs of histology must be in colour (with the costs borne by the author).

Sizing: The maximum height for all images is 650 pts. The maximum width for images occupying a single column is 228 pts and 474 pts for images occupying two columns.

Labelling: Figures must be labelled with their appropriate figure number within the figure file. All labelling must be in black.

Any photographs containing identifiable patient imagery must be accompanied by a signed patient consent form.

CASE REPORTING GUIDELINES

Please find the CARE checklist for case reports: <https://www.care-statement.org/>





Annual General Meeting Report

Mr Neil Welch, Vice President, ASGBI

As you are all aware, COVID-19 meant we had to postpone the 2020 Congress and therefore the planned AGM. Instead, this was held by Zoom and a big thank you to everyone who joined the Zoom AGM on the 7th July. Interestingly we had more attendees at this Zoom AGM than we often get at the face to face AGM when it is held at Congress. The full papers are available to all members by following the links sent to your email address prior to the meeting (www.asgbi.org/meetings/agm Password: 1920@!Apple*Tree).

I would like to take this opportunity of describing some of the highlights for those who could not attend.

We were saddened to hear of the deaths of 3 of our members, and observed a minutes silence in acknowledgement of their service and lives.

We have updated our Memorandum and Articles of Association to reflect the present state of the Association and to allow for some changes going forward. In particular we have changed the term used for our retired members from "Senior Member" to "Emeritus Member" and plan to use the term "Senior Member" as a progression from "Fellow" if they fulfil the expectations as laid down by the Board in positive acknowledgement of their commitment to General Surgery and the Association. To become a Senior Fellow the Board have proposed that it will be necessary to have been on the GMC Specialist Register for a minimum of 5 years, be a Fellow of ASGBI for at least 5 years, and to attend 3 days of ASGBI meetings every 3 years (including Congress & EGS meetings whether face to face or virtual). We have also increased the potential number of directors to allow for future developments and inclusivity.

We were delighted to be able to welcome so many newly appointed Regional Representatives to ASGBI Council, and thanked Mr V Trompetas who finished his period of service as a Regional Rep. The Regional Reps have worked together to meet by Zoom on a monthly basis and it has been fascinating to hear what is happening

in different parts of the country especially during the pandemic.

Dr David Murray has been awarded an Honorary Fellowship of ASGBI and I'm sure you will all welcome him. He has done sterling work as Chairman of the National Emergency Laparotomy Audit, and a supporter of the Association.

Financially the Association was on the path to recovery when COVID-19 struck. The postponement of our centenary Congress in June in Glasgow has some significant financial risks with a potential impact in 2021, and your Board has worked hard to understand and mitigate these risks. We are very grateful to all our strategic & industry partners for their support, and for members who had registered for the 2020 Congress and agreed to defer this registration until the 2021 Congress.

Reports from the Executive Members of the Board were also tabled. There are some exciting new developments expected this year including the establishment of a trainee group "The Moynihan Academy", a new clinically orientated open access e-journal (the current working title is ASGBI Surgery), a social media editor (Cleo Kennington was our first, and now Jonny Epstein will be taking on the mantle – well done both), and Medical Student Apprenticeships.

Many of you will have seen or been involved in the programme of ASGBI Educational Webinars, and Covid:Harem research. We have also been running Zoom presentations of the short papers and abstracts that would have otherwise been presented at the 2020 Congress to allow people a chance to present and get the abstract published. These have been well received.

COVID19 has resulted in a huge amount of change and hard work. Many of the changes will become embedded going forward. We are enormously grateful for the support and drive shown by so many members in support of the Association.



Future Plans

Director of the Scientific Programme, Mr Christian Macutkiewicz

We were disappointed to have to postpone the Centenary Congress in June however we have taken the opportunity to move a number of sessions on-line. We are now mid-way through our Centenary Free Paper Series, which is allowing us to continue with a virtual programme. Thanks to all the presenters who are sharing their work in these sessions. If you have not joined any of the sessions yet, we would encourage you to do so. In addition to the weekly sessions, running from 1830 – 2000 hours on Tuesday and Wednesday evenings, there are e-posters that can be viewed on-line. Previous sessions have been recorded and are available to view on our web site.

The full programme and ePosters can be found here (<https://www.asgbi.org.uk/event/asgbi-events>)

Our new dates at the SEC in Glasgow from 5th – 7th May 2021. We hope that this will be an opportunity for us all to get together in person again but should that not be possible we'll have contingency plans in place for a virtual Congress.

The congress will feature an exciting selection of state of the art symposia and punchy educational sessions.

There is a fantastic line up of national and international speakers and we will be calling on their experience in cancer care, technical innovations, robotics and latest guidelines in surgical care. We will also look at the impact of COVID19 on our practice and what we can learn from it to improve.



ASGBI CENTENARY FREE PAPER SERIES

30th July	1830 - 2000 hours	Prize Session
4th, 5th, 11th & 12th August	1830 - 2000 hours	Emergency general surgery : NELA, all sub specialities, cancer
18th & 19th August	1830 - 2000 hours	Colorectal
25th August	1830 - 2000 hours	HPB
26th August	1830 - 2000 hours	Oesophagogastric cancer
1st September	1830 - 2000 hours	Breast & Endocrine





The Association of Surgeons 1920 - 2020

A century of education and fellowship

Mick Crumplin, ASGBI Archivist

Sadly, a world pandemic has prevented a celebration of a great society of British surgeons. At least we can all look forward to a postponed centenary meeting in May 2021, in Glasgow.

As honorary Archivist, I would like to provide a short ‘trailer’ for a presentation on the evolution of the Association from its inception a hundred years ago. In this time there have been monumental changes in surgical education, examination, techniques, also, in attitudes and outcomes. These have been developed and practised on a population, which has also undergone explosive changes in size, longevity, expectations and co-morbidity.

As the great discoveries of Anaesthesia (1846) and Antisepsis (1867) accompanied a surge in industrial power and capability, demands upon the surgical brotherhood expanded. Thus, there was a need to increase learning and promote communication between surgeons, often working in isolated areas and industrial ‘pockets’ of Britain. The concept of creating an Association of Surgeons took place before the Great War of 1914-18. This terrible conflict interrupted the introduction of the Association, yet bred a nation of surgeons who took advantage of great experience, improved surgical techniques and the potential for surgical specialisation.

In a letter written to Sir George Gask in 1936, Berkeley Moynihan, whilst a surgeon at the Leeds General Infirmary, had complained, in 1909, that he had been:

‘... struck by the lack of adhesion amongst members of my profession. A surgeon from Manchester had never, as far as I could hear, visited an operation theatre in Leeds, nor had ever been asked in consultation. As a consequence, it was not infrequent to have to listen to disparagement of one surgeon by

another; and jealousies, openly expressed were too often heard’.

Lord Moynihan, ultimately himself, an ennobled and eminent surgeon from the North of Britain, who was to practice in London and Leeds, had clearly seen that the nation’s surgery could benefit by better education, interchange of ideas and surgical cohesion.

Moynihan was born in Malta, the son of a soldier who had been awarded the Victoria Cross, in the Crimean War (1853-6). Moynihan qualified in Leeds in the year of Queen Victoria’s Golden Jubilee, 1887. He became a surgeon and consultant and later took the Chair of Surgery in Leeds, from 1910 to 1927. He also fulfilled the role of President of the English College from 1926 to 1932. He was a modernising surgeon with many interests. His surgical technique was gentle and he was an early champion of blood transfusion.

In 1909, Moynihan had invited 20 surgeons to Leeds, to encourage friendship and collaborations between surgeons. With Harold Stiles, he founded the ‘Chirurgical Club’. In 1913, despite some initial reticence, the British Journal was first published. This remains a prestigious publication with a high impact level. At first, chaired by Moynihan, the production and drive for the journal was provided by Ernest Hey Groves. A successful surgical pioneer, Groves edited the journal for 27 years. After Berkeley Moynihan’s death in 1940, Groves gave the first Moynihan Memorial Lecture.



Berkeley, Lord Moynihan of Leeds

THE BRITISH JOURNAL OF SURGERY

UNDER THE DIRECTION OF THE FOLLOWING EDITORIAL COMMITTEE:

Sir BERKELEY G. A. MOYNIHAN (Leeds), Chairman	
GEORGE E. ARMSTRONG (Bristol)	Sir ALEXANDER MACCORMICK (Glasgow)
Sir CHARLES B. BAILEY, Bart. (Dublin)	GEO. H. MAKINS, C.B. (London)
ARTHUR E. J. BAKER (London)	HENRY A. MOFFAT (Cardiff)
GILBERT BARKING (Birmingham)	Sir HENRY MORRIS, Bart. (London)
Sir WILLIAM BENNETT, K.C.V.O. (London)	A. W. MAYO-JONES, C.V.O. (London)
FREDERIC F. BETHUNE (London)	RUTHENFORD MORRISON (Newcastle-on-Tyne)
FRANCIS M. CAIRD (Edinburgh)	Sir THOMAS MYLES (Dublin)
Sir W. WATSON CHEVNE, Bart., C.B. (London)	R. H. PARRY (Glasgow)
EDWARD M. CORNER (London)	DARCY POWER (London)
THOMAS CRISP ENGLISH (London)	SIR HENRY W. F. RICHARDSON (Cardiff)
CHARLES H. FAGGE (London)	THOMAS SINCLAIR (Glasgow)
Sir NORMAN J. GOSWELL, Bart., K.C.V.O. (London)	LEO GEORGE H. STEVENS (Cardiff)
Sir A. PEARCE GOSWELL, K.C.V.O. (London)	HAROLD I. STILES (Edinburgh)
W. SAMPOON HANREY (London)	EDWARD H. TAYLOR (Dublin)
ROBERT JONES (Liverpool)	T. LYNN THOMAS, C.B. (Cardiff)
Sir WILLIAM ARDRETHNOT LANE, Bart. (London)	HENRY ALEXIS THOMSON (Edinburgh)
	WILLIAM THURBERN (Manchester)

E. H. GUY GROVES (Bristol), Editorial Secretary.

VOLUME I.

July 1913 to April 1914. Numbers 1 to 4.

LONDON: JOHN WRIGHT AND SONS LTD.,
LONDON: SIMPKIN, MARSHALL, HAMILLTON, KENT AND CO. LIMITED.

PRINTED BY THE MANGLAY CO. OF GARRA LTD.
GLASGOW: BUTTERWORTH AND CO. (PRINTERS) LTD. 1, THURLOUGH, ST. AND CO.
BOMBAY: THAKUR AND CO. LTD.
MADRAS: SUNDAY, ADAMS, AND WILKINSON. D. ROBERTSON AND CO. PROPRIETORS LTD.
SYDNEY: ANGUS AND ROBERTSON LTD. NEW ZEALAND: WILKINSON AND THOMAS LTD.
UNITED STATES OF AMERICA: WILLIAM ROSS AND CO., NEW YORK.

Front page of the first issue of the BJS, July 1913



In 1914, fuelled by a fervour to proceed with his ideas, Moynihan persuaded the President of the English College, Rickman Godlee, to convene a meeting of 20 surgeons to discuss the proposed Association. After the meeting, which, stimulated by a good dinner at Godlee's house in Wimpole Street, the concept was enthusiastically accepted and Moynihan was asked to set up a constitution. This he started to do, assisted by several noted surgeons. The two all-important objectives, foremost to this year, a hundred years later, were:

'The advancement of the science and art [craft] of surgery'

and,

'The promotion of intercourse and friendship amongst surgeons of the United Kingdom'



Major-General Sir Cuthbert Wallace, Consultant Surgeon to the 1st Army. President of ASGBI, in 1926, he progressed abdominal surgery on the Western front

Whilst all was set to begin, the dark clouds of war were to engulf the world in four years of appalling loss and suffering. Matters were shelved for just over a year after the cessation of hostilities. Having gained much experience on the bloody fields of Picardy and Flanders, coupled with many RAMC meetings and some research into trauma, shock and transfusion services, there was, no doubt, a significant enthusiasm to settle into a safer and more progressive civilian surgical environment in Britain.

On January 8 1920, a preliminary meeting was convened to take the formation of the Association forward. On 12 February the first council meeting under the chairmanship of Sir John Bland-Sutton decided that a limit of 250

Fellows should be set. On May 13 to 15, the first meeting of the Association took place in Lincoln's Inn Fields. There were a few keynote lectures and 12 operating theatre sessions, followed by a dinner at Claridge's.

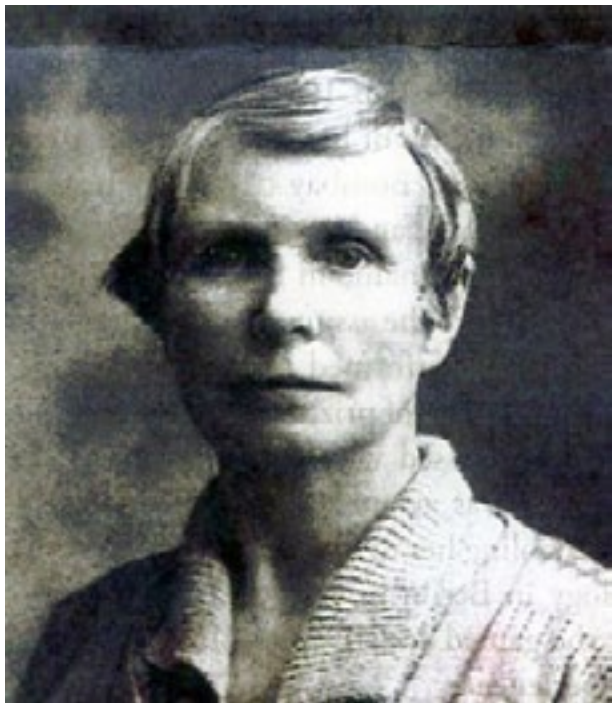


Sir John Bland-Sutton in his operating theatre at the Middlesex Hospital

In 1924, Moynihan presented a gold chain and badge for the President to wear. Two years later it was decided to introduce a £350 research grant for trainee surgeons and in 1927, importantly, there were some early discussions about surgical training for students and young surgeons. As the 1920s passed, the era of early thoracic surgery and the use of sulphonamides, led into years of the Depression. In 1931, a lady

surgeon, Miss Maud Forrester-Brown, was refused admission into the Association. As the decade wore on, the Association vowed to avoid getting involved in medical politics and in 1936, a Moynihan Fellowship was established and it was eventually decided to admit women into the Association!





Maud Forrester-Brown MS MD (1885-1970)

Another world conflict interrupted the progress of the Association. In 1942 there was an ad-hoc meeting on war topics and the Moynihan medal was introduced. This was the time of intravenous anaesthetic induction, muscle relaxants, partial gastrectomy and penicillin – the latter, just in time for D-Day. A report on surgical training in 1944, preceded a conference in the last year of the Second World War on the same topic.

The country was again shattered by war and a Labour government, which had promised a Welfare State, resulted in the formation of a National Health Service in 1948. By 1951, a Moynihan Prize was established in the Association and it was decided in 1953 to have some Associate Fellows for senior trainees. Between 1953 and the end of that decade, aneurysm and cardio-pulmonary bypass surgery evolved. By 1957, at the annual meetings, Fellows' visits to operating theatres ceased. In 1966, the Moynihan Fellowship was re-invigorated and a year later, discussions were started on the JCHST. Transplantation, hip replacement and the rod lens system took off in the second half of the decade.

In 1970, all consultants were eligible for Fellowship of the Association. As this new decade moved on and CT and MRI came into use, in 1975, the EU directed specialist medical

registers to be created. The Association then introduced a Travelling Fellowship and audio-visual awards at meetings. At the start of, and into the 1980s, the discovery of H. Pylori and minimal access surgery started to make significant changes to surgical practice. The 1990s saw an expansion of Associated Fellowships, which could then include non-consultant career grades. Calman reforms had set up a working group to bring the British system of specialist training in line with the requirements of the European medical directives and new examinations came in as the 1990s moved on. In 1998, ASGBI set up its own internet site.

As we passed the Millennium, new challenges and therapies were introduced and robotic surgery, UK major trauma centres and increasing antibiotic resistance came on the scene. The Association created an Education and Training Board in 2002. At last, an intercollegiate MRCS exam was agreed upon and surgical training moved through PMETB and MMC to BST and HST. In 2007, the JCST acting for the four Colleges and supported by the SACs, introduced formal curriculum-based training under the regulation of the PMETB (taken over by the GMC in 2010). The debate and controversies over run-through training for specialist surgery lurks

around for the future, while the need for improved care and outcomes for emergency surgical patients, with their significant mortality rates, remains a priority within the generality of surgery.

Surgical practice and strategies have now been rudely interrupted and delayed by the COVID-19 pandemic and the decade to come will, with resource and manpower limitations, be

an enormous challenge to Britain's surgeons. However, The Association with its multiple educational opportunities, links and facilities, must remain as the regional & speciality representation of 'General Surgery' in the UK and Ireland. The original tenets introduced one hundred years ago remain a solid foundation for the Association's future.



Looking to the future

We have asked some of our newer members to share their thoughts on ASGBI membership as part of a campaign to attract members. Thanks to Farah and Tabitha for their thoughts. Click on the images to see the full videos.





Memories of running International Surgical Training Courses

Bob Lane, Past President of ASGBI

The rationale of running such Courses in low and middle income countries (LMICs) is unequivocal.

5 billion people worldwide do not have access to safe, timely and affordable surgical care. 19% of post-operative deaths are due to poor surgical treatment as a result of a lack of trained surgical providers. LMICs account for 57% of the 14 million people diagnosed with cancer worldwide and 65% of the deaths. Cancer kills more people in LMICs than Aids, Malaria and TB combined. In LMICs 1.5 million deaths could be averted each year if access to essential surgical procedures such as trauma care, obstetric care and abdominal emergencies were available and undertaken by trained surgical providers.

Training in sub-Saharan Africa (s-SA) began in 1999 when ASGBI was invited to run a Basic Surgical Skills Course (BSSC) for 24 surgical trainees in Kumasi, Ghana at the AGM of the West African College of Surgeons. Ethicon supported us greatly.

In retrospect this was not such a good idea for in addition to the 24 trainees 148 other attendees at the AGM also wandered in to see what it was all about! It was therefore somewhat chaotic but lessons were learned!

Since then we have undertaken a total of 38 BSSC's in s-SA. We adapted the BSSC, then available in the UK, to be more appropriate for LMICs by adding, for instance, topics such as tracheostomy, chest drain insertion and skin grafting. All BSSCs are preceded by a Train the

Trainers Course and this over a period of one day. Also running in parallel with the BSSC is a Theatre Nurse Training Course run by a very experienced and able retired Theatre Sister. I sometimes think that her contribution may be greater than ours. The standard of theatre nursing in some areas is not as we experience in the UK. Subsequent to each course a report is written and disseminated to each site lead and this because we do not return to the same site twice. This is why the Train the Trainers Course is so important. However, we do keep in touch with the site leads for a year or two to make sure the situation is satisfactory.

It is essential to liaise carefully with the local team lead with regard to time of year, local requirements such as refreshments and most important of all the presence of a dead pig. I say dead because on one occasion the pig walked in! Money changed hands and it was dispatched appropriately. I have learned a lot about pigs over the years! However, the reason that they are ideal is because in many ways they are very similar to us humans and in particular the trachea, stomach, intestines and bladder etc. I do accept that the feet (trotters) are somewhat different! Our experience of obtaining pigs is very variable, not only in size but also in preparation. So much so that over recent years all the animal material required, for whatever Course, is sent out from the UK frozen in a box and picked up at the airport. When we come to utilise the contents everything is neatly labelled in plastic bags and so we do not have to enter into all that kerfuffle which was not only time consuming but also in some cases quite difficult.



A time consuming dissection



Life gets easier!

Our next challenge was to design a new Course entitled the Management of Surgical Emergencies. This included, over a five day period, Critical Care (2 days), General Surgery (1 day), Orthopaedics (1 day), Urology and Obstetrics (half a day each). The Train the Trainers Course was held on the Sunday before the five days of the Course.

I was very pleased to have excellent Leads from the UK for the five domains mentioned above. We ran 7 MSE Courses overall including a pilot course and had excellent reviews from both local trainers and trainees alike.

Training Courses in s-SA, 1999 - 2020

	Courses	Participants
➤ Basic Surgical Skills.....	38	546
➤ Colorectal Skills Courses.....	2	26
➤ Laparoscopic Skills.....	23	200
➤ Anastomosis Workshops.....	11	131
➤ Management of Surgical Emergencies.....	7	126
➤ Theatre Nurse Training Courses.....	32	722
➤ Training the Trainers.....	27	452
TOTAL	132	2,179

However, this was an expensive Course to set up and there was no way each country in the Region could have afforded it. We therefore divided East Africa into two with Nairobi covering essentially the northern half and Lusaka the southern half. As with all Courses we leave the question of charging trainees to the local leads. It is imperative that the local trainers support the MSE Course as and when needed. This is not easy as it might seem for they have their clinical work to consider and so we strongly

advise that the dates of the Course are known well in advance. This allows the Lead to know when to fill in any gaps in the relevant specialty. I emphasise that the Course covers common elective and emergency surgery. The Theatre Nurse Training Course is held as with the BSS Course. The complexity of this Course has meant that after we have shown them how to run it, we leave the content and the length of the Course to the local trainers.

Dr Zulu hands out Certificates of Satisfactory Completion of the MSE, Lusaka, March 2014

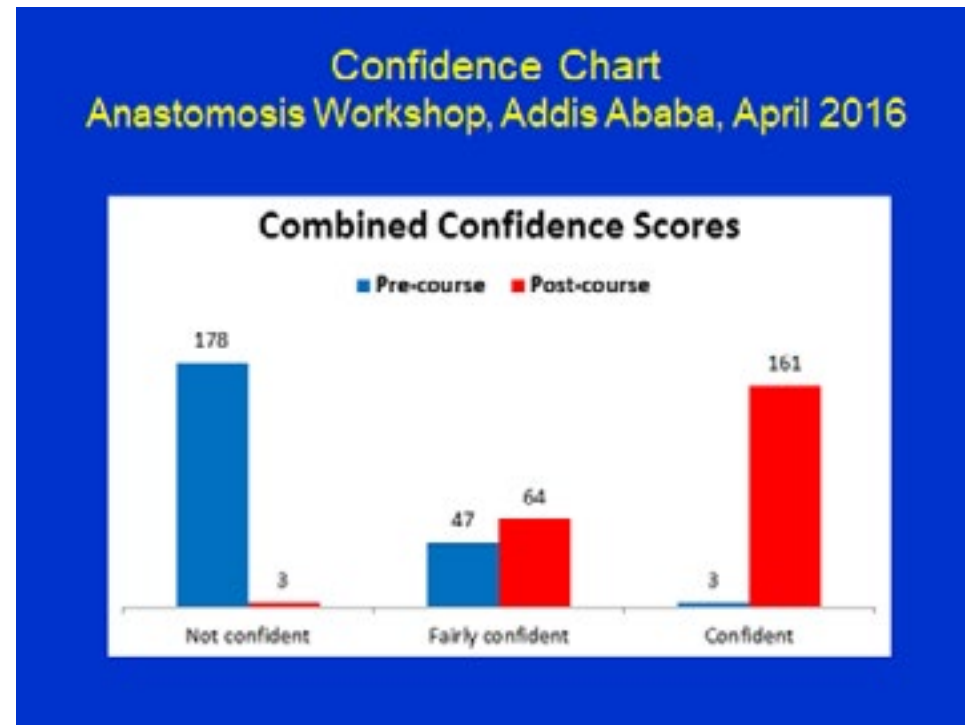




The third and final training Course which has been introduced to s-SA is an Anastomosis Workshop designed by Clive Quick, a surgeon in Cambridge. He invited me onto the Faculty several years ago and I was immediately taken with the whole structure of anastomosis demonstration followed by participant undertaking the exercises and all in a well-spaced laboratory. We decided to take the Workshop to s-SA where it was immediately welcomed. Participants must have undertaken a BSSC

beforehand. As with the other Courses, the pig contribution is sent out from the UK beforehand. This makes life so much easier.

Attendees at all Courses/Workshops complete satisfaction forms at the end of each event and again 6 months later and particularly with regard to confidence levels in undertaking the elements of each event. This feedback has allowed us to adjust the content accordingly.



I must emphasize that the MSE and Anastomosis Workshops are aimed primarily at surgical trainees and Consultants. The implication being that, as it stands, it would not be suitable for Clinical Officers working in District Hospitals for obvious reasons. Therefore, we are considering an MSE "Lite" version for those surgical providers working in District Hospitals. Up to a sense we allow the local Faculty and the training cadre who are responsible to Government for Clinical Officer training to utilise the MSE content as they see fit.

What is the future with regard to ASGBI's contribution to Overseas Training? Clearly there is scope to include countries we have not visited, in West Africa for instance. In fact we are waiting for the pandemic to pass before running an Anastomosis Workshop in Dakar, Senegal which had been planned for this year.

We could also consider other continents such as India and elsewhere in the Far East. At present the visiting Faculties consist of highly experienced but retired gentleman and it is very important the younger generation of surgeons become involved in this highly rewarding enterprise. The friendships we have made over the years have been long lasting and it has certainly been a privilege to have been involved.



Please contact either myself or Tan Arulampalam, Chair of the International Development Committee, if you are interested in learning more.

Reports for all three courses are available by request at rhslane@btinternet.com.

Support your Association

Collaborations with industry and other surgical organisations allow us to improve our education offering and services to members. Share your relevant contacts with us and contribute to a sustainable future for the ASGBI.

More details [here](#).





Reflections on the past twenty-five years

Sir Barry Jackson President 1994/5

The editor has asked me to contribute a short piece relevant to the Association's 100th year despite the fact that I am long since retired from clinical surgery and from surgical politics. What can an oldie write, apart from a bit of history? Twenty-five years ago, I had the privilege of being the President on the occasion our 75th anniversary and at the annual meeting gave an address titled Towards 2001. In it, I traced some of the Association's history from its inception in 1920 but, more importantly, reflected on the future as it then appeared to me. I quote "All of us in the auditorium today face the years leading to the twenty-first century at a time when surgery is changing at a rate unparalleled in former times. There are changes in the operations that we perform and the methods by which we perform them, that is to say changes in the craft of surgery; there are changes in the provision of surgical services, that is to say political changes introduced by the NHS that affect our practice; there are changes in the public perception of surgery and of those who practice it; there are changes in the training of surgeons that inevitably impinge on its practice and, in the minds of those entering upon a surgical career, there are increasing signs of changing attitudes towards the expected life style of a surgeon. Fixed hours of work and regular time off may yet be with us." I went on to examine each of these areas and how I believed the Association should respond.

I take no credit for being a soothsayer as many colleagues would have said the same as me but, be that as it may, all of these predicted changes and many more came about, some for the better, others perhaps less so. Minimal access surgery soon became fully established (in 1995, this was by no means the case even for cholecystectomy) and then further developed to the current age of robot assisted surgery. High tech applied to the surgeon's craft has enabled continuing advance. Conversely, successive NHS Acts impacted in a way that many believe has been detrimental to the way surgical practice is managed; certainly, nearly all surgeons accept that the average 48 hours per week Working Time Directive has been especially harmful to clinical surgical training. While accepting that it would not impact to the same degree for some other specialties, the Association (and the four surgical Royal Colleges) argued strongly against the enforced introduction of an average 48-hour limit for surgical trainees

but to no avail. Restriction of hours of work has led to loss of continuity of patient care by the introduction of rotas, the loss of the traditional firm structure and a greatly limited clinical experience by the end of the training years. However, other changes in training, such as the learning of operative techniques on mannikins rather than on patients has been hugely beneficial. And as for a changing perception by much of the public towards the profession of surgery, I need only mention 'Bristol babies', the aftermath of which has been revalidation and all that that word implies. Thankfully, the animosity which developed at the turn of the century by many members of the public and much of the media towards surgeons has now dissipated. (Younger readers may be unaware that the broadsheet newspapers were as critical as the tabloids with headlines such as 'Stop the butcher surgeons' (The Times) and The Independent's first leader 'Greater accountability will bring the surgeon 'gods' to earth'). Even so, the occasional rogue surgeon still exists, most recently Paterson.

Did I leave anything out in my predictions? Certainly. Most notably, I failed to predict the pleasing and very important rise in the number of women pursuing a surgical career. How could I have been so blind? Although Women in Surgical Training (WIST now WinS) was established as early as 1991, it was slow to become noticeably effective, but by 2001 it was making a definite impact for the good on the surgical workforce and this has continued apace in the 21st century. Workforce issues generally have become of ever-increasing concern as the country desperately needs more trained surgeons to cope with patient demand, never more so than in 2020 as a consequence of COVID-19.

In the mid-90s, I do not believe anyone could have foreseen the loss of morale and unhappiness of so many employees in so many areas of the NHS during the past few years; nor the outbreak of a pandemic which has done so much to reverse this loss of morale. Never has the NHS been so highly praised as in the past four months. But will surgeons regain the sense of enjoyment and satisfaction in their NHS posts that existed 25 years ago? I do hope so although I fear not, at least in the short term.

What of the Association in the years ahead? Let me quote from the closing paragraph of my presidential address "... history teaches that it is impossible to predict the future with accuracy beyond a very short time span. But of one thing I am sure. The Association will continue its evolution from a gentlemen's surgical club at its founding into the major force in continuing surgical education and surgico-political debate that it is at present. What form that continued evolution will take is for others to decide in the face of changing circumstances". Since those words were spoken, the Association has indeed evolved and flourished and I am sure it will continue to do so as it faces the future. Our strapline Uniting Surgeons and Promoting Excellence in Surgery concisely encapsulates what Moynihan had in mind when he envisaged the need for such a professional organisation. I know he would be immensely proud to see his concept come to such a successful fruition over the past 100 years.

Floreat, the Association of Surgeons of Great Britain and Ireland.

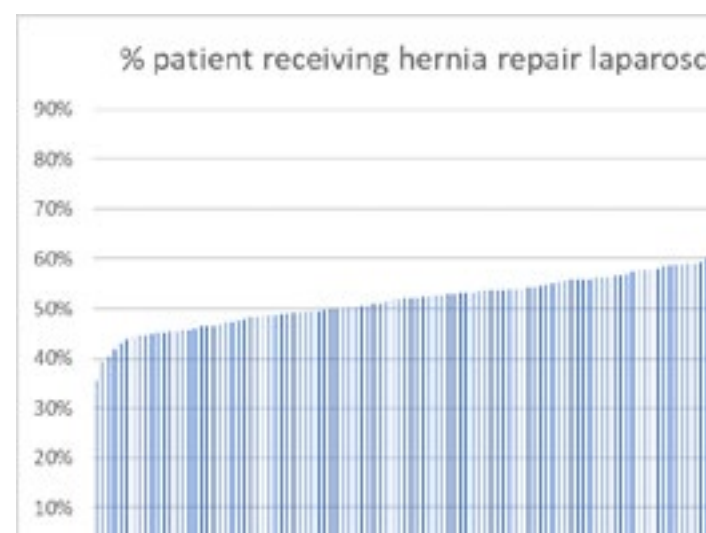




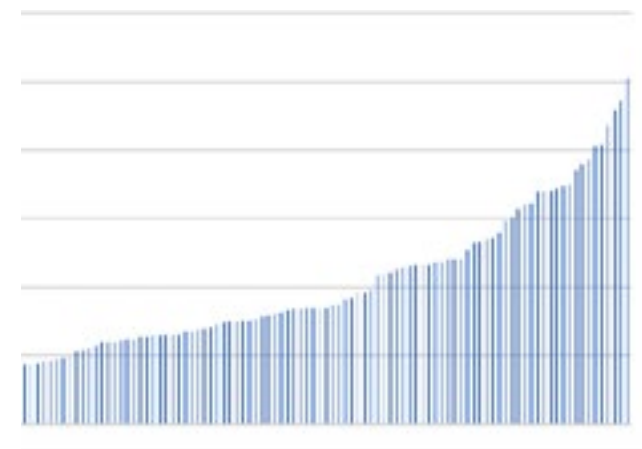
Getting it right first time: Update and next steps

John F Abercrombie, Consultant Surgeon, Nottingham University Hospitals & GIRFT Lead for General Surgery

The “Getting It Right First Time” (GIRFT) project is the brainchild of Professor Tim Briggs, of the Royal National Orthopaedic Hospital, Stanmore. It has grown to be a major initiative in clinically led quality improvement across the surgical specialities and subsequently expanding into medical specialities and diagnostics, as well as general practice. The aim of the project is to improve the quality of care by reducing unwarranted variation. A patient should be able to expect to receive the same standard of diagnosis, advice and treatment regardless of where and to whom they present.



2018-2019



2018-2019

There have been 10 speciality reports to date, diabetes, radiology and paediatric surgery will be published shortly. These have all shown that there is considerable clinical inconsistency between units. Similar variations in

Every GIRFT stream has found that this “null hypothesis” does not hold. In general surgery, for instance, there was remarkable variation in many areas. In one hospital almost all inguinal hernia surgery was carried out using an open mesh technique at the behest of the commissioners and the medical director. At the other extreme there were units carrying out the vast majority of groin hernia surgery laparoscopically. Index admission cholecystectomy for cholecystitis varied from 50% to <5%.

commissioning and procurement have been well documented.

The essence of the GIRFT process is to compile, for each Trust, a data pack populated from HES, registries, audits and questionnaires. This is benchmarked against data from the other providers. This is followed by a “deep dive” visit where a senior clinician from the speciality meets with the hospital team to discuss the data and to generate a programme of clinical quality improvement measures for the local team to take forwards. GIRFT implementation managers provide support to teams to ensure that Trusts invest the time and resource required to deliver the improvements.

A cornerstone of the GIRFT concept has been to try to separate planned and emergency work. This has been embedded into many orthopaedic units but remains something of a challenge for the general surgical community. The leaking anastomosis is the disaster that stalks much of our practice. Fear of this complication makes clinical teams reluctant to move away from the acute care units with their resources rich in intensive care and effective rescue mechanisms. However, hospitals such as the Marsden and the Christie are able to carry out some of the most complex, difficult and dangerous general surgical resections with outstanding clinical outcomes and no loss of patient safety; yet they do not provide acute care.

Oxford has successfully split emergency and elective general surgery. Several other Trusts are actively considering a similar separation; GIRFT has been involved with supporting these units. The potential benefits, predictability of intensive care support and an ability to deliver the principles of ERAS without distraction are obvious.

Many hospitals have reacted very swiftly to the new reality of working in the presence of COVID-19. Trusts are now in the process of trying to establish pathways of practice that will be sustainable as COVID-19 becomes endemic. While emergency services have been sustained this has not been the case for much elective work. In Nottingham GI cancer resections have been able to continue, but only by the establishment of a “green” site at a local private provider. A large number of GI resections have now been carried out in that unit, far away from the conventional rescue mechanisms that we are accustomed to having behind us. There has been no evidence of a drop in the quality of outcomes.

To that end the London ICSs have grouped together and asked GIRFT to get involved with a

transformation programme for elective services across the City. This programme intends to support the STPs/ICSs to implement best practice in clinical outcomes and productivity across all high volume, low complexity elective surgery.

This will be delivered by high volume activity restarting using GIRFT principles to achieve performance equivalent to the current top decile alongside the development of high volume centres in a phased approach. Transition to a ‘one workforce, one estate’ mindset will allow implementation of continuous improvement methodology within STP/ICS’s to remove all unwarranted variation in clinical outcomes. There are clear opportunities to challenge the continuation of complex care being delivered in small numbers. The success of reconfiguring services for upper GI cancer and trauma exemplify the potential advantages of this approach. Rectal cancer and inflammatory bowel disease surgery are surely suitable for centralisation to high volume units. Local leads will be able to hold Trusts to account, to ensure that they comply with guidelines from organisations such as ASGBI. The failure of teams to deliver antibiotics within an hour of the documentation of sepsis is a glaring example of how guidelines alone are not enough to ensure the change that is needed.

GIRFT has also been at the forefront of developing a tool to deliver consultant specific data to individuals in support of their appraisal. The NCIP programme, led by Sir Normal Williams, is using HES and theatre data to generate reports for individuals in real time. At present we can access high quality data regarding endoscopic performance but almost nothing that reflects our surgical practice. Mortality data have now been accepted but it does not have the depth of information that is required to help surgeons achieve their best possible level of performance. NCIP has been trialled in seven hospitals and is now rolling out to the next tranche of units.

COVID-19 has been an unprecedented challenge to our hospitals and services. It has forced reconfiguration to allow cancer surgery to occur on elective only sites. This has shown that this can be achieved with safety and should be a driver to think more radically about how and where we off the best possible care to our patients.





Young BJS

Des Winter, BJS Editor-in-Chief, Clinical Professor of Surgery, St Vincent's University Hospital, Dublin.

Julio Mayol, Professor of Surgery and Chief Medical Officer, Hospital Clinico San Carlos, Universidad Complutense de Madrid & Secretary of the BJS Society

On behalf of BJS and BJSOpen editorial teams and the BJS Society

How does surgery engage the digital community?

The current social and economic crisis triggered by the SARS-CoV-2 pandemic has profoundly affected healthcare in general. In particular, the demand for medical care and the inevitable delays in elective care have restricted surgery more than many fields. The pandemic has accelerated technological advances, exposing unmet societal needs for rapid development, so clear vision is crucial to navigate change. In tandem with these events, the more global mentorship sought by modern surgical trainees has delayed the limits of the arcane apprenticeship model and ended their historical impuissance. Teamwork provides the energy for momentum, visible in collaborative research by early career investigators, where worldwide co-operation is more needed than ever. Unrestricted digital connection generates idea coalescence for confluent goals to build trust and holocratic regulation.

What is Young BJS?

BJS captured the zeitgeist of the emerging surgical ecosystem by launching the Young BJS initiative in May 2020 with more than 1000 members already (Figure 1). This is a worldwide network of early career surgeons interested in digital learning and surgical publishing in every inhabited continent. The vision of Young BJS is to be a global knowledge-based community for students, trainees, and those who have completed training early in their careers to define unmet learning needs, refine surgical publishing ideals, and align them with the BJS mission to promote excellence in clinical and translational research.

What does it do?

Young BJS will be self-directed by surgical trainees with oversight from the BJS editor-in-chief in addition to active support from the BJS and BJS Open editorial teams, the BJS Society,

and the combined editorial boards. Members will work collaboratively to propose specific actions to address their defined needs and innovations. Leadership in surgery will be cultivated by providing opportunities in reviewing/writing/editing papers and assisting the generation of an educational forum.

Who should join?

Young BJS is free to join and open to all surgical specialties in every nation. Language, politics, and other barriers to integration will be overcome within the rational limits of our collective efforts. The principles for Young BJS to achieve initial success include a large number of participants displaying cultural, career stage, and specialty diversity with an ability to share information widely.

What can be achieved?

One of the first initiatives to be implemented is the Young BJS Reviewer Mentoring Programme, that will be launched in collaboration with the BJS/BJSOpen editorial teams and the BJS Society. Members will complete formal certified training to review scientific manuscripts. After satisfactory completion, high scoring and certified members will be included in the BJS database of reviewers. Education is another cornerstone of the Young BJS initiative. Trainees will be encouraged to complete courses and workshops to develop their publishing skills. Given the global reach of the project, learning will be facilitated through digital technology for maximal engagement.

Global initiatives like the Young BJS need social interactions and efficient knowledge transfer tools to be both successful and sustainable. That is why anyone can connect and engage with the Twitter account (@Young_BJS) and the cuttingedgeblog.com administered by the BJS/BJSOpen editorial teams. Newer platforms for social interactions online will be explored in order to understand how surgical trainees will

BJS

tackle rapid social changes and technological challenges. Balancing global disparities in access to published work is a medium-term goal.

How do you join?

Are you an enthusiastic individual or group willing to transform surgery for the better? Please email your details including name, career stage and specialty interest (if applicable), country and institution (if applicable) to admin@youngbjs.org so that we can welcome you to the new age of surgical publishing and education.



Figure 1: the Young BJS network



Young BJS



The Young BJS represents a community of early-career researchers with enthusiasm for surgical academia. The ethos is aligned with that of the BJS with a mission to promote excellence in clinical and scientific research. Specific goals of the group will be to network, educate, and innovate in surgical publishing on a global scale.

Structure

The Young BJS is led by surgical trainees under the guidance and governance of the BJS and BJS Open Editorial Teams and the BJS Society. Membership is free of charge and open to everyone from junior consultants to medical students.

So how can you get involved?

Enthusiasm is all that is required. Those interested in becoming part of Young BJS, please email your details including name, institution, career stage and specialty interest (if applicable) to admin@youngbjs.org. We will inform you of upcoming projects, educational opportunities, and collaborative efforts.

We look forward to welcoming you.
The Young BJS Coordinating Team
On behalf of the BJS and BJS Open Editorial Teams

BJS

 @young_bjs @BJSurgery @BJSOpen

www.bjs.co.uk

WILEY

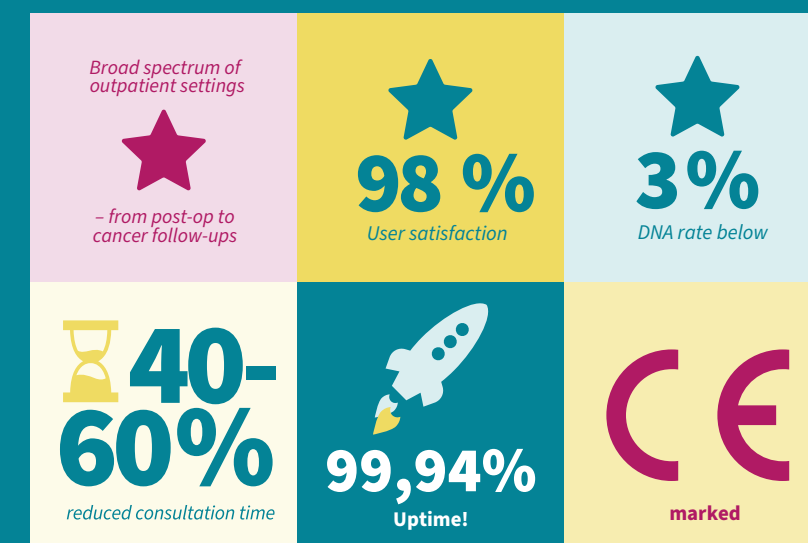
Your virtual clinic – for today and tomorrow

The pandemic unveiled the necessity of online consultations. Healthcare is still facing the challenge of covid-19, now added to a looming backlog of outpatient appointments. When less shall handle more, new ways of working are required. Build a digital ecosystem and create a new working habit for healthcare, today.

Communicate with your patients from your own branded virtual clinic. Transform outpatient appointments to online consultations and reduce administration. Scale up at your pace and provide care to more patients, beyond institutional barriers. Improve staff workload by reducing consultation time. Improve your patients' lives by providing security, continuity of care, and accessibility.

Visiba Care is by the healthcare professional's side to transform online consultations into a secure, seamless digital offer for patients. We provide a solution with customisable pathways and features, such as video consultations with up to 5 participants, messaging, forms, and integrations with EMR systems.

Let's tailor your 'how' together.



 **VISIBA CARE**
Your patients, your virtual clinic



tina.marshall@visibacare.com
01865 502503
www.visibacare.com



APPLY NOW

The ASGBI and Pancreatic Cancer UK are delighted to offer a fellowship to support a Trainee or Junior Consultant with an interest in advancing the clinical management of pancreatic cancer. This individual will visit centres of excellence abroad and bring this experience back to the NHS to advance UK clinical expertise. The successful candidate will be offered a grant of up to £3,000 to assist with travel costs, accommodation, and to provide a reasonable living allowance for the period of Fellowship.



ASGBI fellowship programmes encourage apprenticeship style training. We recognise the value in mentorship and teaching surgery as a craft to develop skills and promote career development.

Application Timeline

The deadline for application has been extended due to COVID-19. Please visit the web site for the most up to date information.

Eligibility

To apply, applicants must be:

To apply, applicants must be:

- A current member of the ASGBI in good standing.
- Trainees or Consultant Surgeons (within first 5 years of their appointment) engaged in general surgery or one of its sub-specialties.
- Resident of the United Kingdom and Ireland.



APPLY NOW

The aim of the ASGBI and Intuitive Surgical Robotic Fellowship, is to support Trainees and early career Consultants with an interest in robotic-assisted techniques to visit centres of excellence overseas, bringing back this new expertise to their teams in the UK. Successful candidates will be offered a grant of up to £5,000 to assist with travel costs, accommodation, and to provide a reasonable living allowance for the period of Fellowship.



The ASGBI travelling fellowships promote the exchange of surgical knowledge and encourage the apprenticeship style training. We recognise the value of mentorship and collaboration in the surgical community with the ultimate aim of improving surgical care of patients.

Application Timeline

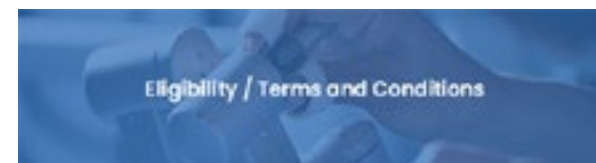
The deadline for application has been extended due to COVID-19. Please visit the web site for the most up to date information.

Eligibility

To apply, applicants must be:

To apply, applicants must be:

- A current member of the ASGBI in good standing.
- Trainees or Consultant Surgeons (within first 2 years of their appointment) engaged in general surgery or one of its sub-specialties.
- Resident of the United Kingdom and Ireland.





Introducing our Guest Editor Professor Susan Moug

Professor Susan Moug is a Consultant Colorectal Surgeon at the Royal Alexandra Hospital in Paisley Scotland and Honorary Professor at the University of Glasgow. Susan has an interest in surgical innovation, frailty in surgical patients and prehabilitation.

Introduction

Professor Susan Moug

I am writing this introduction to the Summer Edition of JASGBI on the 24th anniversary of the Spice Girls' classic Wannabe. This ground-breaking piece of music by 5 talented females who became global superstars seems to reflect our 5 contributors.

Each topic focuses on important areas that are not often discussed. Jen Law starts by telling us what patients really want from their emergency laparotomy and how that differs from what us surgeons think. Carla Hope highlights that trainees' needs have significantly

changed meaning that working patterns have to become increasingly flexible. Ruth Parks explains what has happening in older women's care of their breast cancer to achieve a balance of biology and quality of life. Hannah Boyd-Carson returns to the emergency setting to report that trainees can be trained successfully in an emergency setting and finally, Hannah Javanmard-Emamghissi argues for removal of the diagnostic laparoscopy.

I thank each of these Spice Girls for their efforts and hope you enjoy!



Contributors

Jen Law

Jen is a specialty trainee in general surgery and colorectal in the North West. She has recently returned from OOPR at The University of Liverpool and is currently writing her MD. She has been and continues to be an active researcher, including being on the Steering committee for the ELF study (which so far has achieved 5 publications). She was awarded the BJS presentation prize at the ACPGBI meeting in 2019. She has also recently been appointed as part of the team of colorectal subspecialty researchers for the RCSEng.



Carla Hope

Carla Hope is a General Surgery registrar in the East Midlands and is the current Intercollegiate Surgical Curriculum Programme (ISCP) research fellow. She obtained her primary medical degree from the University of Nottingham and has stayed in the region since Foundation Training. Carla is currently working towards a PhD, with upcoming research focused on differential attainment in surgical specialities using longitudinal data.



Ruth Parks

Ruth is a General Surgery trainee from the East Midlands Deanery with aspirations to pursue a career as a Clinical Academic Breast Surgeon. Ruth is currently doing a PhD under the supervision of Professor KL Cheung and Dr Andy Green at the Nottingham Breast Cancer Research Centre. Ruth's research involves exploring the unique biological features of primary breast cancer in older women, as outlined in this article. She obtained a Research Fellowship from Nottingham Hospitals Charity for the duration of her PhD. Elements of the research are also supported by the Breast Cancer Research Trust. Ruth is the current East Midlands representative for the Mammary Fold Committee and is on the organising committee for the 6th Symposium on Primary Breast Cancer in Older Women (www.nottingham.ac.uk/medicine/breastmeetings).





Contributors

Hannah Boyd-Carson

Hannah is a General Surgical Registrar from the East Midlands North Deanery with an interest in colorectal surgery.

She has just returned to training after completing her PhD at the University of Nottingham looking at Emergency Laparotomy care and training in the UK. She was the National Emergency Laparotomy Audit Surgical Research fellow from 2017 to 2020 and worked with the Project Team at the Royal College of Anaesthetists.

Hannah Javanmard-Emamghissi

Hannah is a General Surgery Specialist Trainee in the East Midlands. She is currently the National Laparotomy Audit Surgical Research Fellow and a PhD student at the University of Nottingham. Her interest is in collaborative research, frailty and surgery in older people. She is the Surgical Trainee Representative for Age Anaesthesia, part of the Emergency Laparotomy and Frailty Study group and leads the COVID:HAREM Study group.



What patients want from emergency laps

Jen Law, Specialty Trainee in General Surgery and Colorectal

In the UK over half of emergency laparotomies (Elap) are performed for patients over 65 years old^{1,2}. Older adults are more likely to have poor outcomes after emergency surgery; including an increased length of stay, requirement for increased care and mortality (over 30% mortality within a year of surgery)^{1,3}. Current studies reporting outcomes after emergency surgery are based on clinician-led outcomes such as mortality, readmission and length of stay; however little information is available as to what outcomes are important to older patients.

We invited patients over 65 years who had previously been admitted to a single centre as an emergency with a pathology which could be treated with an Elap, to attend a patient and public involvement (PPI) exercise⁴. Overall eight patients (7 undergone Elap and 1 clonic stent) participated along with four family members and 8 peri-operative specialists (POS - four surgeons, one anaesthetist/critical care, one geriatrician, two nurse specialists). The modified-

Delphi exercise was divided into four main parts; 1. The POS group listed factors they felt were important in perioperative decision-making, 2. The PPI group listed their important factors, comparing with the POS group, 3. Two separate PPI groups listed their top 10 most important factors in decision making, 4. The whole PPI group reached consensus about their top 10 lists (consensus was deemed to be reached if >70% of the group agreed).

Delphi rounds 1 & 2

Surprisingly, we found that the PPI group only agreed with 50% of the factors listed by the POS group for decision-making in Elap (see below). The PPI group did not agree that risks of mortality, return to theatre, other available clinical options (e.g. interventional radiology), symptom control (e.g. pain management) and input from other specialties would affect their decision-making.

PPI Group 1 Factors	PPI Group 2 Factors	Final agreed PPI Group Factors
Capacity advocates	Capacity advocates	
Independence (own home)	Return to home	Independence (return to home)
Realistic expectations	Duration of recovery	Realistic expectations (recovery)
Post-operative complications	Post-operative complications	Post-operative complications
Readmission to hospital	Readmission to hospital	Readmission to hospital
When can I...(drive, work, etc)	What to expect postoperatively	What to expect postoperatively
Requirement for stoma	Requirement for stoma	Requirement for stoma
Communication - regular updates	Communication - regular updates	Communication - regular updates
Delirium & long-term cognition		Delirium & long-term cognition
Nutrition		Nutrition
	Follow-up	Follow-up
	Relative visiting hours	





Delphi rounds 3 & 4

Initially the two PPI groups had 8 out of their top 10 factors which were the same. The groups decided that the presence of personal advocates (e.g. a friend or family member) was crucial as a standard of care but would not affect their decision-making. This was therefore removed from the final list. The group discussed the further 3 factors (delirium, nutrition and follow-up) and these were added to the final list of factors. There was unanimous agreement about the top 10 final list of factors.

Other thoughts

Alongside several of the already established NELA themes we found others that were not recorded previously. Perceptions of risk were different between the PPI and the POS groups with many patients feeling that a 1 in 5 chance of survival was acceptable compared with the POS group who thought this extremely high risk. The PPI group all agreed that when being admitted to hospital as an older adult they are already significantly aware of their mortality and being reminded by the consent process served little purpose. Interestingly both the POS and the family members felt that being informed of the mortality risk was important regardless of whether it affected a change in decision. The factors usually assessed in studies for Elap, such as length of stay and readmission rates, were discussed but were deemed exceptionally unimportant to the PPI group for decision-making. This highlights strongly that current research outcomes used within both NELA and wider emergency surgery research may not align with those most important to older patients, rather being more clinician led.

Multiple previous studies have reported that patients often feel overwhelmed by the consent process and that patients would sign a consent form regardless of the information it contained⁵⁻⁸. We found that the PPI group would agree to what the clinician proposed and that very little of the consent process was recalled. The group discussed feeling unable to make a decision prior to Elap due to being in pain, unwell and anxious and that the presence of a friend or family member was helpful as reassurance, and to help them recall the discussions with healthcare professionals postoperatively.

The majority of negative comments about patient care generally came postoperatively. The PPI group often felt that there was less of an impetus for clinicians to discuss their procedure postoperatively, and that the focus was all on

preoperative counselling, which they did not fully recall well. This left patients feeling that they were not particularly well informed about what had happened to them and what they could expect for recovery. The PPI group also suggested, perhaps not surprisingly, that this feeling of being ill-informed was increased after discharge from ICU/HDU and particularly on weekends in hospital when another practitioner was in charge of their care. This often left patients feeling that they were 'a tick-list'.

The PPI group were very much divided with regards to stoma formation, with half feeling that requirement for a stoma would lead them to seek alternative management options. The feeling did not continue if the alternative was likely to lead to a reduced quality of life and reduced recovery rate. Previous work suggests that people often show stoma avoidance behaviours on the background of feelings of embarrassment and disgust⁹. This creates another dilemma for clinicians whereby often unwell, frail patients would be more likely to have a good clinical outcome from shorter procedures which may involve stoma formation. Whilst early stoma reversal has been shown to be safe¹⁰, it clearly involves a further surgical procedure and all of the concurrent risks of a further procedure within a population that may be high risk initially. The question is raised here as to whether stoma avoidance for the first procedure is more likely to lead to an outcome with which the patient is more satisfied.

Quality of life was deemed to be exceptionally important to the entire PPI group, more so than any other factor. This included both the ability to be independent and to return to their own home. All of the group agreeing that they would accept an increase in care as long as it facilitated discharge to their own home. The group also felt that quality of life was highly reflective of level of physical function.

Final thoughts

Whilst this study had small numbers of patients and their relatives involved, it has produced some interesting insights into patients' perspectives when undergoing Elap decision-making. In particular, clinicians are not completely aware of what patients most want to know and current research into emergency surgery appears to heavily rely on clinician-led rather than patient-led outcomes. We feel that Elap research should use the specific patient-selected outcomes to ensure that clinicians can provide information about factors that are most

important to their patients. Alongside this we were surprised that quality of life appeared to lead discussions for older adults above the risk of mortality and again this demonstrates the gaps in current research which are most likely to affect patient decision-making.

Differential attainment and the changing surgical workforce

Carla Hope, General Surgery Registrar and Intercollegiate Surgical Curriculum Programme (ISCP) Research Fellow

Differential attainment describes the differences in performance between groups with and without protected characteristics¹. Protected characteristics are; age, sex, disability, gender reassignment, marriage, pregnancy, race, religion and sexual orientation. Despite the General Medical Council prioritising work to identify areas of inequality to ensure all doctors are treated fairly regardless of protected characteristics², this has not been studied in General Surgical Training.

Surgical trainees in the UK today are more diverse and this is partly due to efforts to attract medical students from a range of backgrounds³. These efforts are starting to reflect in the upcoming surgeons of the future. Surgery has historically been dominated by males. Worldwide, the majority of surgical consultants remain male, making up 88% of consultants in the UK and Australia^{4,5}, and 80% in the United States (US)⁶. Social media has highlighted this underrepresentation of women in surgery with various campaigns. The "New Yorker Cover Challenge"⁷ and the #ILookLikeASurgeon⁸ campaign have brought a refreshed awareness to the issue. Encouragingly, women now make up over a third of surgical trainees in the UK and the US^{9,10}.

Women make up the majority of less than full time (LTFT) trainees¹¹, therefore with increasing numbers of women entering surgical training it is probable that the number of LTFT trainees will increase. Currently, surgery has the lowest proportion of doctors working LTFT than any other specialty¹². A cross sectional survey found that over half of LTFT trainees in surgery have experienced undermining behaviour¹¹, and 30% felt LTFT was viewed negatively¹³. The impact of LTFT on progression and achievement of requisite competencies has not been studied on a national scale in the UK.

The number of students aged 30 years and above choosing to study medicine has increased since 2014¹⁴, and the proportion of Graduate Entry Medical graduates entering Core Surgical

Training has steadily risen since 2017¹⁵. Along with the increase in training length due to the greater number of surgical trainees taking time out of training¹⁰, this may result in an older cohort of surgical trainees than in previous decades.

In order to retain and attract surgical trainees from all demographic groups and backgrounds there is a need to ensure progression is fair for all, bias is eradicated and flexible working patterns are accommodated.

Females have a different experience in training than male trainees across the world. A meta-analysis found that there was a higher prevalence of harassment and gender discrimination amongst female trainees than male trainees across all specialities worldwide¹⁶. Within medical specialities in the UK, male trainees are more likely to receive a non-standard Annual Review of Competency Progression (ARCP) outcome than women^{17, 18}. Men were also found to be more likely to require additional training time or be released from the programme than women¹⁹. In the US, general surgery trainees have a high rate of attrition. With some studies reporting that female trainees have a higher rate of attrition compared to men^{20,21}. In part this may be due to the high rates of gender based discrimination reported during surgical training in the US⁹.

Studies looking at the impact of family life on surgical training are largely based on US populations. Parental status was not associated with increased attrition in general surgery programmes in the US²²⁻²⁴. According to a survey of female surgeons in the UK, a perceived barrier to a surgical career is that the profession is not amenable to motherhood and family life¹³. The impact of childrearing on progression through surgical training in the UK has not been studied. With the increasing proportion of women surgeons and trends towards increasing acceptance of childrearing during surgical training, research into how parental status may affect progression and how these groups can be supported is vital²⁵.





With surgical training taking longer and more trainees opting for time out of programme for research or experience, the proportion of older trainees may increase. Previous studies have found that older trainees have worse training outcomes than their younger counterparts in both the UK and US^{5, 26}. A large UK study of over 38,000 doctors found older doctors were at higher risk of receiving non-standard ARCP outcomes and were more likely to be released from the programme²⁶. An international meta-analysis reported older doctors had higher rates of burnout compared to younger doctors²⁷.

Personalising care for primary breast cancer in older women – an overview of work from Nottingham

Ruth Parks, General Surgery trainee

What is the current situation?

The incidence of breast cancer increases with age¹. Due to population ageing, by 2040 around 40% of new breast cancer cases diagnosed per year, will be in patients aged ≥ 70 years². This will have a huge impact both financially and in terms of service provision, on an international scale.

Despite this, most research in the field remains targeted at younger patients. Age-specific guidelines are not widely referred to and guidelines which allude to the older woman as an individual are based solely on conventional factors.

Current guidelines in the UK³, Europe⁴ and worldwide^{5,6}, advise surgery as the first-line treatment of primary operable breast cancer, irrespective of age. Historically, primary endocrine therapy (PET) has been used in older women unfit for surgery, or where the patient declines surgery. The International Society of Geriatric Oncology and European Society of Breast Cancer Specialists now advise that PET should only be offered for patients with ER-positive tumours with a life expectancy of 2-3 years, despite optimisation of medical conditions⁷.

What exactly is the problem?

Despite the above recommendation, over 40% of older women with primary breast cancer receive PET^{8, 9}. While age alone should not be a

deterring to surgery, there is no clear consensus on how to select older patients for breast cancer treatment¹⁰ and their specific needs are not addressed^{11, 12}. Furthermore, curative treatment alone may not be the treatment goal in mind for older women; quality of life and preservation of function may be equally as important¹³.

Existing research related to differential attainment in surgery is based on small non-representative samples or relies on survey data. It is clear that surgical trainees today are more diverse and require a greater flexibility of working pattern and we need to update our knowledge to best serve the consultant surgeons of the future. Further longitudinal studies of surgical trainees utilising logbook and ARCP data are needed to provide an accurate picture of factors affecting progression and ensure any discrimination is addressed.

Therefore, we must seek to provide effective personalised care to the individual older woman with primary breast cancer. Treatment decision making in this cohort is complex. We are beginning to understand how the unique biology of breast cancer in older women, in combination with assessment of frailty and other issues that can be measured by geriatric assessment (GA) are both important.

Traditionally, we have understood breast cancer to have four main subtypes (Figure 1), however, it is now understood that breast cancer is a heterogeneous complex of diseases, with a spectrum of many subtypes with distinct biological features¹⁴. Therefore, treatment plans based on routinely measured biomarkers and our current understanding of disease subtypes may no longer be adequate.

Why is biology important?

Traditionally, we have understood breast cancer to have four main subtypes (Figure 1), however, it is now understood that breast cancer is a heterogeneous complex of diseases, with a spectrum of many subtypes with distinct biological features¹⁴. Therefore, treatment plans based on routinely measured biomarkers and our current understanding of disease subtypes may no longer be adequate.

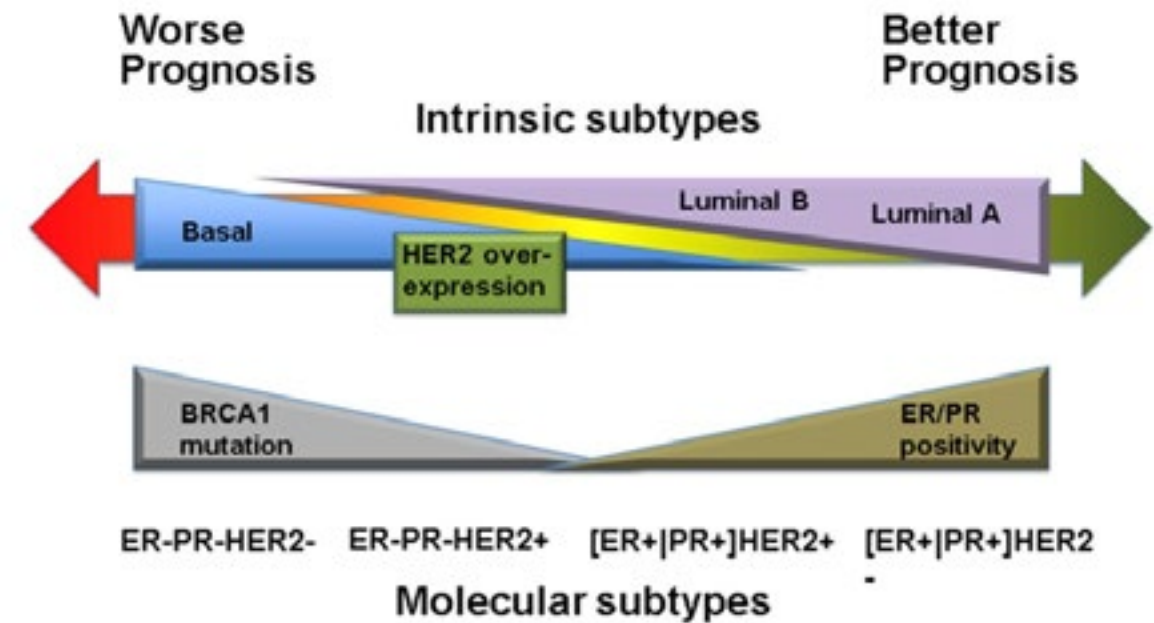


Figure 1: Patient outcome based on breast tumor intrinsic subtypes¹⁵

Older women with breast cancer have distinct biological features compared to their younger counterparts. This means that they are likely to have less aggressive cancers and more likely to demonstrate favourable features, such as oestrogen receptor-positivity¹⁶. Even within the group who have ER-positive tumours, outcome differs depending on the degree of positivity¹⁷.

Surgical samples and clinical data from a series of 575 older women (>70 years) in Nottingham,

with early primary breast cancer were analysed and compared to a younger cohort¹⁸. Partitional clustering technique of a panel of 24 biomarkers based on tissue microarrays (TMAs) identified 6 biological clusters in older patients – 5 of which were common in young patients and 1 novel cluster, identified as low ER-luminal, which was distinctive to the older population and had different breast cancer-specific survival (Figure 2).

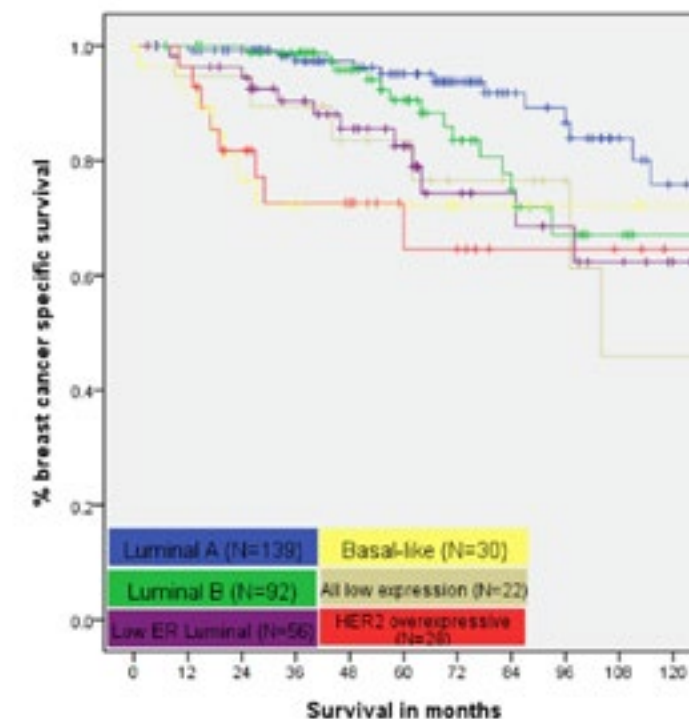


Figure 1: Breast cancer-specific survival of older women with early operable primary breast cancer according to biological clusters¹⁸





Similar findings suggesting a differing biology with differing clinical outcomes according to age have been found in terms of histological type¹⁹ and in human epidermal growth factor receptor 2-positive²⁰ and triple-negative breast cancers²¹, providing evidence that consideration of the role of biology of breast cancer should be made during treatment decision making.

A technique to construct TMAs from core needle biopsy specimens²² has been developed in Nottingham. This has the advantage of obtaining biological information from older women, regardless of primary treatment; most biological studies use surgical excision specimens only. Work is underway to construct and analyse TMAs from core needle biopsy (CNB) specimens from a historical series of >1700 older women diagnosed with breast cancer. This will fill a crucial gap in our understanding of the biology of breast cancer in older women.

Why is Geriatric Assessment (GA) important?

Some areas of medicine, for example, orthopaedic surgery and stroke medicine, routinely utilise GA to help identify patients who may benefit from more detailed interventions. The concept of GA in oncology is recommended²³, however, more work is needed to clarify the exact nuances of how this should be conducted and results evaluated in this setting.

Breast cancer carries a much lower morbidity compared to other visceral surgeries, however, there are still issues specific to the older population which must be considered and addressed including delivery of anaesthesia, social support, mood disturbances or concerns with caring for a spouse.

Geriatric assessment generally consists of a few major components including: medical assessment of current diagnoses, medications and nutritional status; assessment of physical function, psychological evaluation of mentality and mood; social and environmental assessments²⁴. Full GA itself can be very time-consuming and may not be useful in all cases. Some studies have opted for the use of a frailty screening assessment to decide who should receive full GA, but which tool best serves this purpose remains debatable^{25, 26}.

A pilot study performed in Nottingham assessed GA in 47 older women with primary breast cancer²⁷. Decision of treatment followed consultation with the clinical team and was not guided by GA. A validated cancer-specific tool was used and GA conducted within 6 weeks of diagnosis²⁸. Older age, greater comorbidity, higher number of daily medications and slower Timed Up and Go test (a measure of physical function) were significantly related to non-surgical treatment. The study has expanded to include 2 countries with the aim to definitively identify the components which should be included in GA in this setting.

What does the future hold?

In the future, we expect the development of a tool to analyse an extensive panel of biomarkers for an individual patient based on their CNB specimen. This would help to generate a predicted outcome for each potential treatment option for that individual patient. There are currently a number of gene assay tools on the market that provide prognostic and predictive information, however, their use is applicable in the adjuvant setting, rather than at diagnosis, when a personalised decision to operate or use an alternative treatment that is potentially as effective, is needed¹⁰.

In time, development of a breast cancer-specific GA that can be implemented in the clinic setting for older women with potentially operable breast cancer, is anticipated. There should be clear guidelines on how to use the information derived from this.

The goal of achieving personalised care in older women with primary breast cancer will involve a combination of biological features and GA considerations, alongside conventional measures, discussion with the multidisciplinary team and most importantly, patient preferences.

The role of the trainee in emergency laparotomy cases

Hannah Boyd-Carson General Surgical Registrar

Trainees in general surgery are required to be competent, to a level defined by the syllabus, in a group of procedures performed at Emergency Laparotomy. They must have performed (either supervised or independently) 100 Emergency Laparotomies by the end of training, to include Hartmann's procedure and segmental colectomy¹.

During the recent months, both elective and emergency general surgical cases have reduced dramatically, leading to a decline in learning opportunities for trainee surgeons. To date, we do not have an understanding of the effect on trainees' log book numbers and training progression².

In an attempt to negate the impact of this caseload reduction on training it is important for trainers in all specialities to prioritising training opportunities. In particular, Emergency Laparotomy patients are a high risk heterogenous group, and consultants may be reluctant to let trainees take the lead in these cases due to the need for an accelerated anaesthetic and operation.

Previously there was little literature concerning trainee involvement with Emergency Laparotomy patients. International work provided differing conclusions^{3,4} with a large American study suggesting trainee involvement in emergency operating was associated with adverse outcomes. The authors faced criticism due to methodological concerns^{5,6}. To date there was limited work focusing on purely Emergency Laparotomy operating and trainee participation.

The National Emergency Laparotomy Audit (NELA) has been running from 2013, and collects high level, contemporaneous patient level data about those who have had Emergency Laparotomies in England and Wales^{7,8}. The data set also includes the grade of both the most senior surgeon and anaesthetist who were present during the operation. This data was used to investigate the impact of trainee involvement on mortality and morbidity following Emergency Laparotomy in England and Wales.

To achieve this, a multivariable regression analysis using adult patients who had Emergency Laparotomy and were entered into the NELA database between December 2013 and November 2017 was performed. This analysis did not include patients whose operation had a "Speciality or associate

speciality (SAS) grade, research/clinical fellow, senior house officer, other or unknown" listed as the most senior surgeon. This was to ensure only consultants were compared to junior surgeons who were currently completing a recognised higher general surgical training programme with a defined curriculum.

The main outcomes of the study were 90-day post-operative mortality and return to theatre post operatively. Data was also available for risk adjustment and included pre-operative physiology, biochemical markers, grade of senior anaesthetist, intra-abdominal contamination and whether the patient was admitted to high dependency or critical care unit bed post operatively. Operative subgroups were also analysed; defined using the procedures that are required for certification in general surgery (segmental colectomy and Hartmann's procedure.) The analysis compared trainee only operations with operations where a consultant was listed as the most senior surgeon present in theatre.

The study cohort available for analysis was 87,367 (91.46%) patients for mortality analysis and 86,710 (90.48%) patients for return to theatre outcome analysis. This study suggested there were no increased odds of death if a trainee was the most senior surgeon in any of the operative subgroups required for certification. This finding remained true following risk adjustment (Segmental Colectomy Odds Ratio (OR) (95% Confidence Interval (CI)) 0.98 (0.78-1.23), Hartmann's Procedure OR 1.20 (0.91-1.55).

Furthermore, no increased risk of return to theatre was seen; no significant difference was observed on risk adjusted analysis in rates of return to theatre between trainee and consultant groups (Segmental Colectomy OR (1.06 (0.85-1.35), Hartmann's Procedure OR 1.00 (0.73-1.34).

While it is clear that the trainee will have performed the case independently in the trainee group it is not clear on the level of trainee involvement in the consultant led cases. It may be that a consultant supervised a trainee performing some or all aspects of the Emergency Laparotomy case, or was present in theatre but un-scrubbed. This may have led to an underestimation of "trainee led cases" in this analysis. However, if a consultant were present, one would hope that supervision would include stepping in and taking over from a Junior





colleague in the event of difficulty or the procedure taking so long as to be to the detriment of the patient. It may be that unsupervised trainees are senior and so independent operating judged to be safe by the consultant responsible for the patient's care on a case by case basis. Independence in the later stages of training is important as it is only then that competence at the level of a day 1 consultant can be demonstrated.

This analysis is encouraging for all general surgical trainees. It suggests that trainees acting as lead surgeon in Emergency Laparotomy cases do not appear to have an adverse impact on post-operative outcomes. From these findings it is suggested that an Emergency Laparotomy can provide multiple opportunities for trainees while under guidance of the supervising

The death of the diagnostic laparoscopy in acute appendicitis?

Hannah Javanmard-Emamghissi, General Surgery Specialist Trainee and National Laparotomy Audit Surgical Research Fellow

Acute Appendicitis is the most common emergency general surgical condition worldwide¹. Appendicitis commonly affects the young, and is more prevalent in males with a lifetime risk of 8.6% in males and 6.7% in females². In the United Kingdom (UK), gold standard treatment is early laparoscopic appendectomy within 48 hours of presentation³. Every year more than 30,00 appendectomies are carried out in England alone⁴.

Appendicitis can be challenging to diagnose; its presentations vary wildly from mild symptoms like pain, to diffuse peritonitis and abdominal sepsis. The classic presentation of migratory right iliac fossa pain associated with anorexia and vomiting is only present in half of patients⁵. Despite this, appendicitis is often a clinical diagnosis; in the UK 40% of patients have no imaging to confirm the diagnosis of appendicitis prior to operation, where worldwide this figure is 28.8%^{6,7}. There is also significant variation between sexes, with 27% of females undergoing no preoperative imaging in comparison to 64% of males, and females under the age of 45 more likely to get ultrasound imaging rather than computed tomography (CT) compared to males of the same age group⁶.

There are dangers in diagnostic confusion and delayed treatment; the rate of appendix rupture increases significantly after 36 hours of onset of symptoms and perforated appendicitis is associated with higher morbidity and mortality^{1,8}. This has led to some surgeons favouring early

consultant. However, these data suggest that the presence of a consultant is not necessary for all cases although how patients are selected for independent trainee operating is not clear from the data set available and requires further analysis.

While NELA promotes consultant led care at all points of the patient's Emergency Laparotomy journey, and in particular for high risk patients^{7,9-11}, it is hoped that this analysis will support proactive training in Emergency Laparotomies. This message is of even more importance in the current training climate.

The full paper from this study can be found at: <https://bjssjournals.onlinelibrary.wiley.com/doi/abs/10.1002/bjs.11611>

diagnostic laparoscopy rather than a period of clinical observation in patients where the diagnosis of appendicitis is equivocal.

A common surgical dogma in both Europe and North America is that during a diagnostic laparoscopy if the appendix looks normal but there is no other obvious cause for right iliac fossa pain, then the appendix should be removed^{9,10}. Proponents of this practice argue that a macroscopically normal appendix may still have endoluminal inflammation, that it reduces diagnostic confusion and avoids re-operation if the patient represents with similar symptoms¹¹. Apparently "normal" appendixes have been shown to have a variety of microscopic features such as fibro-obliterative changes, luminal inflammation and lymphoid hyperplasia in between 10 and 29% of cases^{12,13}. However, the significance of these findings is uncertain. In a study that followed up patients for a median of 4 years who were left with a macroscopically "normal" appendix in situ 82% did not require appendectomy, and of the ones that were subsequently removed only 2% had histological features of appendicitis¹⁴.

As a result of this surgical dogma the UK has one of the highest negative appendectomy rates (NAR) in the world: 20.6% of appendixes removed are histologically normal in all patients aged 16-45, and 28.2% in females of the same age group⁶. In countries with comparable healthcare systems to ours, such as Australia, this rate is 19% and

across the Republic of Ireland, Italy, Spain and Portugal it is 10.2% in females and 2.6% in males^{6,15}. The NAR is consistently significantly higher in females than males across all countries^{6,7,15-17}.

Appendectomy whether open or laparoscopic is not without complications. The 30-day complication rate following appendectomy has been reported as 3.3-15.2%, with major complications (Clavien-Dindo grade III-IV) occurring in approximately 5%^{7,15-17}. A similar rate of complications, including major complications, has been shown in patients whether the appendix is inflamed or not, meaning that patients undergoing negative appendectomy are as likely to have serious complications requiring return to theatre as patients with appendicitis^{15,16,18}. Complications arise even when the appendix is left in situ, diagnostic laparoscopy alone is associated with a complication rate of 2%¹⁹. Some studies have even found a longer length of hospital stay and higher healthcare costs associated with negative appendectomies²⁰.

An argument against aiming to reduce the NAR has been that it is associated with higher rates of perforated appendicitis¹⁷. However this has been refuted in numerous studies^{15,21}.

Given this, there is a clear and strong argument for reducing the UK's negative appendectomy rate, and by extension the number of diagnostic laparoscopies carried out in this young population. One strategy that has been shown to reduce the NAR is risk scoring and risk stratification to guide management^{6,22,23}. The Adult Appendicitis Score (AAS) stratifies patients into low and high risk groups based on symptomology, clinical examination, white cell count and C-reactive protein²³. This directs the next steps in investigation and management; high risk young patients would proceed straight to surgery without imaging, low risk patients where appendicitis is not suspected would be managed as outpatients with the option of ambulatory re-assessment, low risk patients with suspicion of gynaecology disorders would have an ultrasound, and low risk patients where a high index of suspicion for appendicitis remains or in whom the diagnosis is unclear would have a CT prior to proceeding with laparoscopy⁶. In centres where AAS was implemented as part of the decision making algorithm the NAR was reduced by up to 10%²³.

The Appendicitis Inflammatory Response Score

(AIRS) is a similar scoring system that also takes into account patient temperature²⁴. The AAS has been shown to be more specific in women, with a risk of one in 27 of appendicitis and one in 200 of complicated appendicitis in the group stratified as low risk⁶. Conversely, the AIRS is more specific in men, with a failure rate of 2.4% the low risk group⁶.

Another strategy to reduce the NAR is to increase the role of imaging in the diagnosis of appendicitis. Reliable imaging has been shown to reduce the rate of negative appendectomy by up to 15%^{7,17}. Ultrasound has variable sensitivity and specificity for appendicitis, likely a reflection of being user dependent²⁵. It has been demonstrated that patients undergoing ultrasound alone are twice as likely to have a negative appendectomy than those who have no imaging, and patients who had an inconclusive ultrasound and no further imaging were nearly 3 times more likely¹⁵. CT has a very high sensitivity and specificity for appendicitis, 98.5% and 98% respectively, and has been proven highly cost effective^{7,26}. In studies where patients had a pre-operative CT the NAR was 6.7%, decreasing to 4.3% in patients who had CT proven evidence of appendicitis¹⁵. In the past clinicians had avoided routine use of CT in the young population due to the long-term risk of ionising radiation. Current low-dose radiation CT protocols have been shown as just as effective at diagnosing appendicitis and access to CT has increased exponentially over the past decade, therefore CT should increasingly be used as the investigation of choice where the diagnosis of appendicitis is equivocal to avoid unnecessary surgery²⁷.

Conclusion

There are very few invasive procedures in surgery where we would tolerate a negative rate of 20%. Diagnostic laparoscopy and negative appendectomy carry equivalent morbidity and mortality to the removal of an inflamed appendix. Advances in the field of diagnostic imaging have allowed for greater precision in diagnosis. Alongside this a number of risk stratification scores have been validated to aid selection of patients for further imaging and for theatre. Together these strategies may lead to the death of the routine diagnostic laparoscopy in the diagnosis of acute appendicitis.





References

What patients want from emergency laps

1. NELA Project Team. Fourth Patient Report of the National Emergency Laparotomy Audit, RCoA London, [Internet], 2018. <http://nela.org.uk/All-Patient-Reports> (accessed August 2019)
2. ELLSA Project Team. The First National Report of the Emergency Laparoscopic and Laparotomy Scottish Audit (ELLSA). Scottish Government 2019 [Internet] 2019 <https://learn.nes.nhs.scot/13211/scottish-government-health-and-social-care-resources/whole-system-patient-flow-improvement-programme/emergency-laparotomy-and-laparoscopic-scottish-audit-ellsa> (accessed August 2019)
3. Parmar K, Law J, et al. Frailty in older patients undergoing emergency laparotomy: Results from the UK observational Emergency Laparotomy and Frailty (ELF) study. *Ann surg* 2019 <http://dx.doi.org/10.1097/sla.0000000000003402> [Epub ahead of print]
4. Law J, Welch C, et al. Decision-making for older patients undergoing emergency laparotomy: defining patient and clinician values and priorities. *Colorectal dis* 2020 <https://doi.org/10.1111/codi.15165> [Epub ahead of print]
5. Bernat JL, Peterson LM. Patient-centred informed consent in surgical practice. *Arch Surg* 2006; 141:86-92
6. Berger ZD, Boss EF, et al. Communication behaviours and patient autonomy in hospital care: a qualitative study. *Patient Educ Couns* 2017; 100:1473-81
7. Akkad A, Jackson C, et al. Informed consent for elective and emergency surgery: questionnaire study. *BJOG* 2004; 111:1133-8
8. Manta CJ, Ortiz J, et al. From the patient perspective, consent forms fall short of providing information to guide decision making. *Journal of Patient Safety* 2016; <https://dx.doi.org/10.1097/pts.0000000000000310> [Epub ahead of print]
9. Reynolds LM, McCambridge SA, et al. Trait and State Disgust: An Experimental Investigation of Disgust and Avoidance in Colorectal Cancer Decision Scenarios. *Health Psychology* 2014;33(12):1495-506
10. Ng ZQ, Levitt M, Platell C. The feasibility and safety of early ileostomy reversal: a systematic review and meta analysis. *ANZ Journal of surgery* 2020 (online prior to print) [doi:10.1111/ans.16079](https://doi.org/10.1111/ans.16079)

Differential Attainment and the Changing Surgical Workforce

1. Regan de Bere S, S Nunn, and M Nasser. Understanding differential attainment across medical training pathways: A rapid review of the literature. 2015 [cited 2020 03/03/2020]; Available from: https://www.gmc-uk.org/-/media/documents/GMC_Understanding_Differential_Attainment.pdf_63533431.pdf.
2. General Medical Council. The GMC asks doctors for diversity data to help ensure fair regulation 2019 [cited 2020 03/03/2020]; Available from: <https://www.gmc-uk.org/news/news-archive/doctors-diversity-data>.
3. Liaison Committee on Medical Education. Liaison Committee on Medical Education (LCME) Standards on Diversity. 2009 [cited 2019 18/10/2019]; Available from: <https://health.usf.edu/~media/Files/Medicine/MD%20Program/Diversity/LCMEStandardsonDiversity1.ashx?la=en>.
4. General Medical Council, State of Medical Education

and Practice in the UK. 2018.

5. Mclain S, V Cook, M Atkinson, et al., Barriers to Women's Participation in Surgery: From Student to Specilaist. *ANZ Journal of Surgery*, 2018. 88(1): p. 230.
6. de Costa J, J Chen-Xu, Z Bentounsi, et al., Women in surgery: challenges and opportunities. *IJS Global Health*, 2018. 1(1).
7. Favre M, Operating Theatre, Cover artwork, in *The New Yorker*. 2017, Conde Nast.
8. Symplur LLC. #ILookLikeASurgeon social media hashtag. [cited 2019 28/05/2019]; Available from: <https://www.symplur.com/healthcare-hashtags/ilooklikeasurgeon/>.
9. Bruce AN, A Battista, MW Plankey, et al., Perceptions of gender-based discrimination during surgical training and practice. *Medical Education Online*, 2015. 20(1): p. 25923.
10. Elsey EJ, J West, G Griffiths, et al., Time Out of General Surgery Specialty Training in the UK: A National Database Study. *Journal of Surgical Education*, 2019. 76(1): p. 55-64.
11. Harries RL, VJ Gokani, P Smitham, et al., Less than full-time training in surgery: a cross-sectional study evaluating the accessibility and experiences of flexible training in the surgical trainee workforce. *BMJ Open*, 2016. 6(4): p. e010136.
12. General Medical Council. The state of medical education and practice in the UK. 2017 [cited 202026/06/2020; Available from: <https://www.gmc-uk.org/-/media/gmc-site-images/about/what-we-do-and-why/data-and-research/somep-2017/somep-2017-final-full.f?la=en&hash=1380D1946084C02C67CF59B0AD527BC8A52AF39E>.
13. Bellini M, Y Graham, C Hayes, et al., A woman's place is in theatre: women's perceptions and experiences of working in surgery from the Association of Surgeons of Great Britain and Ireland women in surgery working group. *BMJ Open*, 2019. 9(1).
14. Higher Education Statistics Agency. What do HE students study?: Personal characteristics. 2020 [cited 2020 02/07/2020]; Available from: <https://www.hesa.ac.uk/data-and-analysis/students/what-study/characteristics>.
15. Royal College of Surgeons of Ireland. Trainee Progression Information Surgical Training Pathway 2019 [cited 2020 02/07/2020]; Available from: <https://msurgery.ie/wp-content/uploads/2020/01/Trainee-Progression-Information-2019-rev9.pdf>.
16. Fnais N, C Soobiah, MH Chen, et al., Harassment and Discrimination in Medical Training: A Systematic Review and Meta-Analysis. *Academic Medicine*, 2014. 89(5).
17. Tiffin PA, J Illing, AS Kasim, et al., Annual Review of Competence Progression (ARCP) performance of doctors who passed Professional and Linguistic Assessments Board (PLAB) tests compared with UK medical graduates: national data linkage study. *BMJ*, 2014. 348: p. g2622.
18. Tiffin PA, J Orr, LW Paton, et al., UK nationals who received their medical degrees abroad: selection into, and subsequent performance in postgraduate training: a national data linkage study. *BMJ Open*, 2018. 8(7): p. e023060.

19. Rothwell CR, A study to identify the factors that either facilitate or hinder medical speciality trainees in their Annual Review of Competence Progression (ARCP), with a focus on adverse ARCP outcomes, in Durham theses. 2017, Durham University.
 20. Khoushhal Z, MA Hussain, E Greco, et al., Prevalence and Causes of Attrition Among Surgical Residents: A Systematic Review and Meta-analysis. *JAMA Surg*, 2017. 152(3): p. 265-272.
 21. Gifford E, J Galante, AH Kaji, et al., Factors associated with general surgery residents' desire to leave residency programs: a multi-institutional study. *JAMA surgery*, 2014. 149(9): p. 948-53.
 22. Yeo H, E Bucholz, J Ann Sosa, et al., A national study of attrition in general surgery training: which residents leave and where do they go? *Ann Surg*, 2010. 252(3): p. 529-34; discussion 534-6.
 23. Sullivan MC, H Yeo, SA Roman, et al., Surgical residency and attrition: Defining the individual and programmatic factors predictive of trainee losses. *Journal of the American College of Surgeons*, 2013. 216(3): p. 461-471.
 24. Brown EG, JM Galante, BA Keller, et al., Pregnancy-related attrition in general surgery. *JAMA Surgery*, 2014. 149(9): p. 893-897.
 25. Turner PL, K Lumpkins, J Gabre, et al., Pregnancy among women surgeons: Trends over time. *Archives of Surgery*, 2012. 147(5): p. 474-479.
 26. Pyne Y and Y Ben-Shlomo, Older doctors and progression through specialty training in the UK: a cohort analysis of General Medical Council data. *BMJ Open*, 2015. 5(2): p. e005658.
 27. Low ZX, KA Yeo, VK Sharma, et al., Prevalence of Burnout in Medical and Surgical Residents: A Meta-Analysis. *Int J Environ Res Public Health*, 2019. 16(9).
- Personalising care for primary breast cancer in older women – an overview of work from Nottingham**
1. UK CR. Breast cancer incidence (invasive) statistics. Available at: <https://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/breast-cancer/incidence-invasive-heading-Zero> [Accessed: 6th April 2020]. 2020.
 2. World Health Organisation. International Agency for Research on Cancer. Available at: <https://www.iarc.fr/> [Accessed: 24th June 2019]. 2019.
 3. NICE. National Institute for Health and Care Excellence. Early and locally advanced breast cancer: diagnosis and management. Nice Guideline. 2018;101.
 4. Senkus E, on behalf of the EGC, Kyriakides S, on behalf of the EGC, Ohno S, on behalf of the EGC, et al. Primary breast cancer: ESMO Clinical Practice Guidelines for diagnosis, treatment and follow-up[†]. *Annals of Oncology*. 2015;26(suppl_5):v8-v30.
 5. National Comprehensive Cancer Network. Breast Cancer: Early Stage. 2016.

6. Kaufmann M, Morrow M, von Minckwitz G, Harris JR. Locoregional treatment of primary breast cancer. *Cancer*. 2010;116(5):1184-91.
7. Biganzoli L, Wildiers H, Oakman C, Marotti L, Loibl S, Kunkler I, et al. Management of elderly patients with breast cancer: updated recommendations of the International Society of Geriatric Oncology (SIOG) and European Society of Breast Cancer Specialists (EUSOMA). *The Lancet Oncology*. 2012;13(4):e148-e60.
8. Monypenny I. UK Symptomatic Breast Audit 1.4.2001-31.3.2002. *British Association of Surgical Oncology*. 2003.
9. Ward SE, Richards PD, Morgan JL, Holmes GR, Broggio JW, Collins K, et al. Omission of surgery in older women with early breast cancer has an adverse impact on breast cancer-specific survival. *BJS*. 2018;105(11):1454-63.
10. Parks RM, Cheung KL. Personalising Care in the Older Woman with Primary Breast Cancer. *Ann Acad Med Singapore*. 2019;48(11):370-5.
11. Markopoulos C, van de Water W. Older patients with breast cancer: is there bias in the treatment they receive? *Therapeutic Advances in Medical Oncology*. 2012;4(6):321-7.
12. Wildiers H, Kunkler I, Biganzoli L, Fracheboud J, Vlastos G, Bernard-Marty C, et al. Management of breast cancer in elderly individuals: recommendations of the International Society of Geriatric Oncology. *The Lancet Oncology*. 2007;8(12):1101-15.
13. Morgan JL, George J, Holmes G, Martin C, Reed MWR, Ward S, et al. Breast cancer surgery in older women: outcomes of the Bridging Age Gap in Breast Cancer study. *Br J Surg*. 2020.
14. Yersal O, Barutca S. Biological subtypes of breast cancer: Prognostic and therapeutic implications. *World J Clin Oncol*. 2014;5(3):412-24.
15. Dai X, Li T, Bai Z, Yang Y, Liu X, Zhan J, et al. Breast cancer intrinsic subtype classification, clinical use and future trends. *Am J Cancer Res*. 2015;5(10):2929-43.
16. Diab SG ER, Clark GM. Tumor characteristics and clinical outcome of elderly women with breast cancer. *J Natl Cancer Inst*. 2000;92(7):550-6.
17. Cheung KL, Wong AWS, Parker H, Li VWY, Winterbottom L, Morgan DAL, et al. Pathological features of primary breast cancer in the elderly based on needle core biopsies—A large series from a single centre. *Critical Reviews in Oncology/Hematology*. 2008;67(3):263-7.
18. Syed BM, Green AR, Paish EC, Soria D, Garibaldi J, Morgan L, et al. Biology of primary breast cancer in older women treated by surgery: with correlation with long-term clinical outcome and comparison with their younger counterparts. *British Journal of Cancer*. 2013;108(5):1042-51.
19. Mathew J, Lee S, Syed BM, Morgan DAL, Ellis IO, Cheung KL. A study of ductal versus non-ductal invasive breast carcinomas in older women: long-term clinical outcome and comparison with their younger counterparts. *Breast Cancer Research and Treatment*. 2014;147(3):671-4.





20. Syed BM, Green AR, Ellis IO, Cheung KL. Human epidermal growth receptor-2 overexpressing early operable primary breast cancers in older (≥ 70 years) women: biology and clinical outcome in comparison with younger (< 70 years) patients. *Annals of Oncology*. 2014;25(4):837-42.

21. Syed BM, Green AR, Nolan CC, Morgan DAL, Ellis IO, Cheung K-L. Biological Characteristics and Clinical Outcome of Triple Negative Primary Breast Cancer in Older Women – Comparison with Their Younger Counterparts. *PLoS One*. 2014;9(7):e100573.

22. Albanghali M. Biology and clinical outcomes of early primary breast cancer in older women - a study based on core needle biopsy. PhD Thesis, University of Nottingham. November 2016.

23. Wildiers H, Heeren P, Puts M, Topinkova E, Janssen-Heijnen MLG, Extermann M, et al. International Society of Geriatric Oncology Consensus on Geriatric Assessment in Older Patients With Cancer. *Journal of Clinical Oncology*. 2014;32(24):2595-603.

24. Parks RM, Lakshmanan R, Winterbottom L, Al Morgan D, Cox K, Cheung K-L. Comprehensive geriatric assessment for older women with early breast cancer – a systematic review of literature. *World Journal of Surgical Oncology*. 2012;10:88-.

25. Biganzoli L, Mislant AR, Di Donato S, Becheri D, Biagioni C, Vitale S, et al. Screening for Frailty in Older Patients With Early-Stage Solid Tumors: A Prospective Longitudinal Evaluation of Three Different Geriatric Tools. *The Journals of Gerontology: Series A*. 2017;72(7):922-8.

26. Valentini A, Federici M, Cianfarani MA, Tarantino U, Bertoli A. Frailty and nutritional status in older people: the Mini Nutritional Assessment as a screening tool for the identification of frail subjects. *Clinical Interventions in Aging*. 2018;13:1237-44.

27. Parks RM, Hall L, Tang S-W, Howard P, Lakshmanan R, Winterbottom L, et al. The potential value of comprehensive geriatric assessment in evaluating older women with primary operable breast cancer undergoing surgery or non-operative treatment — A pilot study. *Journal of Geriatric Oncology*. 2015;6(1):46-51.

28. Hurria A, Gupta S, Zauderer M, Zuckerman EL, Cohen HJ, Muss H, et al. Developing a cancer-specific geriatric assessment: a feasibility study. *Cancer*. 2005;104(9):1998-2005.

The role of the trainee in Emergency Laparotomy cases

1. ISCP (Intercollegiate Surgical Curriculum Programme). General Surgery Curriculum [Internet]. 2016 [cited 2018 Nov 20]. Available from: https://www.iscp.ac.uk/curriculum/surgical/specialty_year_syllabus.aspx?enc=Ttek+oCN/eOTQZ3fsf5Klg==

2. Joint Committee on Surgical Training. COVID-19: JCST Statement update_1 June 2020. 2020.

3. Iannuzzi JC, Chandra A, Rickles AS, Kumar NG, Kelly KN, Gillespie DL, et al. Resident involvement is associated with worse outcomes after major lower extremity amputation. *J Vasc Surg [Internet]*. 2013;58(3):827-831.e1. Available from: <http://dx.doi.org/10.1016/j.jvs.2013.04.046>

4. Hwang CS, Pagano CR, Wichterman KA, Dunnington GL, Alfrey EJ. Resident versus no resident: A single institutional study on operative complications, mortality, and cost. *Surgery*. 2008;144(2):339–44.

5. Kasotakis G, Lakha A, Sarkar B, Kunitake H, Kissane-Lee N, Dechert T, et al. Trainee participation is associated with adverse outcomes in emergency general surgery: an analysis of the National Surgical Quality Improvement Program database. *Ann Surg*. 2014 Sep;260(3):483.

6. Singh P, Harrison E, Bhangu A. Trainee Involvement in Surgery Is an Asset to the Surgical Team. Vol. 263, *Annals of surgery*. United States, United States; 2016. p. e12-3.

7. NELA Project Team. First Patient Report of the National Emergency Laparotomy Audit [Internet]. The Royal College of Anaesthetists, London. London; 2015. Available from: <http://nela.org.uk/All-Patient-Reports>

8. NELA Project Team. Frequently Asked Questions [Internet]. 2018. Available from: <https://www.nela.org.uk/NELAFaq>

9. NELA Project Team. The Second Patient Report of the National Emergency Laparotomy Audit. [Internet]. London; 2016. Available from: <http://www.nela.org.uk/Second-Patient-Report-of-the-National-Emergency-Laparotomy-Audit#pt>

10. NELA Project Team. The Third Patient Report of the National Emergency Laparotomy Audit [Internet]. London; 2017. Available from: <http://www.nela.org.uk/Third-Patient-Audit-Report#pt>

11. NELA Project Team. The Fourth Patient Report of the National Emergency Laparotomy Audit [Internet]. The Royal College of Anaesthetists, London. London; 2018. Available from: <http://nela.org.uk/All-Patient-Reports>

The Death of the Diagnostic Laparoscopy in Acute Appendicitis?

1. GlobalSurg Collaborative. Mortality of emergency abdominal surgery in high-, middle- and low-income countries. *Br J Surg [Internet]*. 2016 Jul [cited 2020 May 7];103(8):971–88. Available from: <http://doi.wiley.com/10.1002/bjs.10151>

2. Addiss DG, Shaffer N, Fowler BS, Tauxe R V. The epidemiology of appendicitis and appendectomy in the united states. *Am J Epidemiol*. 1990;132(5):910–25.

3. The Association of Surgeons of Great Britain and Ireland. Commissioning guide: Emergency general surgery (acute abdominal pain). London; 2014.

4. NHS Digital. Hospital Admitted Patient Care Activity 2018-2019. London; 2019.

5. Petroianu A. Diagnosis of acute appendicitis [Internet]. Vol. 10, *International Journal of Surgery*. Int J Surg; 2012 [cited 2020 Jul 7]. p. 115–9. Available from: <https://pubmed.ncbi.nlm.nih.gov/22349155/>

6. Bhangu A, Nepogodiev D, Matthews JH, Morley GL, Naumann DN, Ball A, et al. Evaluation of appendicitis risk prediction models in adults with suspected appendicitis. *Br J Surg*. 2019;107(1).

7. Sartelli M, Baiocchi GL, Di Saverio S, Ferrara F, Labricciosa FM, Ansaloni L, et al. Prospective Observational Study on acute Appendicitis Worldwide (POSAW). *World J Emerg Surg [Internet]*. 2018 Apr 16 [cited 2020 Jun 16];13(1):19. Available from: <https://wjeb.biomedcentral.com/articles/10.1186/s13017-018-0179-0>

8. Bickell NA, Aufses AH, Rojas M, Bodian C. How time affects the risk of rupture in appendicitis. *J Am Coll Surg*. 2006;202(3):401–6.

9. Jaunoo S, Hale A, Masters J, Jaunoo S. An international survey of opinion regarding investigation of possible appendicitis and laparoscopic management of a macroscopically normal appendix. *Ann R Coll Surg Engl [Internet]*. 2012 Oct 11 [cited 2020 Jul 8];94(7):476–80. Available from: <http://publishing.rcseng.ac.uk/doi/10.1308/003588412X13373405385377>

10. Jane E, Turner R, Lightwood, Turner E. Management of the 'Normal'Appendix during Laparoscopy for Right Iliac Fossa Pain. *World J Laparosc Surg*. 2AD Apr 1;

11. Bhangu A, Begaj I, Ray D. Population level analysis of diagnostic laparoscopy versus normal appendectomy for acute lower abdominal pain. *Int J Surg [Internet]*. 2014 Dec 1 [cited 2020 Jul 8];12(12):1374–9. Available from: <https://pubmed.ncbi.nlm.nih.gov/25448660/>

12. Ekeh AP, Wozniak CJ, Monson B, Crawford J, McCarthy MC. Laparoscopy in the contemporary management of acute appendicitis. *Am J Surg [Internet]*. 2007 Mar [cited 2020 Jul 8];193(3):310–4. Available from: <https://pubmed.ncbi.nlm.nih.gov/17320525/>

13. Phillips AW, Jones AE, Sargen K. Should the macroscopically normal appendix be removed during laparoscopy for acute right iliac fossa pain when no other explanatory pathology is found? *Surg Laparosc Endosc Percutaneous Tech*. 2009 Oct;19(5):392–4.

14. Van Den Broek WT, Bijnen AB, De Ruiter P, Gouma DJ. A normal appendix found during diagnostic laparoscopy should not be removed. *Br J Surg [Internet]*. 2001 [cited 2020 Jul 8];88(2):251–4. Available from: <https://pubmed.ncbi.nlm.nih.gov/11167876/>

15. Arthur T, Gartrell R, Manoharan B, Parker D. Emergency appendectomy in Australia: findings from a multicentre, prospective study. *ANZ J Surg*. 2017 Sep 1;87(9):656–60.

16. Lee M, Paavana T, Mazari F, Wilson TR. The morbidity of negative appendectomy. *Ann R Coll Surg Engl*. 2014 Mar 11;96(7):517–20.

17. Bhangu A, Richardson C, Torrance A, Pinkney T, Battersby C, Beral D, et al. Multicentre observational study of performance variation in provision and outcome of emergency appendectomy. *Br J Surg*. 2013 Aug 1;100(9):1240–52.

18. Allaway MGR, Eslick GD, Cox MR. The Unacceptable Morbidity of Negative Laparoscopic Appendectomy. *World J Surg [Internet]*. 2019 Feb 15 [cited 2020 Jul 8];43(2):405–14. Available from: <https://pubmed.ncbi.nlm.nih.gov/30209573/>

19. Moberg AC, Ahlberg G, Leijonmarck CE, Montgomery A, Reiertsen O, Rosseland AR, et al. Diagnostic laparoscopy in 1043 patients with suspected acute appendicitis. *Eur J Surg [Internet]*. 1998 [cited 2020 Jul 7];164(11):833–40. Available from: <https://pubmed.ncbi.nlm.nih.gov/9845129/>

20. Mock K, Lu Y, Friedlander S, Kim DY, Lee SL. Misdiagnosing adult appendicitis: clinical, cost, and socioeconomic implications of negative appendectomy. *Am J Surg [Internet]*. 2016 Dec 1 [cited 2020 Jul 7];212(6):1076–82. Available from: <https://pubmed.ncbi.nlm.nih.gov/27836098/>

21. Aanning HL. Negative appendectomy and perforation rates in the SCOAP trial [Internet]. Vol. 249, *Annals of Surgery*. Ann Surg; 2009 [cited 2020 Jul 8]. p. 699. Available from: <https://pubmed.ncbi.nlm.nih.gov/19348033/>

22. Andersson M, Kolodziej B, Andersson RE, Andersson RE, Andersson M, Eriksson T, et al. Randomized clinical trial of Appendicitis Inflammatory Response score-based management of patients with suspected appendicitis. *Br J Surg [Internet]*. 2017 Oct 1 [cited 2020 Jul 8];104(11):1451–61. Available from: <https://pubmed.ncbi.nlm.nih.gov/28730753/>

23. Sammalkorpi HE, Mentula P, Savolainen H, Leppäniemi A. The Introduction of Adult Appendicitis Score Reduced Negative Appendectomy Rate. *Scand J Surg [Internet]*. 2017 [cited 2020 Jul 7];106(3):196–201. Available from: <https://pubmed.ncbi.nlm.nih.gov/28737110/>

24. Andersson M, Andersson RE. The appendicitis inflammatory response score: A tool for the diagnosis of acute appendicitis that outperforms the Alvarado score. *World J Surg [Internet]*. 2008 Jun 14 [cited 2020 Jul 7];32(8):1843–9. Available from: <https://link.springer.com/article/10.1007/s00268-008-9649-y>

25. Florence M, Flum DR, Jurkovich GJ, Lin P, Steele SR, Symons RG, et al. Negative appendectomy and imaging accuracy in the washington state surgical care and outcomes assessment program. *Ann Surg [Internet]*. 2008 Oct [cited 2020 Jul 8];248(4):557–62. Available from: <https://pubmed.ncbi.nlm.nih.gov/18936568/>

26. Romero J, Sanabria A, Angarita M, Varón JC. Cost-effectiveness of computed tomography and ultrasound in the diagnosis of appendicitis. *Biomedica*. 2008 Mar;28(1):139–47.

27. Kim K, Kim YH, Kim SY, Kim S, Lee YJ, Kim KP, et al. Low-dose abdominal CT for evaluating suspected appendicitis. *N Engl J Med*. 2012 Apr 26;366(17):1596–605.





Delivery of surgical services during the COVID-19 pandemic: A succinct review

Jeevan Prakash Gopal¹, Vassilios E Papalois^{1,2}

1 Renal and Transplant Directorate, Imperial College Healthcare NHS Trust, Hammersmith Hospital, London, UK

2 Department of Surgery and Cancer, Imperial College, London, UK

Introduction

The current COVID-19 pandemic has disrupted global health in an unparalleled way. In response to this unprecedented circumstance, healthcare systems have undergone rapid reorganization and as a consequence of this, delivery of surgical services has been universally hampered. Surgical societies like the ASGBI and the Surgical Royal Colleges have been instrumental in providing timely guidance about various COVID-19 related issues that are crucial for safe conveyance of surgical services. We aimed to appraise and summarize the articles pertaining to COVID-19 and linked to surgery.

Established practices

Although evidence is evolving day to day, some of the practices in common are as follows:

- (1) halting or reduction of elective non-urgent, non-cancer surgeries in order to conserve resources (material and manpower),
- (2) reduction in outpatient clinic activity, increasing virtual clinics and triaging new surgical referrals in order to prevent cross-infection,

(3) prioritizing patients and continuing cancer surgeries as much as possible, using neoadjuvant treatment for high risk and frail patients,

(4) continuing emergency surgical care with appropriate risk-assessment model based on patient and procedural factors,

(5) developing customized clinical pathways with emphasis on:

- a) segregating SARS CoV 2 positive and negative patients,
- b) safe transfer in and out of theatre without infecting other patients, and
- c) dedicated COVID theatre (with negative pressure ventilation), radiology and endoscopy suites

(6) training of staff with regards to patient transfer, usage of PPE (personal protective equipment), and identification and management of patients with COVID-19, and

(7) continuing delivery of surgical care in dedicated “green” site/ collaborating with independent sector with appropriate patient and staff testing and shielding prior to surgery. The key domains to be addressed from the review by COVIDSurg collaborative¹ is shown in Figure-1.

Domain	Recommendations
Prepare a pandemic response plan for surgical services	All hospitals should prepare context-specific pandemic plans that can be implemented as soon as COVID-19 cases are identified locally. Plans should include all surgical specialties and both elective and emergency services
Ensure staff are trained to deliver surgery safely during pandemic	Practise drills with experienced infection control teams, including: patient transfers between different areas of the hospital; donning and doffing personal protection equipment; recognizing and managing COVID-19 infection
Support hospital response to COVID-19	Reduce non-urgent activities, including outpatient clinics, endoscopy and non-cancer elective operations. Plan how to continue delivering urgent elective surgery safely, for example for patients with cancer
Agree a team-based approach for running emergency services	Anticipate increased pressure on emergency surgical services during the pandemic, with staff absence owing to illness or quarantine. Establish team structures that minimize cross-contamination and risk of nosocomial infection
Recognize and manage COVID-19 infection	Have a high index of suspicion for COVID-19 infection in both emergency surgical admissions and patients who develop postoperative respiratory complications. Ensure there are arrangements in place for patients with suspected COVID-19 to be isolated and tested

Figure 1: Key domains to be addressed by COVIDSurg Collaborative group

Pandemic preparedness plan

Interestingly, in the review by Soreide et al², proposal of a framework for surgical planning has been briefed (Figure-2) and global deficits in pandemic preparedness for delivering surgical services has been voiced along with the need to

incorporate surgical delivery before, during and after a pandemic in the WHO agenda for national health planning. These elements are crucial as cancellation of elective surgery causes collateral damage to health and well-being along with a potential risk of shortened life span.

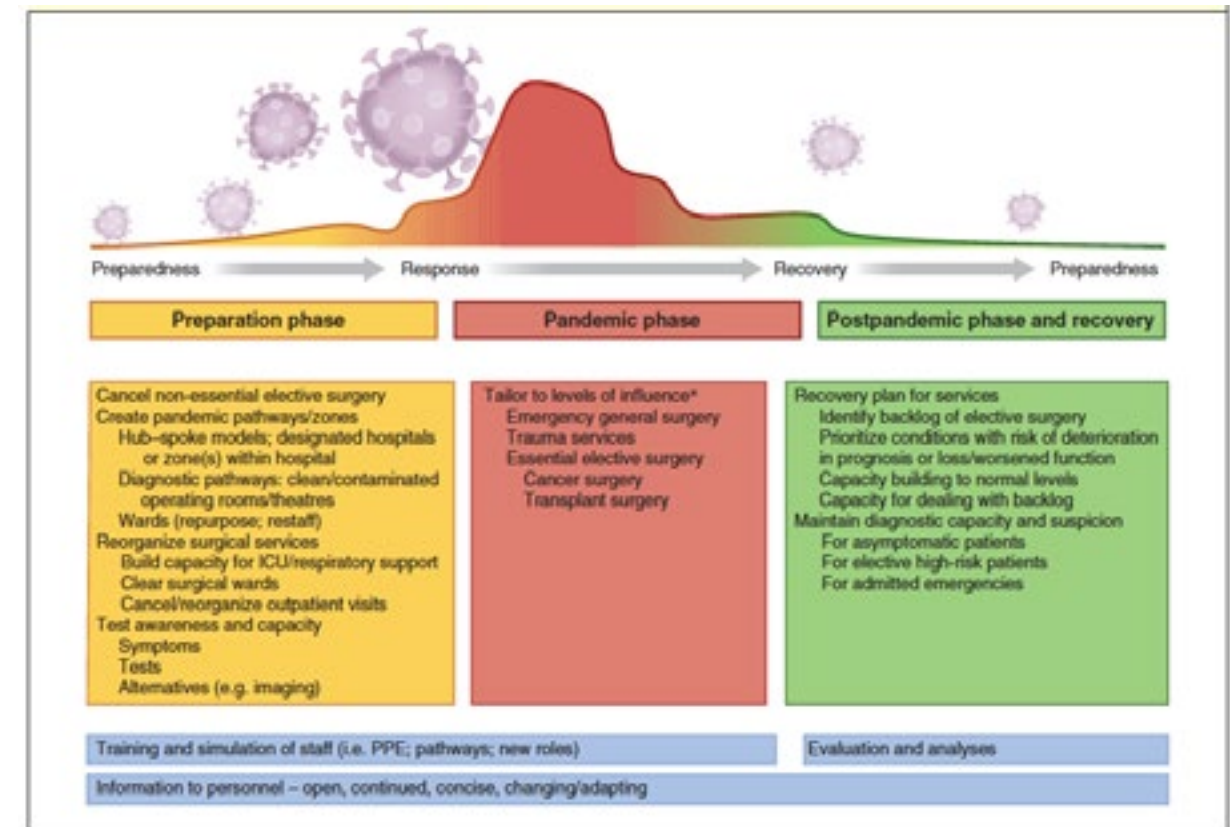


Figure 2: Figure-2: Pandemic preparedness plan by Soreide et al



Delivering Safe Surgical Services (DSSS)

The FSSA guidelines by ASGBI and several other associations has elaborated the Developing Safe Surgical Services (DSSS) for COVID-19 era³. They have uniquely alluded to COVID lite facilities and Getting It Right the First Time (GIRFT) and have suggested them as some of the changes to consider in the patient pathway. These are essential for the delivery of super-specialist care (especially lifesaving organ transplants and elective cancer care). At the same time these arrangements should not be continued permanently as patients in certain locations are particularly disadvantaged due to reduced access and geographical imbalance in the delivery of care. The guidance regarding consent is immensely valuable as the surgeon is legally responsible for ensuring patient's understanding of all the material risks involved in the joint decision-making process.

The COVID:Harem Study

The COVID:Harem study⁴ supported by ASGBI is really the need of the hour. As the COVID-19 pandemic has demanded exceptional focus and resources, delivery of even emergency surgical services is strained. Studies looking at the outcomes of medical management of certain surgical conditions like the appendicitis, cholecystitis, diverticulitis would be useful as resources could be conserved if medical management has favorable outcomes.

Supporting BAME community

As people from Black Asian Minority Ethnicity (BAME) are disproportionately represented among those with critical illness and death due to COVID-19, the ASGBI has extended its support to the members of the BAME community by safeguarding the elderly and those with comorbidities by strongly advocating certain recommendations through the Colleges to Public Health England⁵.

Safe operating room practice

The Welsh Surgical Research Initiative (WSRI) collaborative has conducted a rapid modified Delphi exercise to identify the knowledge needs of the global operating room workforce during the pandemic⁶. Although several high levels of consensus were arrived, there were several controversial areas that need to be addressed in order to delineate safe operating room practice.

Restarting planned surgery

As we are considerably advanced through the pandemic and as the critical care bed occupancy and deaths are consistently falling, it is prudent to resume elective surgeries sooner rather than later. The strategy document by the Royal College of Anaesthetist for restarting planned surgery highlights the relevant considerations and have rated the readiness for a return to activity⁷. This is a very realistic approach which can be easily implemented. In addition to patient outcomes, the need to consider resource priorities, staff safety and infection rates are likely to persist.

References

1. COVIDSurg Collaborative. Global guidance for surgical care during the COVID-19 pandemic [published online ahead of print, 2020 Apr 15]. Br J Surg. 2020;10.1002/bjs.11646. doi:10.1002/bjs.11646
2. Søreide K, Hallet J, Matthews JB, et al. Immediate and long-term impact of the COVID-19 pandemic on delivery of surgical services [published online ahead of print, 2020 Apr 30]. Br J Surg. 2020;10.1002/bjs.11670. doi:10.1002/bjs.11670
3. https://www.asgbi.org.uk/userfiles/file/covid19/developing-safe-surgical-services-dsss-for-the-covid19-era_may2020.pdf
4. <https://www.asgbi.org.uk/emergency-general-surgery#COVIDHAREM>
5. <https://www.asgbi.org.uk/userfiles/file/covid19/asgbi-support-for-bame-members-070520.pdf>
6. Welsh Surgical Research Initiative (WSRI) Collaborative. Surgery during the COVID-19 pandemic: operating room suggestions from an international Delphi process [published online ahead of print, 2020 May 12]. Br J Surg. 2020;10.1002/bjs.11747. doi:10.1002/bjs.11747
7. <https://www.asgbi.org.uk/userfiles/file/covid19/restarting-planned-surgery.pdf>

Comments from ASGBI Regional Representatives on post-COVID-19 surgery recovery July 2020

Mr Neil Welch, Vice President, ASBI

In July the ASGBI Regional Representatives discussed how the various parts of the country were slowly returning to elective surgical activity after full lockdown was imposed in March.

There is a lot of variation across the regions that seems to be dependent on a few factors including local background rates of COVID-19, local clinical leadership, and availability of "green" sites. A frustration with an inability to provide a full elective service to patients is evident, and also concerns about training opportunities particularly if the green site is a private hospital which restricts operations to consultants only.

With the permission of your regional representatives I wanted to share some comments with you. Please contact your local representative if you want to feed your comment into the ASGBI. Their names can be found on the website <https://www.asgbi.org.uk/about-us/elected-regional-representatives>.

North East: many patients are refusing to self-isolate for 14 days before elective categories 3 & 4 type surgeries as they were furloughed before and got back to jobs and worried about losing jobs due to self-isolate for 2 weeks pre-op and 2 weeks post op. One of the trusts in North East is swabbing all their staff members on weekly basis (Northumbria Healthcare), religiously.

Glasgow: 2 weeks self-isolation with swab the day before or the morning of surgery. No way of proving they are sticking to that 2 weeks but at least the swab is about as close as we can get. Almost no COVID in Scotland at present.

Nottingham: we have established green pathways and still insist on 14 days self-isolation and a negative swab before allowing patients into the green areas. However, we can't actually verify the self-isolation and have to trust the patient. If the patient doesn't want to have the operation yet, then they are left on the list for a time when pathways are less restrictive. We have found up to 20% of category 4's remove themselves from the waiting list completely when contacted. The symptoms are not so bad anymore!!

London: so far, we have only been doing

urgent cases, all the patients say they are self-isolating, but we don't check it at all. I am very concerned about the number of patients on the elective waiting list we have seen admitted as an emergency. One patient waiting for lap chole with CBD stent was admitted with gallbladder perforation and has spent days in ITU.

South Wales (Cardiff): for all elective surgery 2 weeks isolation and swabs taken 72hrs prior to admission are required. Patients seem to be reasonably compliant. Many patients on phone call consults just declining surgery for lap choles etc. as symptoms mild. The symptomatic ones still keen to jump through all the hoops. Emergency numbers with biliary pathology high.

North Wales: we appear to be progressing most quickly with returning to surgery in Wrexham than the other two sites, but still mainly doing urgent day cases or in-patient cancers. We have no access to off-site "green" locations, but they are looking at the possibility of converting the 2 Nightingale sites for elective work, but this is still in the discussion stages (and maybe mainly endoscopy rather than surgery). We are still not routinely testing emergency admissions or staff and I understand there has been a spike in cases in Wrexham, which further adds to the concerns but I am not aware of any elective surgical cases who have become positive in the hospital.

Our biggest issue is the huge increase in emergency workload because of the lack of elective operating - gallbladders particularly; and a definite increase in presentations of advanced cancers on the emergency take. We are also doing a lot of emergency endoscopies in theatre, to keep the endoscopy department as clean as possible.

East of England: similar experience here.

North West of England: Same experience.

South West of England: very similar experience.

Northern Ireland: we are really only getting category 2 and 3 patients done but most pretty compliant with self-isolation and grateful to get their surgery done. In our hospital we have been taking a pragmatic stance and have been accepting 7 days isolation as a minimum as we thought a lot of our working individuals might





struggle to manage 14 days and a lot of our older patients were often shielding (or living with people shielding) anyway. We may have to revise this as the place opens up. Some regional sub-specialties like OG and HPB still have large backlogs of cancers to get through. Most colorectal and breast cases getting sorted. Urgent benign OG and choles only are getting done. We remain down a significant number of surgical beds in our hospital that haven't returned from the physicians' control after the COVID surge but we have a fairly well established green pathway through to a separate theatre block for scheduled non-emergency patients. Its working pretty well but one of the drawbacks is that we can no longer add an emergency on to the end of an elective list if space becomes available.

West Midlands: mostly 14-day isolation and a negative swab 72 hrs pre-admission - patients compliant. Lots of biliary pathology on the acute take - the GS pancreatitis worry me. Not sure if they are getting their lap chole's within 2-4 weeks. Colorectal Cancers - delayed diagnostics/modifications to oncological treatments resulting in acute presentations.

Yorkshire: 2 weeks isolation then swab. Not really sure that it is practical for people to 'strictly' isolate for 2 weeks. Lots of small terraced houses with one toilet in Yorkshire which means it is impossible for patients to isolate properly especially if they have family living at home. I think that asking people to self-isolate for 2 weeks is something we are doing but we don't really go into the practicalities of how they are actually doing it by enquiring about their home circumstances. If a patient is honest and says they can't truly isolate in their home circumstances are we going to delay their cancer operation? On a similar note - how green is green on our wards. In my experience

If you want to contact your regional representative, the list of representatives can be found here:

<https://www.asgbi.org.uk/about-us/elected-regional-representatives>

staff can only be green for their shift and as they leave to go home, nip to the shops etc. they are orange at best! In summary I think all we can do is try to stick to as many practical avoidance advice given. Regular swabbing of staff is coming into our 'green' Spire hospital as of next week but not NHS hospital staff.

Republic of Ireland: very similar. Green pathways in all hospitals. Fractured process with inpatient surgery requiring cocooning and testing. Not for outpatient day case. Major challenge for waiting list. Different interpretation in some hospitals of the same guideline. We have very little COVID (at the moment). Private hospitals were taken over by the government at great expense but very poorly used.

Impact of COVID-19 pandemic on surgeons and surgery

Islam Omar¹, Rishi Singhal², Kamal Mahawar³

1. Bariatric Fellow, Sunderland Royal Hospital
2. Consultant General and Upper GI Surgeon, Birmingham Heartlands Hospital & Medical Director, Healthier Weight, UK
3. Consultant General and Bariatric Surgeon, Sunderland Royal Hospital & Visiting Professor, University of Sunderland

Sometime in the second week of March this year, many surgeons in the United Kingdom (UK) were waking up to the news that a distant pandemic which was a problem in a foreign land far away until just a few days ago, was now wreaking havoc in a land not too far from us. Hundreds were dying in Italy to a new disease called Coronavirus Disease -2019 (COVID-19) caused by a new virus called Severe Acute Respiratory Syndrome coronavirus 2 (SARS-CoV-2).

Epidemiologists were predicting that we were only two weeks behind the curve and the number of new cases was already surging in London. Surgeons knew that whatever happened, we would have patients needing emergency surgery who would need to be operated on and that our colleagues elsewhere in the hospitals might also need help. Many of us were surprised that elective surgery was still going on and life in the UK was largely continuing as normal.

The country did go into lockdown eventually - a week after most of us (surgeons not epidemiologists) had predicted - and probably two weeks too late! The guidance did come around 17th March from National Health Service (NHS) bosses that all non-urgent elective operations should be stopped from 15th April at the latest but many surgeons had refused to put their patients at risk almost a month before that date and certainly before the advice came out. This foresight must have saved some lives because we know now that the outcomes of patients who underwent an operation with a perioperative SARS-CoV-2 infection were far from satisfactory¹.

We were working in a new environment and odds of all decision making had changed overnight. Almost all aspects of our personal and work lives were about to change in a very significant way and we had no idea how to go about it. Once again, the surgical community responded to the challenge. We formed a Facebook group called "Safe Surgery During COVID-19 Times". Within a few days, the group had more than 3000 surgeons - mostly from the UK

- but also from around the world, supporting and learning from each other. Guidelines published from around the world were summarised and shared by well-meaning colleagues and friends in a matter of sometimes minutes after publication. New management plans were being discussed and implemented at breakneck speed. Many of us - surgeons and consultants for many years (and decades) - found ourselves back in the school of life where we had to re-test all our well-rehearsed algorithms in a new environment.

At the same time, and not entirely unexpectedly, news started filtering from other countries that healthcare workers were succumbing to this disease in alarming numbers and a disproportionate number of them were surgeons². We had an added responsibility now to also keep our colleagues and families' safe and no matter how willing we were to sacrifice ourselves to achieve this objective, this time around you couldn't do that without keeping yourself safe too. We knew it was just common sense that one should wear masks while in the hospitals but that was not the recommendation from the Department of Health and colleagues were even chastised by well-meaning Infection control personnel on the ground for wearing them in the hospital.

Public Health England (PHE) issued guidance on what would constitute an Aerosol Generating Procedure (AGP) but to many of us on the ground, it was obvious that it was written with the supply of equipment in mind rather than the need. Several procedures that surgeons felt were AGPs (unpublished survey) were not included in the guidance by PHE. Much credit should go to the Association of Surgeons of Great Britain and Ireland (ASGBI) and the Surgical Royal Colleges for trying their best to ensure the voice of surgeons was heard. They did not hesitate to even put themselves at odds with PHE to ensure that the interests of surgeons, and by implication, that of our patients and families, were protected.

This however also led to enormous confusion on the ground. Some surgeons and Endoscopists (with stronger voices in the hospital hierarchies) were able to use Personal Protective Equipment





(PPE) as and when they wanted whereas others were told it was unnecessary. A simple look at the demographics of doctors and nurses who have lost their lives to this pandemic or needed admission to the Intensive Care Unit in the UK would be enough to remind you how much sway a certain group of doctors and nurses have in the current National Health Service. On top of it, the practices varied from hospital to hospital, presumably because the supply levels of PPE were different, leaving the PHE advice in tatters.

There are other issues. A large number of elective procedures were cancelled or postponed³ as many surgeons, quite justifiably, were only offering life-saving operations. Conditions that we in the UK have been managing with emergency surgery for decades were managed non-operatively at the peak of the pandemic and procedures that would often be carried out as an emergency were deferred. This means that we now have a huge backlog of semi-urgent and elective surgeries to go through to prevent further suffering and even deaths.

But we work in a chronically stressed system where the only solution that our policymakers can think of to deal with bed crisis every winter is to stop elective surgery. Many of us did not do much elective surgical work (still working very hard though and doing things that don't always

Is COVID the end or just the beginning of a new era of surgical training?

Miss Niroshini Rajaretnam, Vice President of ASiT

The past six months have been a tumultuous time for our nation. Between lockdown measures, disease burden, mental health struggles, and of course the impact on job security, career progression and training – we continue to survive through this unpredictable time. As a result of this, the hot topic of course has been the disastrous effect of COVID-19 on our lives. However, it's important to remember that we are transitioning through this time together and WILL see the light at the end of this tunnel. Already, services are being restructured as we move into the recovery phase of the pandemic and measures are being taken to accommodate for potential second and third waves thus allowing the NHS to resume some of its regular business. This being said, it won't be for quite some time before we gain some stability in our working

need a surgeon and not what we trained for) last winter and nothing over the spring and the early summer. It should be possible to plan for it better in the interest of patients seeking this surgery; preservation of morale and the expertise of the surgical workforce; and quite frankly the loss in a financial sense. But that is a dream yet to materialise! Whether this winter will be any different, we will find out. But one thing is for certain - there is probably nobody fighting the corner of patients seeking so-called elective surgery (and surgeons) at the top of the healthcare decision making in this country.

References

1. COVIDSurg Collaborative. Mortality and pulmonary complications in patients undergoing surgery with perioperative SARS-CoV-2 infection: an international cohort study. *Lancet*. 2020; 396(10243): 27-38.
2. Zhan M, Qin Y, Xue X, Zhu S. Death from Covid-19 of 23 Health Care Workers in China. *N Engl J Med*. 2020; 382(23): 2267-2268.
3. COVIDSurg Collaborative. Elective surgery cancellations due to the COVID-19 pandemic: global predictive modelling to inform surgical recovery plans [published online ahead of print, 2020 May 12]. *Br J Surg*. 2020;10.1002/bjs.11746. doi:10.1002/bjs.11746

lives again and in the ways in which we deliver patient care. ASiT (Association of Surgeons in Training) is the largest surgical trainee body in the UK that represents and advocates for all surgical trainees from the different surgical subspecialties. The impact of COVID-19 has led to unforeseen consequences and as a result we have seen some key decisions made by the four main Royal Colleges and surgical governing bodies that have greatly influenced the future progression of surgical trainees in the current year.

The recruitment process for National Selection has probably thrown the biggest curveball this year leaving many promising candidates without a post for the upcoming August and October rotations. Being unable to host face-to-face interviews and run the standard circuit stations of variable skills, the subspecialty committees

ranked applicants deemed the best on self-assessment and application scores. A third of applicants were randomly selected to provide evidence of their scores but the process heavily relied upon probity of candidates in providing accurate assessments of their achievements. Not only has the recruitment process into surgical posts been heavily impacted, the number of posts available has also been reduced. Due to COVID, many trainees have been unable to progress onto further rotations, Out of Programme (OOP) interests, fellowships etc. resulting in fewer posts needing to be filled nationwide. Many trainees are left in limbo with their national and international post-CCT fellowships being cancelled or postponed, bringing into question what they do after they have completed national training. Do they take up locum consultant posts, staff grade posts or are left unemployed? For some, these options are yet to be determined but Training Programme Directors (TPDs) across the country are doing their best to ensure that no trainee or junior doctor is left bereft in such difficult circumstances.

Postponement of the MRCS and FRCS exams has also caused much turmoil and has had unfortunate consequences with the progression of trainees onto the next stages of their career. Suffice to say there is now a huge backlog of candidates wishing to sit their surgical exams which will put strain on the Royal Colleges into accommodating as many applicants as possible. Measures have already been taken to ensure for extra capacity at the next run of MRCS which is due to take place this autumn whilst ensuring the safety of the candidates and staff alike. The same consideration will undoubtedly be given to the Fellowship exam but further details will be released in due course.

For those not sitting an exam or are not at a major milestone in their training pathway, there is a state of limbo. From medical students up to senior trainees, there is a no-man's land where career progression and training has been on pause. Departments across the country are doing their best to ensure that training hasn't been too severely devastated but with the lack of regular elective activity, streamlining of services and dual-consultant operating, the impact of COVID has been greatly underestimated. All of the above as well as redeployment and the implementation of COVID rotas, means that as a trainee there is a level of anxiety that we will be playing catch up for some time in order to achieve those required benchmarks – the

rat race will be turned into a full on marathon with a not so clear finish line. However, with all this doom and gloom, there most certainly is a rainbow. The pandemic has made us consider how we function as trainees and how to adapt in unpredictable circumstances. We have seen an increase in collaborative research projects which has unified us in collecting high quality data that will be used to assess the impact that COVID has had on patient outcomes and also help inform future practice as well as allowed trainees to reflect on their academic interests. One such project that is specifically focussed on surgical training is COVID-STAR - a pan-specialty pan-grade collaborative project between ASiT and the 15 trainee surgical specialty associations that aims to measure the impact of the COVID-19 situation on UK surgical training. We have vowed to closely monitor the impact of COVID-19 on surgical trainees and their training. During and after the pandemic has settled, real-world data will be a powerful and essential tool to advocate for trainees and influence training during the recovery phase.

One such aspect we have already seen from this is a complete shift towards teleconferencing and webinars that have transformed our educational needs over the last few months. With applications such as Zoom, WebEx, Microsoft Teams and more – online lectures, meetings, conferences and presentations have continued to be delivered and have allowed for more productivity within the comfort of your own homes or at work. Although the social networking aspect of these gatherings is missed, there is no doubt that the use of virtual conferencing and webinars will continue in the future. Time management and overall costs have improved as there is no need to travel long distances to meetings and conferences thereby reducing time and money on commutes, study leave for whole days off no longer need to be taken, and multitasking in the background can also occur whilst having the webcam function in 'off' mode. We at ASiT have embraced this new era of web-based teaching by delivering a series of Spotlight sessions on topical issues throughout the pandemic which are available to view on our website, as well as having partnered with Proximie to create a fantastic online video library of educational resources for our members to access.





We will also be hosting virtual courses such as Essential Radiology for Surgeons and Core Training / Higher Surgical Training prep courses in due course.

Many trainees may have been redeployed during the COVID period into other specialties such as Respiratory and Acute Medicine but would have hopefully transitioned back into their base surgical specialties by now. Although redeployment and rota amendments were common for most of us, for some teams we did see a shift back to the old firm structure creating a sense of comradery and team bonding. The firm structure has been disbanded for many years in most hospital Trusts but many have favoured its return both from consultant and trainee perspectives. This support network has helped both juniors and seniors alike in sharing concerns, maintaining good mental health and also ensuring continuity in training. The sense of ownership within the team allows for higher surgical trainees to develop their mentorship skills fulfilling a pastoral role for their junior colleagues. Recognising the importance of mentorship in Surgery, ASiT has developed its Mentoring Scheme to help guide trainees during this volatile period in their career.

Finally, the declaration that the implementation of the new surgical curriculum will be delayed

Impact of COVID-19: recruitment to surgical training and progression

Dr Emily Durity, FY2 Trent Foundation School, BMA Local Negotiating Committee Junior Doctor Representative at Chesterfield Royal Hospital

Miss Tabitha Gana, ASGBI Affiliate Representative, ST6 Yorkshire and the Humber Deanery

The COVID-19 pandemic has significantly affected all facets of healthcare, there has been a massive restructuring in the delivery of care in a very short space of time. Emergency rotas were implemented across the UK with longer shift lengths and more unsociable hours to ensure adequate staffing levels around the clock. This was facilitated by the British Medical Association through temporary relaxation of the 2016 Terms and Conditions of Service¹. These changes combined with re-deployment of many doctors to different specialties presented challenges to all trainees.

As healthcare focused solely on the wave of COVID-19 patients, there has been a detrimental

until August 2021 has been well received by most. The initial plan was to roll out the new curriculum this coming August, however realistically this potentially would have been like adding fuel to an already chaotic fire. Sufficient training for trainees and trainers alike, appropriate induction, familiarisation with the new ISCP format including Multiple Consultant Reports (MCRs) and more would have been difficult to ensure during a time where job plans, workforce planning and restructuring of services are already in upheaval. The extra year allows for provisions to be made to ensure a smooth transition of trainees onto the new format of competency-based training rather than time-based, allowing surgical trainees to continue to complete Higher Surgical Training to the highest standard.

With all the disruption that has occurred over the last few months, we will continue to deal with the impact of COVID-19 for months to come... but we will deal with it together. No matter what grade or surgical subspecialty you are, ASiT will continue to support your needs and provide you with resources to get you through this exceptional time in your surgical training. We are one nation and will stand united to ensure that surgical training will be protected and delivered to the highest standards so that we in turn can deliver the best patient care possible.

impact on educational opportunities within surgical training. Operative competencies have been affected by the cancellation of elective theatre lists, dual consultant-led emergency theatre lists and the general lack of theatre time for trainees due to redeployment of staff and shortages. Cancellation and postponement of research, teaching, conferences, courses and conversion of outpatient clinic appointments to consultant-led telephone appointments, have also affected other educational opportunities.

There has been some consideration on training progression by Health Education England (HEE) and modifications have been made to ARCP outcomes to enable as many trainees as possible to progress to the next

stage in their training². However the requirements of CCT have not changed.

Application to surgical training programmes by medical graduates and foundation doctors have significantly declined in recent years³. The nature of their experiences during surgical placements is a significant deciding factor. There is good cause for concern on how the pandemic will affect prospective surgical trainees perspectives on the specialty and whether it may deter future applicants. Recruitment is influenced not only by increasing exposure, but also by having a positive outlook on surgical trainee's lifestyles and career prospects. Unfortunately the start of the pandemic cast a cloud over surgical trainees' achievements and progression.

In the wake of possibly the first peak of COVID-19, delivery of training is unlikely to return to traditional methods, and we must consider what the future holds for surgical training and how best to adjust to the new normal.

Rota development needs to be re-evaluated. The stress and burnout from frequently changing rota patterns during the first COVID-19 peak cannot be ignored, especially with the looming risk of future spikes in cases. It is important therefore that trainee input in rota development is sought, to improve work-life balance, morale and overall well-being.

Furthermore, it is absolutely necessary that theatre lists are more inclusive of surgical trainees whether we are in the midst of a pandemic or not. Ideally, dedicated training theatre lists should be established with a good case mix to optimise hands-on exposure³. Prospective applicants to the specialty need to see that they will be provided with every available opportunity for ongoing use and development of surgical skills. Afterall, it is what trainees signed up for. To further promote time in theatre, introducing more Allied Health Professionals into Surgical Departments will assist in reducing the burden of administrative tasks and general service provision. It will be important however to define their roles to ensure that they do not replace doctors but rather complement them⁴.

The quality of teaching and other educational opportunities is also important for prospective trainees. Online platforms are excellent tools for education and have been gaining popularity especially in light of the COVID-19 pandemic. They should be encouraged long-term for the

delivery of teaching sessions, multidisciplinary team meetings, webinars and courses especially as they are preferred in some ways. Not only does it importantly allow for social distancing but it is also often more convenient given trainees' busy schedules.

The current use of technology can be expanded to social media platforms such as Twitter and Facebook to showcase the surgical specialty and share learning materials. There also needs to be increased mentorship and involvement of medical students, foundation and core surgical trainees. Creation of a database of enthusiastic surgeons interested in mentoring will allow for networking and positive interaction to encourage interest in the career. There is growing evidence for simulation training⁵ which will benefit not only established trainees but also new recruits as it will provide the ability to develop and practice surgical skills outside of the operating theatre.

COVID-19 offers a fresh perspective on how surgical training and recruitment into the specialty can be improved. We have the chance to not only improve the lives of our hard-working surgical trainees but also show prospective trainees that surgery is the career for them and still has a lot to offer.

References

1. Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 -Joint Statement on the Application of Contractual Protections during the Pandemic.; 2020. <https://www.nhsemployers.org/-/media/Employers/Documents/Pay-and-reward/Junior-Doctors/Joint-statement-on-managing-rotas-NHS-Employers-and-BMA.f?la=en&hash=A91E5E8C448CEE795862F54877F20B7B2E587B4E>.
2. Supporting the COVID-19 Response: Enabling Progression at ARCP <https://www.hee.nhs.uk/sites/default/files/documents/Enabling%20Progression%20at%20ARCP%20-%202020-04-20.pdf> Published 2020. Accessed July 2, 2020
3. Bartlett J. Addressing the recruitment shortfall in surgery - How do we inspire the next generation? *Annals of Medicine and Surgery.* 2018;25:30-32. doi:10.1016/j.amsu.2017.11.024
4. Gokani VJ, Peckham-Cooper A, Bunting D, Beamish AJ, Williams A, Harries RL. The non-medical workforce and its role in surgical training: Consensus recommendations by the





Association of Surgeons in Training.
International Journal of Surgery. 2016;36:S14-S19.
doi:10.1016/j.ijssu.2016.09.090

5. Nagendran M, Gurusamy KS, Aggarwal R, Loizidou M, Davidson BR. Virtual reality training for surgical trainees in laparoscopic surgery. Cochrane Database of Systematic Reviews. August 2013. doi:10.1002/14651858.cd006575. pub3



#NotrainingtodayNosurgeonstomorrow

Surgical practice during COVID-19 – an Audit by FY1's

Rahim Akram, FY1 junior doctor, Sidra Hasan, FY1 junior doctor, Omar Desouky, FY1 junior doctor, Subba Rao Kanchustambam, Consultant HPB Surgeon), Royal Blackburn Teaching Hospital

Corresponding Author: Subba.kanchustambam@nhs.net

Introduction

Severe Acute Respiratory Syndrome Coronavirus-type 2 (SARS-CoV-2), an RNA virus, has been acknowledged to cause the 'Coronavirus Disease 2019' (Covid-19) following cases of pneumonia in Hubei Province in China (Zhu et al., 2020). Rapidly, this virus spread throughout the world and the World Health Organisation (WHO) was recently declared a pandemic on 11th March 2020 (Sohrabi et al., 2020).

Covid-19 has significantly impacted surgical practice, ranging from workforce and staffing issues, procedural prioritisation and surgical education. Scheduled surgeries were cancelled in order to increase surge capacity as well as avoiding the risk of patients' developing Covid-19 respiratory symptoms (Al-Jabir et al.).

We conducted an audit to assess how Covid-19 impacted our surgical practise at Royal Blackburn Hospital and how this has differed to pre-Covid times.

Methods and Materials

The peak of COVID-19 was thought to have occurred in the second week of April (IHME, 2020). Hence, surgical on-call lists from the 2nd week of April were selected from 2019 (Pre Covid-19) and 2020 (COVID-19). The data was extracted from the surgical on-call lists and discharge summaries. Data included hospital number, suspected pathology, management, outpatient management and length of hospital stay. Our local standard was 50% as this is the proportion of patients who previously underwent surgical intervention.

Results

Mean length of stay pre COVID-19 times was 13 days with 45% undergoing conservative management and 55% undergoing intervention. Whereas, the mean length of stay during COVID-19 was 5 days with 61% for conservative management and 39% undergoing intervention. Outpatient management entailed 15.6% of patients being followed-up in clinic with the remaining undergoing outpatient intervention in pre COVID-19 times. Whereas in COVID-19 times, 52.2% of patients were followed-up in clinic with the remaining undergoing outpatient intervention in COVID-19 times.

Discussion

COVID-19 is an unprecedented health crisis where people have adapted different ways to stay alive from this unknown virus. In doing so, people tried to hide the symptoms which otherwise would have made them rush to accident and emergency and avoid getting exposed to hospitals overwhelmed with COVID patients. Surgeons, trying to catch up with the rapidly changing guidelines, adapted a conservatism policy to active intervention. It was consequently recommended that those for conservative management during COVID-19, to compare their outcomes with pre-COVID times in terms of their readmissions/recurrence rates.

Additionally, we want to raise awareness to the public that common surgical conditions such as appendicitis/cholecystitis need urgent surgical review to prevent development of complications such as sepsis or perforation. This was done via posters in the Emergency Department, making literature available on the ELHT website and in hospital and for GPs to be aware of this in order to educate patients. Finally, we need to ensure full PPE is available for theatre staff to prevent risk of COVID-19 infection to both patient and staff.

In the era of the COVID-19 pandemic, health

care providers must implement standardised essential perioperative measures including the use of personal protective equipment to minimise disease transmission and avoid unwanted complications. For all interventions, patients need to be managed as COVID-19 patients until results are confirmed. Sadly, elective procedures are recommended to be postponed. Only urgent, lifesaving interventions and oncologic surgeries that are associated with worse outcome if delayed should be considered.

Conclusion

Bread and butter surgical emergencies were managed conservatively with shorter length of hospitalisation. Larger audit data is needed to look at the long term effects on COVID conservative approach towards surgical emergencies.

Al-Jabir, A., Kerwan, A., Nicola, M., Alsafi, Z., Khan, M., Sohrabi, C., O'Neill, N., Iosifidis, C., Griffin, M., Mathew, G. and Agha, R. 'Impact of the Coronavirus (COVID-19) pandemic on surgical practice - Part 1 (Review Article)', Int J Surg.

IHME (2020) IHME | COVID-19 Projections: IHME. Available at: <https://covid19.healthdata.org/>.

Sohrabi, C., Alsafi, Z., O'Neill, N., Khan, M., Kerwan, A., Al-Jabir, A., Iosifidis, C. and Agha, R. (2020) 'World Health Organization declares global emergency: A review of the 2019 novel coronavirus (COVID-19)', Int J Surg, pp. 71-6.

Zhu, N., Zhang, D., Wang, W., Li, X., Yang, B., Song, J., Zhao, X., Huang, B., Shi, W., Lu, R., Niu, P., Zhan, F., Ma, X., Wang, D., Xu, W., Wu, G., Gao, G. F. and Tan, W. (2020) 'A Novel Coronavirus from Patients with Pneumonia in China, 2019', N Engl J Med: Vol. 8, pp. 727-33.





BASO ~ The Association for Cancer Surgery presents the Cancer Surgeons “Surgical life” during the COVID-19 Pandemic

Dr Afsana Elanko, Director of Education and Mr Hassan Malik, President, BASO-ACS)

<https://baso.org.uk>

Cancer Surgery during COVID-19

A Pandemic is defined as “an epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people”¹. During the global pandemic we saw this increased mortality due to COVID-19 ripple through the different countries and continents of the world. The general public, healthcare systems and governments were unprepared for what was around the corner. We saw unprecedented demand placed on our healthcare systems and tried to accommodate the increased surge on hospitals by pooling healthcare professionals to deliver care for patients as the infections soared. The rapid global sharing of knowledge between healthcare professionals, governments and the general public became commonplace. This was aided through the integrated use of technology and social media. No matter how much preparation each country undertook, the impact of COVID-19 took its toll.

The ability of a system and organisations to work together on a common goal and respond to changes quickly as knowledge increased was the paramount factor in keeping the mortality low. There was a steep learning curve for governments, healthcare providers and the general public. However, the incidence of other diseases remained the same. Generally across the UK we saw a decrease in patients presenting to hospital with other illnesses. Elective surgery and screening for cancer, was curtailed. This was inevitable, but a collaborative and agile response from the profession led to the development of guidance that was rapidly adopted at point of delivery to ensure “safe” cancer surgery could be delivered during the pandemic². The ability to react to a pandemic has highlighted the importance in working across borders with colleagues globally is important. <https://baso.org.uk/news/excellence-award-for-dr-afsana-elanko.aspx>

As an organisation we always encourage further collaboration.

Experiences at the “coal face”

Personal Protection Equipment (PPE) is essential in reducing the risk of potential intra-hospital transmission of disease for both patients and the staff. This is especially important in cancer patients, who are at increased risk of contracting the corona virus due to the underlying disease and the immunosuppression associated with the treatment. Cancer services should continue to investigate, treat and deliver care to patients in equal capacity to the norm, but within a “Safe” practice framework³ whilst siphoning resources for the COVID-19 Pandemic⁴ in the eventuality of a second surge. This is imperative in reducing the secondary increased mortality due to missed diagnosis and treatment of cancer during the COVID-19 pandemic.

We saw that robust plans that took into account possible cancer service compromise, through staff or supply shortages, were able to deliver treatment using best evidence in a timely fashion to their patients. We saw the important role of weekly MDT meetings (these were conducted in many cases remotely) in order to decide and prioritise treatment for those patients most in need using best practice and clear communication to patients. Phased approaches, which took into account guidance from tumour specific societies, and were flexible enough to be adopted in different hospital trusts provided a robust deliver of cancer services. The main facets of such an approach included:

1. “Safe” emergency/urgent cancer surgery delivered with the following considerations where practicable:
 - a. Maintaining capacity to undertake cancer surgery for urgent cases at acute hospital sites. This was effective where the surgeons were involved in pooling theatre capacity, theatre lists and surgical teams to deliver cancer surgery.

b. Operational support from managers to allow clinician lead decision making for resource management and process development where cancer care, emergency surgery and COVID-19 response were balanced seem to have been the best practice to deliver cancers surgery/care during the pandemic

c. The Triage system to review cancer patients balancing COVID-19 risk and urgency was important in reducing adverse outcomes post surgery. During the pandemic, surgery was not recommended for patients with low chance of success or life prolongation. An example of a triage system to score Clinical priority:

Table 1: Categorising patients for surgical cancer treatment

Priority level	Categorisation
1a	Emergency - operation needed within 24 hours to save life. This should be undertaken on the acute site, as currently.
1b	Urgent - operation needed with 72 hours. This should be undertaken on the acute site, as currently.
2	Elective surgery with the expectation of cure, prioritised to: Surgery within 4 weeks to save life or prevent progression of disease beyond operability. This should be prioritized for phase 2 (below).
3	Elective surgery can be delayed for 10-12 weeks with no predicted negative outcome. This should be prioritized for recovery phase, depending on length of pandemic.

Table adapted from NHS England's Clinical guide for the management of non-coronavirus patients requiring acute treatment: Cancer 23 March 2020 Version 2⁵.

- d. Triage system was put into place to modify the cancer waiting time guidance in order to free up the NHS capacity to respond to the COVID-19 pandemic⁶.
- e. Co-morbidity and frailty was factored into decision-making and patients at highest risk of COVID related morbidity/mortality were managed at a “COVID-19 free” clean sites where practicable. We saw new data being published which was factored into making decisions (e.g. information being published was indicating 20% mortality for patients who develop post-operative COVID-19 pneumonia)⁷.
- f. We saw a consultant delivered service to reduce the number of people in theatres and thereby reducing the risk of transmission.
 2. Introduction of “Clean” COVID-19 free sites^{2,3} were used for surgical cancer cases. In some trusts these were identified as a separate pathways within the acute hospital and in other

cases as separate “Cancer Alliance hub” sites. Generic principles included the following:

- a. “Clean” ring-fenced site used to deliver well-coordinated cancer surgery for immediate and medium term during the pandemic. These sites were isolated from COVID-19 patients.
- b. Locations of clean sites were placed regionally to ensuring equality of cancer services for the public.
- c. COVID-19 screening of staff was essential to keep the site “COVID-19 free”.
- d. Screening and testing was carried out on all patients being admitted to and whilst at the designated COVID-19 free sites when screening capacity was increased.
- e. Patients being advised to self-isolate for 2 weeks before elective surgery.





f. Theatre and ward space were cleaned according to guidance and PPE was available. However guidance varied for individuals working in the same environment based on their job roles.

g. Post-operative major cancer surgery patients were advised to follow the social isolation advice as they fell in the high-risk category.

We did however see difficulties in delivery of Cancer services where Trusts deployed surgical staff to the frontline of COVID-19 response and no provision was made to maintain cancer surgery in a ring-fenced safe environment. Although throughout the pandemic great strides were made to protect NHS ventilator/ITU capacity, restrictions in access to elective HDU admissions have impacted upon delivery of complex cancer surgical care.

The above experience and lessons learnt cannot be underestimated and will be especially important if we see another second surge of cases so that mistakes are not repeated and we learn from good practice that maintained cancer services. BASO recognises the impact the pandemic has had on the Surgical teams during the pandemic on a personal and professional level. We acknowledge the Royal colleges have provided resources to support individuals through this time and we recommend that these resources are referred to moving forward too as the “new” norm of working and personal life develops.

The Surgical Virtual Conference in light of COVID-19

In order to support our colleagues, both senior and junior, we have set up our first Virtual BASO conference due to be hosted in November 2020. Further information can be found at:

BASO Virtual conference:
<https://baso.org.uk/baso~acs-conferences.aspx>

We recognise that colleagues, and especially trainees, have had reduced opportunities for presenting original research at international conferences so we are also including virtual oral and poster presentations for BASO awards and prizes. Abstract Submission is open and we urge you take the opportunity to take part in the BASO Virtual conference by submitting and abstract:

<https://baso.org.uk/baso~acs-conferences/baso-2020-conference/abstract-submissions.aspx>

We have had interest from other organisations regarding the logistics of a virtual conference and we are keen to support our colleagues, so please feel free to get in touch with BASO in relation to this or anything else we may help you with: admin@baso.org.uk At BASO we welcome all surgeons, trainees, researchers, nurses, healthcare professional and medical students with an interest in surgical oncology, in addition to any new and innovative collaborations.

References

1. Last JM, editor. A dictionary of epidemiology, 4th edition. New York: Oxford University Press; 2001.
2. https://baso.org.uk/media/99217/baso_guidance_for_cancer_surgery_9th_april_2020_v7.pdf
3. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0119-_Maintaining-cancer-services-_letter-to-trusts.pdf
4. Elanko A, Khan J, Hamady ZR, Malik H. 2020. ‘Cancer surgery sustainability in the light of COVID-19 pandemic’ European Journal of Surgical Oncology. vol. 46, no. 6, pp1174-1175
5. <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/specialty-guide-acute-treatment-cancer-23-march-2020.pdf>
6. <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/cancer-alliance-information-on-managing-cancer-referrals-19-march-2020.pdf>
7. [https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370\(20\)30075-4/fulltext](https://www.thelancet.com/journals/eclinm/article/PIIS2589-5370(20)30075-4/fulltext)



Dr Afsana Elanko and College Presidents



GMC Director at BASO Conference



Mr Hassan Malik, BASO ACS President



BASO Conference Parallel Session



BASO Conference Poster Session





Colorectal Surgery in the Covid-19 era – An Italian interview

Miss Nuha A Yassin
MBChB, MSc, FRCS, PhD
Consultant Colorectal Surgeon
United Kingdom

Interviewing

Professor Antonino Spinelli
MD, PhD, FASCRS
Professor of Surgery and Head of the Division of Colon and Rectal Surgery
Milan, Italy



The outbreak of the COVID-19 pandemic caused by the SARS-CoV2 viral infection has disrupted various aspects of life as we used to know it. The World Health Organisation declared the disease as a pandemic in March 2020, but the disruptions to services started a few weeks earlier. These disruptions were caused by the lack of knowledge associated with the virus itself, its clinical manifestations and management in addition to the lack of world-wide preparation for the major insult and burden on healthcare and economic systems.

In the UK, the government and department of health kept a watchful eye on the global pandemic and advice trickled through to the essential workers as we were all dealing with cases and making difficult decisions. Published guidance was emerging from various responsible bodies across the UK.

The ASGBI were at the forefront of this as were the Royal College of Surgeons and the Sub-Speciality organisations. For Colorectal Surgery, the ACPGBI published their guidance and updated it as the situation developed further. Variability in the impact on services across the various regions within the UK have been noted and discussed at the ASGBI's council meetings with our president, vice president and the regional representatives.

It is really important to note that Italy was initially one of the mostly badly affected countries with COVID-19 and its consequences. The UK were lagging behind Italy, and in hindsight, there are a lot of things we could have learnt from the Italian experience. The management of colorectal cancer and inflammatory bowel disease were

greatly affected. The advice was ever changing and the variability in practice meant that some centres were offering open surgery, whereas others were still offering laparoscopic and robotic surgery; primary anastomoses vs stomas; short course radiotherapy as a holding measure for rectal cancers vs primary surgery; more medical therapies and less surgery for IBD patients. The possibilities were endless depending on which advice was followed by the specific centres.

Now that we are more than four months down the line from the peak of the pandemic, it seems like a good idea to learn and re-learn from the Italian experience. Rather than quoting published guidelines that you are all very much familiar with, I thought this piece would be much more interesting if it was an interview with one of the very well-known Professors of Colorectal Surgery, Antonino Spinelli. I had the pleasure and honour of spending some fellowship time in Milan with Professor Spinelli some years ago at Humanitas Research Hospital and have learnt a vast amount from him. It is an honour to be able to interview him for the ASGBI e-journal.



Prof Spinelli, you are a great mentor and a dear friend, thank you ever so much for allowing us to conduct this short interview. I would like to start by asking you how you are all doing?

Have you or any colleagues you know been personally affected by the covid-19 virus - if yes, how was that experience?

I haven't been infected by SARS-CoV-2, however, one member of my team became ill because of COVID-19. He has a family with kids and had to self-quarantine in his own bedroom without getting into contact with the rest of the family. His symptoms were mostly respiratory, associated with fever, lack of taste and smell, it felt weird at first and then very annoying. For the first two weeks he told me he's been feeling very tired and was worried that he would have required further treatments in the hospital. Luckily, that wasn't the case and recovered in a few weeks. However, almost two months passed before his nasal swab turned negative. He was eager to come back to work and help his colleagues in those hard times. From my side, I understood I could represent a liability for my family, exposing it to a greater risk of infection, thus I temporarily moved out of my home and started living in a different location for the first three months of the pandemic.

How did the department deal with PPE, staff and patient safety issues?

As we were the first Western country to be hit by COVID-19, there weren't many info at the time and we weren't completely aware of what we were dealing with. My hospital started monitoring the COVID-19 outbreak situation since early January 2020 and started provisioning stocks of PPE. We have been lucky, as they were sufficient, however there have been moments when we feared that there would have been an immediate shortage. Checkpoints for temperature monitoring and rapid anamnesis were established at each Hospital entrance for patients and hospital employees. Covid clear pathways were put in place for the Emergency Department and for the remaining part of the hospital. Non-essential personnel was left working remotely. With the surge, several departments have been converted to COVID wards with negative pressure rooms and ICU capacity was expanded from the initial 25 to 60 beds. An important issue, especially for surgery, has been the dramatic

blood shortage due to fall in donations.

Did your department follow any national or international guidance? Was there any guidance from the various societies? Was the guidance changing with time or conflicting?

My Department was active in contributing to national and international guidelines. However, especially at the beginning of the pandemic, due to the scarcity and low quality of information, guidelines coming from different societies where conflicting and changed several times over the course of the pandemic.

You have a very busy and thriving colorectal unit with seven elective theatre lists a week, a lot of training and weekly research meetings. How was your elective Colorectal surgery affected by Covid-19? What about training juniors and conducting research?

The activity of the Division of Colon and Rectal surgery has been affected in the type of operations performed. Due to a regional decree, Humanitas University Hospital was designated as one of three oncologic hub for the Region of Lombardy. For this reason, only oncologic colorectal procedures have been performed during the pandemic. The number of oncologic colorectal surgeries over the past three months has been comparable to those of previous years and with the same results in terms of quality and 30-days complications. At the same time, the training activity for the residents has been reduced, although especially for earlier years. Residents in the last years of training had a key role in allowing staff rotation to preserve the activity in case of possible infection from SARS-CoV-2.

From an academic point of view, surgical research has been very active, as this new disease unveiled several questions that still require an answer. Our Department has been very active in this sense, with many different published papers in high ranking journals.





What do you think is the new norm for Colorectal Surgery - covid swabs, CT thorax, PPE, Airseal/ laparoscopy, 2 consultant operating? Etc.. What should we be doing?

In one word, the new norm for colorectal surgery is: screening. Testing patients with CT thorax + covid swabs ensure we operate safely on patients without risking the higher mortality risks present with COVID perioperative infections. There's no current need for staff reduction in the operating theatre, as well as for additional precautionary measures, if appropriate screening is performed. In case of emergency and unavailable rapid tests, full PPEs are mandatory.

What do you think you would you do differently if there's a second wave?

I think that with the means that we had at the time we did the best we could. Probably, in case of a second wave, we would act faster to enforce all the precautionary measures that we learned to be effective during these months.



Do you have any final advice for us?

The fight is not over. We know more about COVID-19 but still not enough. The guard should be kept high and transparent information should continue to be shared globally, as we are all together in this pandemic and all together we'll come out of it.

Thank you once again for your time, Prof Spinelli and for sharing your pearls of wisdom. We wish you, your family and your team all the best.

COVID-19 A pandemic during a pandemic. The impact on bariatric surgery

Sulaiman Almazeedi^{3*}, Khaled Alyaqouti^{2*}, Ali Lairy^{1*}, Salman Al-Sabahi², Evangelos Efthimiou^{1,2}

1 Chelsea and Westminster Hospital, Department of Bariatric and Metabolic Surgery, London, UK

2 Imperial College London

3 Jaber Al-Ahmad Al-Sabah Hospital, Kuwait

* Sulaiman Almazeedi, Ali Lairy and Khaled Alyaqout have contributed equally to this work.

Corresponding Author: Ali Lairy Email: Ali.lairy@gmail.com

Introduction

COVID-19 reached pandemic proportions rapidly and stressed health care systems across the world. Countries were forced in lockdown to protect health care systems from becoming overwhelmed. Hospitals filled rapidly with high numbers of infected patients and ITU capabilities had to expand to accommodate the increasing numbers of infected patients needing mechanical ventilation and ITU support. Elective surgical procedures were immediately suspended with surgery restricted to emergency cases only. Worldwide obesity was already a pandemic and as bariatric surgery was also suspended millions of obese patients were left unable to access bariatric surgery.

COVID-19 Impact on Surgery in General

Multiple operating theater protocols were implemented globally in an effort to reduce viral transmission¹. This has led to longer turnover times², limited number of theater rooms available for surgery with subsequent reduction in the number of elective cases performed each day. The redeployment of staff to attend to COVID-19 patients created a shortage in both anesthetists and nurses available for elective surgery. Surgeons were not spared, and many assisted outside their field of expertise³. Hospitals were challenged by a depletion in personal protective equipment (PPE) and essential intensive care unit (ICU) drugs^{4,5}, and consequently non-urgent and elective non-oncological procedures had to be postponed. Additionally, scarcity of ICU resources and blood products will likely further prolong the delay of elective surgeries⁶. The risks of operating on an asymptomatic patient are also becoming increasingly worrisome. In a retrospective cohort conducted in Wuhan City, over 50% of patients received ICU care following an operation. The authors observed a 9 folds increase in the case-fatality rate of COVID-19 amongst these

patients⁷. Another study involving 1128 COVID patients concluded that the thresholds to operate during the pandemic should be higher, as even minor elective procedures were found to have increased mortality when compared to the pre-pandemic baseline⁸. Not only does surgery predispose patients to higher morbidity and mortality, but also exposes the healthcare workers to risk of infection.

COVID-19 Impact on Bariatric Surgery

There is no doubt the effect of COVID 19 on bariatric surgery is multidimensional. Since the beginning of the pandemic, a number of bariatric operative triaging systems were created. For example, the American College of Surgeons restricted surgery to urgent and emergent cases only⁹. This may be justified by the fact that obese patients are in a chronic inflammatory status, with comorbidities that are associated with considerable operative morbidity and mortality in a COVID-19 environment¹⁰. In addition, laparoscopy, with the debatable higher contagion rate, remains the best option for these patients in terms of operative ergonomics, patient mortality, and in-hospital stay¹⁰.

Another aspect that was affected were the outpatient clinics. There has been a global shift from face-to-face outpatient visits to telemedicine and virtual clinics. In the United Kingdom (UK), for example, the National Health Service (NHS) implemented a number of regulations to facilitate their usage and thus reduce the risk of cross-infection between healthcare workers and patients³. These virtual modalities help bariatric teams maintain adequate follow-up and proper engagement with their patients. Furthermore, it serves as a tool to decide if a face-to-face visit is warranted.

The bariatric team dynamics was not spared from these changes, with multidisciplinary





meetings having to comply with the governmental social distancing regulations. This necessitated the implementation of virtual meetings on web-based platforms¹¹. Finally, surgical training has been affected greatly, with Bernardi et al. demonstrating that residents performed significantly fewer procedures during the pandemic. This was also true for emergency cases, where to limit the risk of transmission, operations were performed by consultants rather than trainees. Furthermore, due to the lockdown rules, patients present with more advanced disease, which would necessitate consultant driven involvement¹². Al-Jabir et al. noted in his review that surgical training in the United States of America (USA) and the UK was affected, and the bodies governing the training will take into consideration the reduced exposure to surgeries and operating time due to the pandemic³.

COVID-19 Psychosocial Impact on Bariatric Patients

One of the major social impacts the COVID-19 pandemic had was the government-imposed curfews and lockdowns. In an effort to control the spread of the disease, these measures will unfortunately have detrimental effects on both the psychological wellbeing and lifestyle behavior of people. A few papers have highlighted this subject and point out these curfews limit the physical activity of the population and increase the overall stress levels, both considered risk factors for obesity¹³. Two studies from Italy, a country hit hard and early by COVID-19, observed the effect of the pandemic on eating habits and body weight^{14,15}. In the paper by Pietrobelli et al., the authors looked specifically at the eating habits of obese children and adolescents during the pandemic and found a significant increase in high-calorie food consumption, sleep and screen time, with a reduction in physical activity¹⁴. A more extensive study surveying 3,533 people in Italy during the COVID-19 pandemic found 48.6% of the population perceived an increase in their weight, and 17.7% felt a change in their perception of hunger and satiety¹⁵.

COVID-19 Impact on the Obese Population

The aforementioned effects of COVID-19 lockdown measures on population lifestyles could lead to an increase in obesity levels, which in turn may lead to further disease impact. Many studies today have shown a worse outcome in patients infected with COVID-19 with a high

BMI^{16,17,18,19,20}. In a study from France, the prevalence of obesity was 1.35 times higher in the severe COVID-19 group compared to the general population ($p=0.0034$) after controlling for age and sex¹⁶. Data from the USA also shows similar findings, with patients of BMI greater than 30 kg/m² having an increased risk of intensive care unit (ICU) admission²⁰, and those with BMI > 35 kg/m² more likely to require oxygenation and intubation¹⁸. In addition, a study by Simonnet et al. found that patients with BMI > 35 kg/m² were seven times more likely to require invasive mechanical ventilation compared to those with BMI < 25 kg/m² (odds ratio (OR) 7.36 [1.63-33.14] $P=0.02$)¹⁹. Finally, a study from China looking at 383 consecutive patients hospitalized for COVID-19 and stratified by BMI found that overweight patients were 1.84 times more likely to develop severe COVID-19 (OR 1.84 [0.99–3.43] $P=0.05$), while obese patients were 3.40 times more likely of developing severe disease (OR 3.40 [1.40–2.86] $P=0.007$)¹⁷.

Transitioning to the next phase

As with all the other medical specialties, bariatric surgery also had to adapt during the COVID-19 outbreak. Bariatric bodies around the world have developed guidelines on how and when to start bariatric surgery. It is inevitable different surgical specialties will have to compete for scarcely available resources^{10,21}. Prachand et al. proposed a scoring system that claims to put all surgical specialties on a level playing field. Moreover, the scoring system can be used to further categorize patients within a specific specialty according to their risk²¹.

Setting the Priorities

The safety of patients should be the highest priority, as the population affected by metabolic syndrome treated by bariatric surgery is also the most susceptible to the complications of COVID-19^{10,21-22}. There is no one-size-fits-all solution to restarting bariatric surgery in different centres, as each region will have its own specific challenges to overcome. This is evident by the spectrum of opinions of different bariatric bodies, which range from suggesting postponing bariatric surgery until the pandemic is over, to calling for the restart of bariatric surgery as soon as it is safe to do so^{23,24}.

Perhaps one of the most difficult and controversial decisions to make is which patients to prioritise. This controversy is reflected in the different approaches the bariatric bodies adopted. For example, the Kuwait Association of Surgeons recommends giving priority to the low-risk group when first starting while The Diabetes Surgery Summit statement suggests that the patients with complications and patients pending surgery who require pre-operative weight loss should be prioritized¹⁰. Due to the lack of data to guide such decisions, The British Obesity & Metabolic Surgery Society suggested that bariatric surgery should start cautiously with limited numbers and the decision on which patients to prioritize to be taken by the multidisciplinary teams and according to the available hospital resources. The collection of near-real time data should be mandatory to help make data-driven decisions²². Finally, once the eligibility criteria are determined, it may be necessary to construct a dedicated COVID-19 surgical pathway for bariatric surgery. We can see that in the work of Angrisani et al., where they established a scholarly protocol for bariatric surgery in the context of COVID-19" (Figure 1).

Conclusion and Recommendations

As the world faces an increasing number of cases of COVID-19, the medical community is slowly beginning to understand the nature and behavior of this novel disease. New research into the effects of this virus on the physical health of patients and its impact on social, psychological and lifestyle behaviour are suggesting that this pandemic within the obesity pandemic will take years to control.

It is unfortunate that the people who were faced with a decreased quality of life as a result of the obesity and needed bariatric surgery are also the most vulnerable group to suffer the devastating effects of COVID-19.

As the majority of the elective bariatric procedures have now been put on hold due to COVID-19, the higher fatal outcomes in infected patients with obesity and the risk-benefit ratio of any delay in bariatric surgery must be put into perspective to avoid further harm.

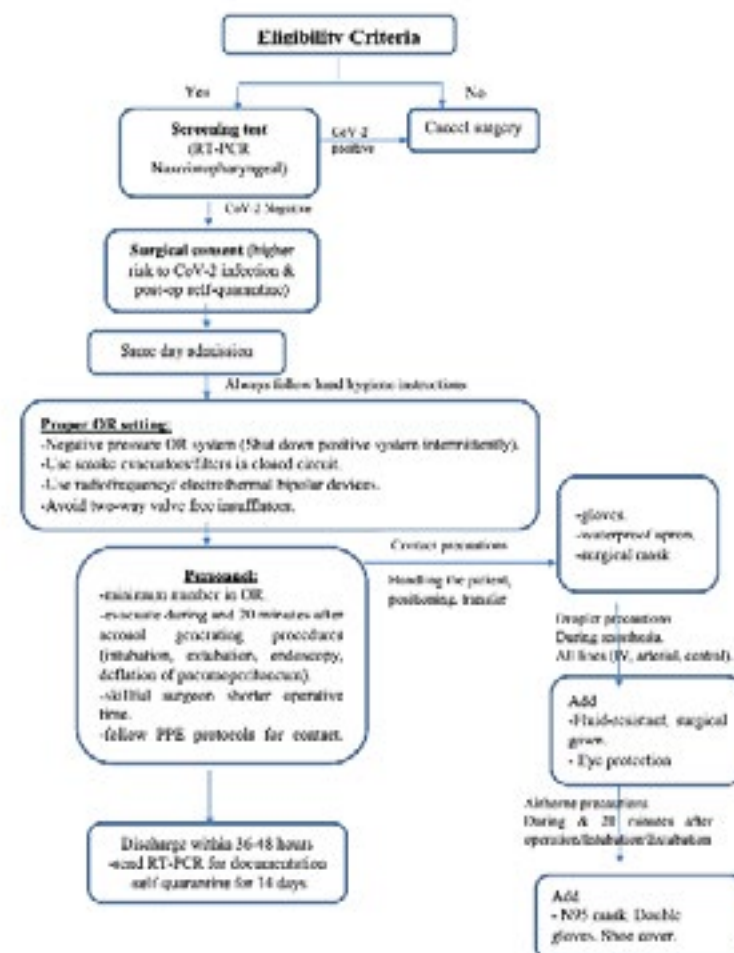


Figure 1: Protocol to restart performing elective bariatric and metabolic surgery after the peak of the COVID-19 pandemic.





References

1. Hojajj FC, Chinelatto LA, Boog GHP, Kasmirski JA, Lopes JVZ, Sacramento FM (2020) Surgical Practice in the Current COVID-19 Pandemic: A Rapid Systematic Review. Clinics. doi: 10.6061/clinics/2020/e1923
2. Wong J, Goh QY, Tan Z, Lie SA, Tay YC, Ng SY, Soh CR (2020) Preparing for a COVID-19 pandemic: a review of operating room outbreak response measures in a large tertiary hospital in Singapore. Canadian Journal of Anesthesia/Journal canadien danesthésie 67:732–745
3. Al-Jabir A, Kerwan A, Nicola M, et al (2020) Impact of the Coronavirus (COVID-19) pandemic on surgical practice - Part 1. International Journal of Surgery 79:168–179
4. Paraiso MFR, Brown J, Abrão MS, Dionisi H, Rosenfield RB, Lee TT, Lemos N (2020) Surgical and Clinical Reactivation for Elective Procedures during the COVID Era: A Global Perspective. Journal of Minimally Invasive Gynecology. doi: 10.1016/j.jmig.2020.05.012
5. Siow WT, Tang SH, Agrawal RV, Tan AYH, See KC (2020) Essential ICU drug shortages for COVID-19: what can frontline clinicians do? Critical Care. doi: 10.1186/s13054-020-02971-x
6. Maintaining a safe and adequate blood supply during the pandemic outbreak of coronavirus disease (COVID-19). In: World Health Organization. [https://www.who.int/publications/i/item/maintaining-a-safe-and-adequate-blood-supply-during-the-pandemic-outbreak-of-coronavirus-disease-\(covid-19\)](https://www.who.int/publications/i/item/maintaining-a-safe-and-adequate-blood-supply-during-the-pandemic-outbreak-of-coronavirus-disease-(covid-19)). Accessed 28 Jun 2020
7. Lei S, Jiang F, Su W, et al (2020) Clinical characteristics and outcomes of patients undergoing surgeries during the incubation period of COVID-19 infection. EClinicalMedicine 21:100331
8. Archer JE, Odeh A, Ereidge S, et al (2020) Mortality and pulmonary complications in patients undergoing surgery with perioperative SARS-CoV-2 infection: an international cohort study. The Lancet. doi: 10.1016/s0140-6736(20)31182-x
9. Online March 24 2020 COVID-19 Guidelines for Triage of Metabolic and Bariatric Surgery Patients. In: American College of Surgeons. <https://www.facs.org/covid-19/clinical-guidance/elective-case/metabolic-bariatric>. Accessed 28 Jun 2020
10. Rubino F, Cohen RV, Mingrone G, et al (2020) Bariatric and metabolic surgery during and after the COVID-19 pandemic: DSS recommendations for management of surgical candidates and postoperative patients and prioritisation of access to surgery. The Lancet Diabetes & Endocrinology 8:640–648
11. Lindeman R-J, Sund M, Löfgren J, Basso T, Søreide K (2020) Preventing spread of SARS-CoV-2 and preparing for the COVID-19 outbreak in the surgical department: perspectives from two Scandinavian countries. Journal of Surgical Case Reports. doi: 10.1093/jscr/rjaa131
12. Bernardi L, Germani P, Zotto GD, Scotton G, Manzini ND (2020) Impact of COVID-19 pandemic on general surgery training program: An Italian experience. The American Journal of Surgery. doi: 10.1016/j.amjsurg.2020.06.010
13. Abbas AM, Fathy SK, Fawzy AT, Salem AS, Shawky MS (2020) The mutual effects of COVID-19 and obesity. Obesity Medicine 19:100250
14. Pietrobelli A, Pecoraro L, Ferruzzi A, Heo M, Faith M, Zoller T, Antoniazzi F, Piacentini G, Fearnbach SN, Heymsfield SB (2020) Effects of COVID-19 Lockdown on Lifestyle Behaviors in Children with Obesity Living in Verona, Italy: A Longitudinal Study. Obesity. doi: 10.1002/oby.22861
15. Renzo LD, Gualtieri P, Pivari F, et al (2020) Eating habits and lifestyle changes during COVID-19 lockdown: an Italian survey. Journal of Translational Medicine. doi: 10.1186/s12967-020-02399-5
16. Caussy C, Pattou F, Wallet F, et al (2020) Prevalence of obesity among adult inpatients with COVID-19 in France. The Lancet Diabetes & Endocrinology 8:562–564
17. Cai Q, Chen F, Wang T, et al (2020) Obesity and COVID-19 Severity in a Designated Hospital in Shenzhen, China. Diabetes Care 43:1392–1398
18. Palaodimos L, Kokkinidis DG, Li W, Karamanis D, Ognibene J, Arora S, Southern WN, Mantzoros CS (2020) Severe obesity, increasing age and male sex are independently associated with worse in-hospital outcomes, and higher in-hospital mortality, in a cohort of patients with COVID-19 in the Bronx, New York. Metabolism 108:154262
19. Simonnet A, Chetboun M, Poissy J, et al (2020) High Prevalence of Obesity in Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV-2) Requiring Invasive Mechanical Ventilation. Obesity 28:1195–1199
20. Lighter J, Phillips M, Hochman S, Sterling S, Johnson D, Francois F, Stachel A (2020) Obesity in Patients Younger Than 60 Years Is a Risk Factor for COVID-19 Hospital Admission. Clinical Infectious Diseases. doi: 10.1093/cid/ciaa415
21. Prachand VN, Milner R, Angelos P, Posner MC, Fung JJ, Agrawal N, Jeevanandam V, Matthews JB (2020) Medically Necessary, Time-Sensitive Procedures: Scoring System to Ethically and Efficiently Manage Resource Scarcity and Provider Risk During the COVID-19 Pandemic. Journal of the American College of Surgeons. doi: 10.1016/j.jamcollsurg.2020.04.011
22. (2020) Reintroducing safe bariatric surgery. In: bomss.org.uk. https://www.bomss.org.uk/wp-content/uploads/2020/06/BOMSS-Restarting-Bariatric-Surgery-in-the-COVID-Era-Guidelines_May-2020.pdf. Accessed 28 Jun 2020
23. Yang W, Wang C, Shikora S, Kow L (2020) Recommendations for Metabolic and Bariatric Surgery During the COVID-19 Pandemic from IFSO. Obesity Surgery 30:2071–2073
24. (2020) Safer through surgery: American Society for Metabolic and Bariatric Surgery statement regarding metabolic and bariatric surgery during the COVID-19 pandemic. Surgery for Obesity and Related Diseases. doi: 10.1016/j.soard.2020.06.003
25. Return to Elective Surgery. In: Kuwait Association of Surgeons. <http://kas.org.kw/covid-19.html>. Accessed 28 Jun 2020
26. Luigi Angrisani, Nesreen Khidir, Gerhard Prager, Juan Pujol Rafols, Michel Suter, et al. (2020) How are We Going to Restart Elective Bariatric and Metabolic Surgery after the

Surgical research in the COVID-19 pandemic

Nicola C Quinnen, Seema Yalamanchili, and Christopher J Peters

On behalf of the The PanSurg Collaborative

Department of Surgery and Cancer, Imperial College London

Corresponding author: Mr Christopher J Peters Email: christopher.peters@imperial.ac.uk

Introduction

Though not initially considered a surgical disease, COVID-19 has undoubtedly had a profound impact on surgical patients, operating teams and surgical units. The swift and deadly spread of SARS-CoV-2, a hitherto unknown virus, has created substantial demand for emerging knowledge to arm the global community attempting to address the pandemic. This includes the surgical fraternity, which has mobilised to gather evidence informing new surgical ‘best practice’ and health service policy. We present an overview of such research pertaining to the realms of the surgical patient, operative safety, surgical services and the workforce

COVID-19 & Surgical Patients

The cessation of elective surgery has frequently been mandated to reduce exposure risk and preserve resources, including ventilators and staff.

Necessary emergency surgery has continued in ‘hot’ zones and in some cases elective surgery has continued where ‘cold’ centres have been established away from outbreak epicentres. Observational studies of surgical patients from countries caught in the initial wave, such as China, together with global collaborative studies, which largely take data from Europe and the US, have suggested that patients with COVID-19 in the perioperative period have up to 50% risk of pulmonary complications and greater mortality, particularly if male, aged 70 or comorbid¹⁻³. However, these studies have not explored relationships with risk factors such as ethnicity. A number of national and international collaborative cohort studies (figure 1) are ongoing and intend to look further at surgical outcomes as many countries move to systematically reinstate elective practice^{4,5}. This work will look to build risk prediction models for surgery in patients with COVID-19⁴.

Figure 1- Research collaborations quantifying the effect of COVID19 on surgery





Although emergency surgery has continued, practice has been modified to increase non-operative management where possible and use damage control approaches when operations cannot be avoided. Retrospective analyses of emergency general surgical cases are now evaluating these practices through both systematic review and cohort studies⁶⁻⁸. Similarly, as wider medical research reveals the multisystem complications of SARS-CoV2, surgical specialties, including neurosurgery, orthopaedics, plastics, transplant and vascular surgery, are each conducting similar observational studies to assess how COVID-19 impacts patients with specific surgical pathologies with varying demographic profiles⁹. The first raft of these studies particularly focus on emergency pathology, including hip fractures, neurosurgical emergencies, burns and reconstruction, with work on the cancer cohort only more recently underway. Meanwhile, where data is pending, expert consensus studies have been used to inform guidelines on how surgeons should proceed in the interim¹⁰.

Reconfiguration of Surgical Services

In parallel with observational work, researchers have also undertaken modelling of delays and persistent reductions in diagnostic and therapeutic pathways in a number of surgical pathologies¹¹⁻¹³. Perhaps the most widely reported of these in the UK setting explores the impact on cancer surgery and suggest a significant impact on survival with a 19% and 43% reduction in life years gained for those with a 3 or 6 month delay to surgery respectively. It has therefore become imperative to reinstate all aspects of surgical services, which will also need to be resilient to future resurgence of COVID-19¹¹.

Such modelling and learning from countries hit early in the year, has driven service reorganization whereby workload is shared across sites, with some designated as 'hot' to receive emergency and potentially COVID-19 positive patients, and others tasked with working through the backlog of operations to be performed. Inevitably models have a degree of error through assumptions made and limited knowledge available but as further data become available, models will need to be modified to continue to inform service reorganisation. Surgeons must therefore continue to contribute to such work to ensure that predictions generated are as well informed and practically

useful as possible.

Optimisation of Surgical Safety

Healthcare workers are at increased risk of viral exposure from aerosol generating procedures (AGPs). Whilst initially surgery other than tracheostomy and that employing power tools was not considered an AGP, such guidelines were based on severe acute and Middle Eastern respiratory syndromes (SARS and MERS)¹⁴. By contrast SARS-CoV2 has been found to be more transmissible and severe¹⁵. Therefore early guidelines from surgical colleges and societies advised caution in the operating theatre^{16,17}.

However, reports during the pandemic have identified detectable viral load in blood, saliva, stool, urine and peritoneal fluid¹⁸⁻²². Such detection is variable, and not necessarily a function of how symptomatic patients are or how much viral load is present in respiratory secretions. Moreover detection methods to identify virus particles have varied performance, further hindering delineation of virus exposure from body fluids and surgical procedures. Despite some investigation, there remains limited evidence to definitively quantify the risk of SARS-CoV2 transmission by smoke from energy devices^{23,24}. This has added weight to deferring operative intervention where possible and using stringent testing, minimizing staff numbers in theatre and PPE protocols where surgery is unavoidable.

Endoscopy and laparoscopy have also been considered increased risk through aerosol generation, however the consensus is that given the aforementioned need for diagnostics and the reduced length of admission from laparoscopy, cases should be considered on an individual basis^{16,17}. Devices such as smoke filters have also been employed but surgical technologists are still to fully evaluate their efficacy in the context of COVID-19.

Surgical teams must also consider intersectional research on COVID-19 which describes important factors such as length of virus survival on surfaces and increased risk in particular demographic groups, including those who are older, comorbid or BAME. Such data can underpin procedures for theatre procedure, staff risk assessment and service planning.

Maintaining the Surgical Workforce

During the peak of the coronavirus outbreak, many surgical staff, particularly juniors, were redeployed to other specialties with increased demands in delivering direct care to those critically ill with coronavirus. The protracted exposure to a high stress and emotionally demanding environment, particularly during public health crises increase risk of anxiety, depression, burnout and PTSD²⁵. This has been found to be the case during this pandemic, as has been identified by a number of studies investigating mental health in the surgical workforce. Redeployment and poor emotional support structures in particular increased risk of poor mental health outcomes²⁶⁻²⁸.

As junior surgeons return to training, further

difficulties await with the reduction in elective practice, restriction of personnel in theatres and restructuring within hospital networks - all diminishing opportunities for learning (figure 2). A scoping review of pandemic-related impact on surgical training in the UK, North America and Australasia concluded surgical training bodies were attempting to respond flexibly to trainees needs but that the pandemic has also exposed continued reliance on time-based training and the weaknesses in existing recruitment systems²⁹. There is therefore an increased risk of losing trainees if functional support is not put in place. Further study of the progress of the 'COVID cohort' of trainees is underway, to assess the true impact on surgical training as this generation moves through different phases of the pandemic^{30,31}.

Figure 2- Reported Factors Impacting Surgical Training



Conclusions

Much of the surgical research published to date with respect to COVID-19 takes the form of reports of local experience, case reports and observational studies from countries particularly effected early in 2020, including China, Italy, Spain and the UK. Taken together with experiences from previous health crises, including SARS, and expert opinion, they have informed the current guidelines from various surgical bodies.

However such crises involve many unknowns, and preclude the design and execution of high quality trials in the initial emergency phase. Publishing entities have had to offset standards in study quality for rapid review and dissemination via social media channels to ensure basic insights are delivered to frontline surgeons desperately trying to adapt.





Traditional systematic review has struggled to cope with the heterogeneity and volume of output online.

At this point, many more in depth studies are still underway, and in time, the emphasis must shift to more high quality evidence to justify surgical decision making. Research must provide clearer understanding of how SARS-CoV2 has impacted surgery to date, but also drive the innovation required to overcome the unprecedented challenges we now face as a specialty.

References

1. Lei S, Jiang F, Su W, et al. Clinical characteristics and outcomes of patients undergoing surgeries during the incubation period of COVID-19 infection. *Eclinicalmedicine*. 2020 Apr;100331. DOI: 10.1016/j.eclinm.2020.100331.
2. Doglietto F, Vezzoli M, Gheza F, et al. Factors Associated With Surgical Mortality and Complications Among Patients With and Without Coronavirus Disease 2019 (COVID-19) in Italy [published online ahead of print, 2020 Jun 12]. *JAMA Surg*. 2020;10.1001/jamasurg.2020.2713. doi:10.1001/jamasurg.2020.2713
3. COVIDSurg Collaborative. (2020). Mortality and Pulmonary Complications in Patients Undergoing Surgery With Perioperative SARS-CoV-2 Infection: An International Cohort Study. *The Lancet* [https://doi.org/10.1016/S0140-6736\(20\)31182-X](https://doi.org/10.1016/S0140-6736(20)31182-X)
4. PanSurg PREDICT available to access at <https://www.pansurg.org/predict/>
5. COVIDSurg Cancer available to access at <https://globalsurg.org/covidsurg/>
6. De Simone B, Chouillard E, Di Saverio S, et al. Emergency surgery during the COVID-19 pandemic: what you need to know for practice. *Ann R Coll Surg Engl*. 2020;102(5):323-332. doi:10.1308/rcsann.2020.0097
7. Children with Appendicitis during the CoronAvirus panDEmic (CASCADE) available to access at <https://www.rcseng.ac.uk/coronavirus/rcs-covid-research-group/>
8. HAREM Steering Group. The HAREM (Had Appendicitis and Resolved/Recurrent Emergency Morbidity/Mortality) Study. *Br J Surg*. 2020;107(8):e257. doi:10.1002/bjs.11711
9. Royal College of Surgeons of England COVID Research available at <https://www.rcseng.ac.uk/coronavirus/rcs-covid-research-group/>
10. Welsh Surgical Research Initiative (WSRI) Collaborative. Surgery during the COVID-19 pandemic: operating room suggestions from an international Delphi process [published online ahead of print, 2020 May 12]. *Br J Surg*. 2020;10.1002/bjs.11747. doi:10.1002/bjs.11747
11. Sud A, Jones ME, Broggio J, et al. Collateral damage: the impact on cancer outcomes of the COVID-19 pandemic. *medRxiv*; 2020. DOI: 10.1101/2020.04.21.20073833.
12. Smeds MR, Siddiqui S. Proposed resumption of surgery algorithm after the coronavirus SARS-CoV-2 pandemic [published online ahead of print, 2020 May 23]. *J Vasc Surg*. 2020;S0741-5214(20)31279-9. doi:10.1016/j.jvs.2020.05.024
13. COVIDSurg Collaborative. Elective surgery cancellations due to the COVID-19 pandemic: global predictive modelling to inform surgical recovery plans [published online ahead of print, 2020 May 12]. *Br J Surg*. 2020;10.1002/bjs.11746. doi:10.1002/bjs.11746
14. Public Health England COVID-19: personal protective equipment use for aerosol generating procedures (10th January 2020) Available to access at <https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures>
15. Swerdlow DL, Finelli L. Preparation for possible sustained transmission of 2019 novel coronavirus: lessons from previous epidemics. *JAMA*. 2020;323(12):1129–1130.
16. Royal College of Surgeons of England Guidance for surgeons working during the COVID-19 pandemic (20th March 2020) Available to access at <https://www.rcseng.ac.uk/coronavirus/joint-guidance-for-surgeons-v1/>
17. SAGES & EAES Recommendations Regarding Surgical Response to COVID-19 Crisis (30th March 2020) Available to access at <https://www.sages.org/recommendations-surgical-response-covid-19/>
18. Chen W, Lan Y, Yuan X, et al. Detectable 2019-nCoV viral RNA in blood is a strong indicator for the further clinical severity. *Emerg Microbes Infect*. 2020;9(1):469–473.
19. To KK, Tsang OT, Leung WS, et al. Temporal profiles of viral load in posterior oropharyngeal saliva samples and serum antibody responses during infection by SARS-CoV-2: an observational cohort study. *Lancet Infect Dis*. 2020;S1473-3099(20):30196
20. Cheung KS, Hung IFN, Chan PPY, et al. Gastrointestinal Manifestations of SARS-CoV-2 Infection and Virus Load in Fecal Samples From a Hong Kong Cohort: Systematic Review and Meta-analysis [published online ahead of print, 2020 Apr 3]. *Gastroenterology*. 2020;S0016-5085(20)30448-0. doi:10.1053/j.gastro.2020.03.065
21. Sun J, Zhu A, Li H, et al. Isolation of infectious SARS-CoV-2 from urine of a COVID-19 patient. *Emerg Microbes Infect*. 2020;9(1):991-993. doi:10.1080/22221751.2020.1760144
22. Coccolini F, Tartaglia D, Puglisi A et al SARS-CoV-2 is present in peritoneal fluid in COVID-19 patients *Annals of Surgery* Publish Ahead of Print at <https://journals.lww.com/annalsofsurgery/Documents/SARS-CoV-2%20is%20present%20in%20peritoneal%20fluid%20in%20COVID-19%20patients.pdf>
23. Mowbray NG, Ansell J, Horwood J, et al. Safe management of surgical smoke in the age of COVID-19 [published online ahead of print, 2020 May 3]. *Br J Surg*. 2020;10.1002/bjs.11679. doi:10.1002/bjs.11679
24. Zakka, Kimberley*; Erridge, Simon MBBS, BSc*; Chidambaram, Swathikan*; Kynoch, Michael*; Kinross, James*; Purkayastha, Sanjay* on behalf of the PanSurg collaborative group Electrocautery, Diathermy, and Surgical Energy Devices, *Annals of Surgery*: June 09, 2020 - Volume Publish Ahead of Print - Issue - doi: 10.1097/SLA.00000000000004112
25. Goldmann E, Galea S. Mental health consequences of disasters. *Annu Rev Public Health*. 2014;35:169-183. doi:10.1146/annurev-publhealth-032013-182435
26. PanSurg SSAFE available to access at <https://www.pansurg.org/ssafe>
27. Balasubramanian, A, Paleri, V, Bennett, R, Paleri, V. Impact of COVID-19 on the mental health of surgeons and coping strategies. *Head & Neck*. 2020; 42: 1638– 1644. <https://doi.org/10.1002/hed.26291>
28. Lai J, Ma S, Wang Y, et al. Factors Associated With Mental Health Outcomes Among Health Care Workers Exposed to Coronavirus Disease 2019. *JAMA Netw Open*. 2020;3(3):e203976. Published 2020 Mar 2. doi:10.1001/jamanetworkopen.2020.3976
29. James DHK, Pattison MGTR. Disruption to surgical training during Covid-19 in the United States, United Kingdom, Canada and Australasia: a rapid review of impact and mitigation efforts [published online ahead of print, 2020 Jun 25]. *J Surg Educ*. 2020;doi:10.1016/j.jsurg.2020.06.020
30. ASiT COVID-STAR available to access at <https://www.asit.org/news/asit-covid-star-survey-launched/nwc11205>
31. PanSurg CONSULT available to access at <https://www.pansurg.org/consult/>

COVID-19, social media and education

Maria Irene Bellini

Belfast Heath and Social Care Trust

COVID-19, the disease caused by SARS-CoV-2 infection has been declared a pandemic by the WHO in March 2020. Hot zones of increasing infections are constantly changing, starting from China in late 2019, then moving to Europe at the beginning of 2020 and currently mostly affecting North and South America¹.

To contrast the rapid virus spread, governments worldwide went into lockdown in March 2020, meaning imposed social distancing for the last three months, with inevitable repercussion on the way to communicate and interact among individuals not only limited to the quarantine period (March-May 2020).

Traditional social events as scientific meetings, but also daily lectures at academic institutions and in other organisations have already been severely limited or completely cancelled until next Spring 2021, with the long-term effects of this isolation still to be quantified from an economic and an educational point of view.

New strategies for addressing the downstream sequelae have been explored and an increasing emerging role of online tools seems the potential way forward.

Social media are internet based platforms to gather and communicate information²; more than ever during this pandemic there has been a constant need to share updates on such a rapidly evolving scenario, to help knowledge spread,

save lives and counteract anxiety and frustration due to the unforeseen circumstances and the detrimental effects of SARS-CoV-2 infection³.

Social media is an excellent way to raise awareness in the communities, mobilize resources and support in the absence of physical contact. Following this principle, the European Society for Organ Transplantation (ESOT), almost as a forerunner of this unprecedented crisis and ahead of the pandemic, developed an alternative business model, as part of its e-learning platform earlier this year. The same idea, very helpful to satisfy this unprecedented need to connect, proved to facilitate interaction and favour distance learning.

Webinars (web-seminars) have been used regularly by professional bodies and academic institutions, but in the COVID-19 era, their role seemed reinforced and extended. The discussion over internet has allowed members from all over the world and outside the traditional healthcare organisation to meet virtually and, in particular patients, or other groups that are not routinely able to join the traditional face-to-face events.

Furthermore, from the academics, there is evidence that sharing publications on the internet, aside from reaching out to different audiences, translates into an increased overall impact from the bibliometrics index point of view.





A trusted resource, such as the official Society website, represents the Society testimony and expression to be at the frontline of the emergency, to continue offering a life-long learning experience. Another very meaningful example is provided by the distance mentoring of our ASGBI Women in Surgery Facebook group⁴: help, support and discussion to be continued on the dedicated websites 24/7.

Finally, another emerging resource underutilised in the past has been represented by telemedicine: the use of information and communication technologies to overcome the above described barriers, with a great potential to benefit the whole healthcare system and beyond. Despite being a field in its infancy yet, we have seen how it is possible to run virtual clinics and routine assessments, in this way contributing significantly in terms of cost-effectiveness, but also concretely offering an alternative to patients who felt more vulnerable following reduced access to care.

The COVID-19 pandemic: Impact on ethnic minorities and gender disparities

Urvashi Singh¹, Maria Irene Bellini^{1,2}

1. Queen's University Medical School, Belfast, UK
2. Renal and Transplant Unit, Belfast City Hospital, Belfast, UK

Abbreviations

ACE2: Angiotensin converting enzyme 2
ARBs: Angiotensin II receptor blockers
BAME: Black, Asian and Ethnic Minorities
CDC: Centre for Disease Control and Prevention
COVID-19: Coronavirus disease 2019
EU: European Union
LVH: Left ventricular hypertrophy

Introduction

COVID-19 is a major public health concern. However, it has become apparent that COVID-19 is not a socially neutral disease. It appears to have an unequal impact on certain sections of society more than others. Issues surrounding the impact of COVID-19 on ethnic minorities are currently taking centre stage. The disparities in mortality among ethnic minorities have

References

1. <https://coronavirus.jhu.edu/map.html>.
2. Bellini, M.I., et al., Social Media Use Among Transplant Professionals in Europe: a Cross-Sectional Study From the European Society of Organ Transplantation. *Exp Clin Transplant*, 2020. 18(2): p. 169-176.
3. Bellini MI, Tortorici F, Capogni M. Resuming elective surgical activity after COVID-19 wave: what the patients need to know. *BJS* 2020 (in press) DOI: 10.1002/BJS.11802.
4. Bellini, M.I., et al., Changing the norm towards gender equity in surgery: the women in surgery working group of the Association of Surgeons of Great Britain and Ireland's perspective. *Journal of the Royal Society of Medicine*, 2019. 112(8): p. 325-329.

highlighted and exacerbated pre-existing socio-economic and health disparities. In the United Kingdom, patients from Black, Asian and ethnic minorities (BAME) comprised of a third of all reported cases despite making up only 14% of the overall population¹. Two-thirds of healthcare workers that died due to COVID-19 in the UK were from ethnic minority backgrounds². In the United States, higher rates of hospitalization and death were reported among black, Hispanics and Latinos compared to non-Hispanic white people. The Centre for Disease Control and Prevention (CDC) has reported that non-Hispanic American Indian and black persons are five times more likely to get hospitalized compared to non-Hispanic white persons³. Thus, the pandemic has not only exposed the deficiencies of the political and healthcare system, but it has provoked necessary dialogue about the archaic bias towards people of Caucasian ethnicity, institutional racism, and prejudice against ethnic minorities.

The pandemic is also having a disproportionate impact on sex and gender by widening existing inequalities. Men and women appear to have differences in incidence of COVID-19 and associated mortality. Ongoing studies have reported that men are more likely to get infected and that more men are dying from COVID-19 than women. A population-based study conducted in China reported that men were 2.4 times more likely to die from the disease compared to women⁴. However, sex-related differences in mortality rates are an oversimplification of the socio-economic and domestic effects of COVID-19. Gender and the lived experiences of men and women are different because of the underlying behavioural, biological, and socioeconomic differences. Therefore, these must be discussed and put into context when discussing the impact of COVID-19 on gender disparities.

This review aims understand these differences in the context of the biological, behavioural, and socioeconomic factors.

Ethnic minorities and COVID-19

Ethnicity is a complex amalgamation of genetic inheritance, social-economic circumstances, cultural identity, and behaviours⁵. Studies have previously compared ethnic groups based on these factors to study health outcomes and devise targeted therapies. Broadly, these factors may be divided into biological and non-biological factors.

Pre-existing co-morbidities such as cardiometabolic and respiratory disease have emerged as risk factors for adverse COVID-19 outcomes. The incidence of the cardiometabolic and respiratory disease vary with ethnicity. According to the Health Improvement Network database of over 400,000 individuals registered with general practices in London, BAME individuals not only had a higher prevalence of type 2 diabetes but also tended to develop type 2 diabetes at a younger age when compared with white individuals. The prevalence of cardiac disease is also higher in black, Asian, and ethnic minorities. South Asian patients had 40% higher mortality associated with coronary artery disease when compared with patients of white ethnicity⁶. In a separate cohort study, which focused on racial differences in malignant left ventricular hypertrophy(LVH) and heart failure, it was reported that the prevalence of malignant LVH was three-fold compared to their white counterparts over a 10 year period^{7,8}. Racial differences persist in respiratory disease as well.

A higher number of respiratory disease related admissions to hospital, which includes COPD, pneumonia, respiratory failure and asthma, were reported among black patients compared to Hispanic and white patients in the United States. Asthma related admissions to hospitals were also the highest among black patients in America⁹. Thus, pre-existing cardio-metabolic and respiratory disease among BAME individuals puts them greater risk of incidence and mortality for COVID-19.

Genetic polymorphisms may provide important clues to ethnic differences in the immune response against the virus. Studies have highlighted a link between the angiotensin converting enzyme 2(ACE2) receptor and COVID-19. Severe cases of COVID-19 were correlated with the use of angiotensin-converting enzyme inhibitors(ACEIs) and angiotensin II receptor blockers(ARBs)¹⁰. ACE2 receptor expression may be elevated because of patients being treated with ACEIs and ARBs which can lead to increased severity of disease¹⁰. These anti-hypertensive drugs are prescribed to the South Asian population for hypertension and diabetes and may predispose to greater severity of COVID-19¹¹. The Afro Caribbean population expresses lower levels of ACE2 and different anti-hypertensives are prescribed instead to patients belonging to this ethnicity¹¹. This could confer the Afro-Caribbean hypertensive population with protection from the infection. Further research is warranted with regards to ethnicity-based expression of ACE2 and its association with COVID-19 infection severity and mortality.

BAME individuals have historically been disadvantaged in terms of social and economic attainment. Unemployment rates are twice as high among black people versus their white counterparts. Literacy rates were also reported to be lower among black people (20.2%) compared to non-Hispanic white people (34.2%)¹². Low literacy and unemployment mean that such groups are also more likely to live with low income in crowded and disadvantaged neighbourhoods compared to more privileged individuals. Ethnic minorities are also less likely to have a health insurance. In the United Kingdom, BAME individuals have higher levels of material deprivation compared to those of White ethnicity. The English House Survey released in 2018 by the UK government reported that overcrowding greatly affected BAME individuals compared to white individuals.





Overcrowding affected 30% of Bangladeshi households, 15% Black African households and 11% in Asian households compared with 2% white households¹³.

A study has reported association between material deprivation and the higher odds of COVID-19 positivity among BAME individuals¹⁴. In COVID-19 positive patients, greater risk-taking tendencies were reported among BAME versus white ethnicities¹⁴. Overcrowding and intergenerational familial units are also more likely to affect viral reproduction rates among ethnic minorities when compared with white counterparts¹⁵. These individual differences in behaviour and living conditions are likely to have an impact at the societal level. Further discussion about the effects of the pandemic on ethnic minorities is warranted to draw appropriate conclusions and take further action.

Gender disparities and COVID-19

COVID-19 has had primary and secondary effects on sex and gender. The primary effects include the difference in the incidence and case fatality rate between men and women while the secondary effects include the increased risk of domestic violence and sexual abuse, economic and job insecurity as well as increased domestic workload¹⁶.

Co-morbidities are higher in men than women except in older age groups. Lifestyle behaviours such as smoking, and alcohol consumption also tend to be globally higher among males and contribute to higher incidence of cardio-metabolic and respiratory disease in the long term¹⁶. Other behaviours that may contribute to higher incidence among men include lower rates of hand washing, delayed health seeking behaviours as well as rejection of social isolation, social obligations, and psychological stress. All these factors must be considered to investigate the underlying mechanisms for gender disparities in COVID-19¹⁶.

Secondary effects of COVID-19 on gender disparities have had far more devastating impacts. This is reflected by the socio-economic and domestic effects on women. Women have traditionally done a disproportionately large share of household duties and care work.

Women constitute a large proportion of caregivers in the formal and informal sector. Almost 50-70% of frontline workers such as healthcare workers, nurses and technicians are women^{16,17}. These women not only face increased risk of infection, morbidity, and

death because of their profession but also risk exposure of the virus to their families. With lockdowns and school closures, sources of childcare have not been available to many working women. Women that relied on other family members and grandparents for childcare cannot do so anymore due to social distancing and shielding the vulnerable. This has forced women in many double income households to take up a disproportionate share of the additional responsibility of caring duties, often without any help from their partners. This has meant that they have had to reduce working hours or even give up doing paid work temporarily to focus on caring duties¹⁸. This is slated to have long term adverse effects on closing the gender pay gap between men and women. A prolonged period of an enforced career break is likely to affect overall career growth and widen the motherhood wage gap that is often caused by women going on unpaid maternity leave¹⁸. The effects of this pandemic will be significantly higher on female headed household than for male headed ones thereby exacerbating pre-existing vulnerabilities of already vulnerable households.

Lockdowns have also increased the risk of domestic abuse for women. The EU parliament has reported that domestic violence rose by almost a third in some EU countries during lockdown. Volume of calls by victims have reportedly increased in France, China, and Cyprus by almost 30%¹⁸. However, a large proportion of victims are unlikely to lodge any formal complaints during this period because of fear of infection, isolation from support systems and constant surveillance and manipulation from their perpetrators. Increased sexual violence and lack of access to safe abortions is likely to increase the number of the unwanted pregnancies^{17,18}. These experiences will have a detrimental impact on the mental, emotional, and physical health of women.

Conclusion

While the global impact of the COVID-19 pandemic is unlike anything we have experienced before, the disproportionate impact that it is having on ethnic minorities and gender disparities echoes the public health issues of previous pandemics. Ethnic minorities and women tend to have the worst long-term repercussions from public health emergencies because of historic institutional biases and societal injustices against these groups.

It may be too late to change the trajectory of COVID-19. But going forward it is important that we adopt a lens of equality to address the societal issues and prejudice that underlies health outcomes in these groups. Policies and actions need to be put in place at every level to ensure that public health services and support are available to these groups during the pandemic and beyond.

References

1. Peate I. Why are more BAME people dying from COVID-19? *Br J Nurs*. 2020;29(10):545.
2. Rimmer A. Covid-19: Two thirds of healthcare workers who have died were from ethnic minorities. *BMJ*. 2020 Apr 23;369:m1621.
3. Centers for Disease Control and Prevention. COVID-19 in Racial and Ethnic Minority Groups | CDC [Internet]. CDC - Coronavirus Disease 2019 (COVID-19). 2020 [cited 2020 Jun 30]. p. 1. Available from: <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html>
4. Jin J-M, Bai P, He W, Wu F, Liu X-F, Han D-M, et al. Gender Differences in Patients With COVID-19: Focus on Severity and Mortality. *Front Public Heal*. 2020 Apr 29;8:152.
5. Patel P, Hiam L, Sowemimo A, Devakumar D, McKee M. Ethnicity and covid-19. Vol. 369, *BMJ* (Clinical research ed.). NLM (Medline); 2020. p. m2282.
6. Mathur R, Hull SA, Badrick E, Robson J. Cardiovascular multimorbidity: The effect of ethnicity on prevalence and risk factor management. *Br J Gen Pract*. 2011 May 1;61(586):e262–70.
7. Lewis AA, Ayers CR, Selvin E, Neeland I, Ballantyne CM, Nambi V, et al. Racial Differences in Malignant Left Ventricular Hypertrophy and Incidence of Heart Failure. *Circulation*. 2020 Mar 24;141(12):957–67.
8. Drazner MH, Dries DL, Peshock RM, Cooper RS, Klassen C, Kazi F, et al. Left Ventricular Hypertrophy Is More Prevalent in Blacks Than Whites in the General Population. *Hypertension*. 2005 Jul;46(1):124–9.
9. Goto T, Faridi MK, Gibo K, Camargo CA, Hasegawa K. Sex and racial/ethnic differences in the reason for 30-day readmission after COPD hospitalization. *Respir Med*. 2017 Oct 1;131:6–10.
10. Zhou P, Yang X Lou, Wang XG, Hu B, Zhang L, Zhang W, et al. A pneumonia outbreak associated with a new coronavirus of probable bat origin. *Nature*. 2020 Mar 12;579(7798):270–3.
11. Brewster LM, van Montfrans GA, Oehlers GP, Seedat YK. Systematic review: antihypertensive drug therapy in patients of African and South Asian ethnicity. Vol. 11, *Internal and Emergency Medicine*. Springer-Verlag Italia s.r.l.; 2016. p. 355–74.
12. Singh G, Daus G, Allender M, Ramey C, Martin E, Perry C, et al. Social Determinants of Health in the United States: Addressing Major Health Inequality Trends for the Nation, 1935-2016. *Int J MCH AIDS*. 2017;6(2):139.
13. Overcrowded households - GOV.UK Ethnicity facts and figures [Internet]. Ministry of Housing, Communities and Local Government. 2018 [cited 2020 Jul 7]. Available from: <https://www.ethnicity-facts-figures.service.gov.uk/housing/housing-conditions/overcrowded-households/latest#by-ethnicity>
14. Raisi-estabragh Z, Mccracken C, Bethell MS, Cooper J, Cooper C, Caulfield MJ, et al. Greater risk of severe COVID-19 in Black, Asian and Minority Ethnic populations is not explained by cardiometabolic, Greater risk of severe COVID-19 in Black, Asian and Minority Ethnic populations is not explained by cardiometabolic, socioeconomic or beha. *J Public Health* (Bangkok). 2020;25:1–10.
15. Pan D, Sze S, Minhas JS, Bangash MN, Pareek N, Divall P, et al. The impact of ethnicity on clinical outcomes in COVID-19: A systematic review. *EClinicalMedicine*. 2020;23:100404.
16. Gebhard C, Regitz-Zagrosek V, Neuhauser HK, Morgan R, Klein SL. Impact of sex and gender on COVID-19 outcomes in Europe. Vol. 11, *Biology of Sex Differences*. BioMed Central Ltd.; 2020.
17. Gausman J, Langer A. Sex and Gender Disparities in the COVID-19 Pandemic. *J Women's Heal*. 2020 Apr 1;29(4):465–6.
18. Blaskó Z, Papadimitriou E. How will the COVID-19 crisis affect existing gender divides in Europe? In 2020.





Sustainability and the environment in surgery

Cleo Kenington, London Representative and
Consultant Emergency General Surgery, St George’s Hospital, London

Climate change is here. The glaciers are melting, Australia and the Amazon is burning, temperature levels have reached 0.8-1.2° C higher than the pre-industrial period. The International Panel on Climate Change, the body of the United Nations Environment Programme that assesses the science of climate change issued a report in 2018 which demonstrated the impacts of warming above 1.5° C above preindustrial levels, predicted to happen between 2030-2052 at the current rate of increase, including extreme heatwaves, heavy rainfall combined with droughts, extinction of many species and loss of 70-90% of coral reefs. Risks to health, food security and water supplies are also predicted to increase. To keep within 1.5 degrees we need to reduce Global net human-caused emissions of carbon dioxide (CO2) by about 45 percent from 2010 levels by 2030, reaching 'net zero' by 2050. Climate change will have serious repercussions on public health without significant leadership and action.

The health and care system in England is responsible for an estimated 4-5% of the country’s carbon footprint¹. NHS England has announced that it has commissioned a panel to consider how the NHS can become “net zero” becoming the world’s first major health service to do this.

But in the meantime, what can we as surgeons do to reduce our environmental impact without compromising patient care?

Travel

The latest data from the NHS Sustainable Development Unit demonstrates that 10% of CO2 emissions in the NHS are from either patient, visitor or staff transport². So, improvements can be made by reducing the need for this transport – reducing hospital length of stays, avoiding unnecessary follow up appointments in the hospital, conducting virtual, telephone or even video reviews where possible. Setting an example for your team by using active transport or public transport for commuting where possible and campaigning within the hospital and the local community to improve facilities for this such as showers, lockers and secure storage for bikes. Reducing

parking spaces in and around hospitals also has a great impact to disincentivise driving. Encouraging patients and visitors to use active transport can also help to reduce illness from inactivity and obesity, reducing pollution and road trauma.

Travel to academic conferences is a significant source of CO2 emissions. While this years conferences are mostly by webinar, it is important to plan for the future. The ASGBI promotes the use of trains where possible to attend their annual conference. A lot can be gained from attending local conferences to improve local collaboration and when international conferences are necessary consider the development of webinars and video conferencing. This can be especially useful to include people who can’t afford the international travel or don’t have the appropriate visas.

Diet

A vegan diet produces 75% lower CO2 emissions during its production than a diet rich in meat and dairy. Beef and lamb produce the most greenhouse gases during production with pork then chicken then fish producing sequentially less. Not only do fruits and vegetables provide you with vitamins and antioxidants, but they already come in their own natural wrapping reducing plastic waste.

Advising changes in diet and lifestyle to our patients is important given that over half of general surgery admissions are related to obesity. A vegetarian or vegan diet can provide fewer calories to aid weight loss and higher fibre to reduce diverticular disease, colorectal cancers and even breast cancer.

In the operating theatre

Anaesthetic gases

Modern anaesthetic gases themselves contribute to climate change and represent 5% of the carbon footprint of the NHS. Gases like Desflurane has 2540 times the potency of CO2, compared to Sevoflurane which is only 130 times and Nitrous Oxide which is 298 times the potency of CO2³. Low flow anaesthesia, using technology to reclaim the gases or using

technology to reclaim the gases or using intravenous anaesthesia, can reduce the climate change emissions. Promoting procedures under local or regional anaesthesia can also reduce the impact of anaesthesia.

Waste

Ensuring waste is placed in the correct bags can have a big impact on the CO2 emissions, which are roughly correlated with the cost of

Cost of Waste...

Recycling	General Waste	Clinical Waste Treatment	Clinical Waste Incineration	Offensive Waste
£24.00* per tonne	£113.38* per tonne	£365.09* per tonne	£652.39* per tonne	£238.94* per tonne

A team is working with the NHS to develop reusable sharps bins⁴, so far working with 25 NHS trusts as well as pharmacies and renal clinics. As a result they claim 647 tonnes of single use plastic has avoided incineration.

Re-manufacturing of single-use devices such as resterilising the laparoscopic energy devices has been commonplace in the US for sometime. However it is only recently that EU regulations have been developed to allow the process to take place in Europe.

Working with the procurement team to reduce the number of items in a set if they aren’t always used. Increasing the number of high quality instruments available in the hospital that are for reuse rather than using single use every time.

Energy

Operating rooms are three to six times more energy intense per square foot than the hospital as a whole, due to their stringent heating, ventilation, lighting, patient monitoring equipment and energy devices. Many operating theatres are only used during working hours. Ensuring all this energy is turned off when the theatre is not in use can make a big reduction in CO2 production. This can be with the help from

disposal. The wrapping of sterile instruments is clean, so can be disposed of as normal waste and paper packaging and boxes can be recycled. Staff are often unsure what can be recycled safely or may believe that all clinical waste is contaminated. Staff education is therefore important as is ensuring the layout of bins within the operating theatre is optimised to make it easier for the correct waste to end in the correct bin which can significantly reduce costs and CO2 production in an operating theatre.

the team at the debrief at the end of the day to ensure all the computers and lights are switched off. To the retrofitting of systems to ensure that theatres not in use have their energy supply turned off.

On the wards

Reducing administration of intravenous medication

Intravenous medication comprises a larger volume and higher levels of sterility which is a carbon intense process. So switching to oral medication when safe is not just cost effective, but reduces the carbon footprint too.

In conclusion there is a lot that can be done by individual surgeons in the operating theatre as well as in clinics and on the wards to help the drive towards a net zero NHS. This can not only reduce CO2 emissions, but reduce cost to the trust and lead to health benefits too. At St George’s we have formed a team of staff including surgeons, anaesthetists, management as well as nursing and procurement staff to promote sustainable ideas. If anyone is interested in forming a similar team in their hospital please get in touch.





And for more information on sustainable surgery, join the ASGBI Sustainability in Surgery page on facebook.

1) <https://www.england.nhs.uk/2020/01/greener-nhs-campaign-to-tackle-climate-health-emergency/>

2) <https://www.sduhealth.org.uk/policy-strategy/reporting/natural-resource-footprint-2018.aspx>

3) <https://www.rcoa.ac.uk/sites/default/files/documents/2019-09/Bulletin82-Nov2013-Pages39-41.pdf>

4) <https://www.stericycle.co.uk/news/making-a-world-of-difference-in-the-nhs-fight-against-plastic-waste>

Being the first ASGBI Social Media Editor

Cleo Kenington, London Representative and

Consultant Emergency General Surgery, St George's Hospital, London

When Vassilios first asked me to be the first ASGBI social media rep manning the twitter account for a 2 month period I was a bit anxious about the idea, I have been known to be a bit controversial on twitter – even my husband can't cope with following me. For a 100 year old society I thought I would have to hold my tongue. But it has been a fun experience, as I have brought my slightly outlandish ideas to the surgical community. And I have been able to highlight areas that are important to me, such as Sustainability in Surgery and Emergency General Surgery. As well as now the very important issue of returning to normal operating to prevent further admissions of complications while patients wait for their elective surgery.

I will be sad to log out of the ASGBI account at the end of July and hand over to the next rep. But at the same time, it will be interesting to see what other surgeons bring to the account. I don't think my husband will be upset though, it's been a great excuse to spend more time sat on my phone scouring twitter!



ASGBI Emergency General Surgery CPD

Katie Cross, Consultant Colorectal Surgeon, Northern Devon Healthcare Trust

I have long wondered how to address the difficulty to maintain emergency general surgery (EGS) CPD in this time and cash-strapped era. As subspecialists we often become “experts” in our own field but less so generally unless you are able to attend the excellent ASGBI conference. Following a fact-finding telephone discussion with Iain Anderson, President of the ASGBI, we discussed potential solutions. In the future nationally, joint conferences of AUGIS/ ACPGBI and ASGBI is a potential option. At a local level the opportunity to write training modules and share them between the regional representatives was suggested; however until recently making contact with other regional reps has been an issue.

Covid-19 has been a challenge in many aspects; however it has enabled us to consider solutions to problems in alternative ways. Being based in North Devon, 4 hours from London by car (surprisingly 3 hours by train), I have always promoted virtual meetings to the College, however these have not been felt to offer the networking opportunity and have mostly been rejected thus limiting my, and potentially others, applications for college roles.

The IT departments across the NHS have performed a Herculean task and on the basis of this, I approached the ASGBI to help reach out to 170 General Surgeons across 14 Trusts in the South West, to set up and run a SW ASGBI EGS CPD event. Mr David Sanders, Consultant UGI surgeon based at North Devon District Hospital who runs a tertiary referral practice in the SW for incisional hernias kindly agreed to speak on “Emergency management of complex incisional Hernias”. My greatest difficulty was setting up an email database which I made up from NHS websites, unfortunately due to GDPR regulations, the RCS could not help, however

Bhavrita Patel was so helpful as always and ran the organisation expertly.

Iain Anderson kindly introduced the session updating the 30 attendees on ASGBI activities, followed by a 35 minute excellent talk, 10 minute Q+A and 5 minute wrap-up. I selected to run the session as a Professional Zoom format which could have held 100 attendees, as a more interactive forum rather than a webinar. Within this I ran a poll, 100% felt the session was worthwhile; the vast majority felt 3/12 sessions would be the best interval for further sessions; 45% requested the next session to be on the ischaemic gallbladder; followed by complex diverticulitis and appendix mass.

It was lovely to have participants' videos on initially, to see friends and colleagues from around the region. Following the talk, a very interactive Q+A session via the meeting chatroom appeared to be very successful. The link to the talk is :https://youtu.be/GXy7Cn_0BYU. Interestingly, the speaker found the format of the presentation very awkward due to the lack of feedback from the audience during the talk. I will feedback to the other regional reps via the newly started ASGBI Regional Reps Meeting run by Neil Welch – an excellent forum to share learning and difficulties across the country, saving hours of travel time for all.

We are now receiving daily requests to link for CPD events across the globe and you have to question what the future will hold for expensive national conferences but I believe everything will find their place going forward.





Curing Folly?

Brian Andrews, Medway Maritime Hospital, Gillingham, UK.
Brian.andrews@medway.nhs.uk

A First Class Service: Quality in the NHS (DoH 1998) describes Clinical governance as: “A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish” I believe that these sentiments are depicted in the painting: “Curing Folly” by Hieronymous Bosch c 1485.

The script around the painting reads, “Meester snijt die keye ras – myne nam is Lubbert das” “Master cut the stone out quickly - my name is Lubbert das”. Apparently in medieval Flanders the name Lubbert implied a “simpleton”. The painting depicts a surgeon extracting a blooming flower from Lubbert’s head. The flower is synonymous with a stone since people believed that mental illness, depression and foolishness could be treated by removing a stone from the brain; simpletons were also referred to as “tulip heads” or as having “a bulb” in their heads. The surgeon is abetted in his endeavour by a monk who hails the operation with his right hand whilst holding what I take to be an anaesthetic agent in his left. Across the table a stern faced woman dressed in a nun’s habit looks on disapprovingly.

The surgeon wears an upturned funnel on his head perhaps indicating that he is a charlatan. Although Rhazes criticised trepanation and removal of stones to treat “falling sickness” (epilepsy) as early as 900, stone cutters continued to earn a wage by performing sham operations on a gullible population until the 18th century. I had always assumed that the book balanced on the woman’s head was the Bible, perhaps adding weight to her scorn. However to bring the allegory up to date; I now suspect that the book is in fact an early edition of A First Class Service and that the nun is contemplating whistleblowing.





ACUTE CARE SURGERY TEAM AT CORK UNIVERSITY HOSPITAL THE WHOLE STORY

Mr.Mohd Yasser Kayyal, Consultant General Surgeon, Cork University Hospital, Cork, Ireland.

Email: mohd.alkayyal@hse.ie

Cork University Hospital (CUH) is a model 4 tertiary referral centre and University teaching hospital. The hospital is a public hospital managed by the Health Service Executive (HSE) and is a member of the South/South West Hospital Group.

CUH is unique in that we have 40 different medical and surgical specialties on the campus. As the tertiary referral centre for the HSE Southern area and the supra regional area of Limerick, Kerry, Tipperary, Waterford and Kilkenny CUH serves a total population of over 1.1 million.

In 2019 CUH had 69982 presentations to our Emergency Department, 222,115 outpatient attendances and discharged 31,769 inpatients.

At CUH, we recognized a need for a standardized, efficient, early assessment approach to safely evaluate, investigate and manage patients in need of Emergency /Acute surgery care.

As such, I was asked by the hospital management in April 2017 to start and develop an Acute Care Surgery Program at Cork University Hospital in order to achieve the above-mentioned goals as well as allow other surgical colleagues to focus more on their elective sub-specialty services.

The early days were tough and challenging, to build the service from the scratch, the team consists of two consultant surgeons, two registrars and two SHOs (Senior House Officers), with the help of other colleagues in the department of surgery we developed a model of care to run the service as safely and efficiently as possible, we also started planning for the establishment of the Acute Surgical Assessment Unit ASAU.

During the journey, we faced many challenges which we manage to overcome with the cooperation of other colleagues, and across the road we included more members to the team, to establish a very robust multi-disciplinary team that currently includes different specialties in healthcare professionals including nurses, dieticians, physiotherapists, HCAs, wound care nurses, pain team nurses..etc

Work Pattern:

We developed a model of care for acute care surgery that is unique in UK & Ireland in a way that the emergency surgery consultants have no elective capacity and their time is dedicated for Acute/ emergency surgery care, so a consultant acute care surgeon is on call every day from 08.00 am to 05.00 pm, then a surgeon on call (1 in 10 rota) will be on call from 05.00 pm to 08.00 am next day, in addition to this, we take over patients from the night call surgeon unless they have been operated

on during the call hours, then they stay under the care of the operating surgeon, this model was suggested to improve continuity of care for this group of patients, as well as release the sub-specialty surgeons from their emergency work load in order for them to have more time to manage their already busy elective services, it also has a huge impact on utilization of the emergency theatre with a consultant present all the time to manage patients requiring emergency procedures in a timely fashion.

We also developed the Acute Surgical Assessment Unit in November 2017, as recommended by the RCSI National clinical programme in surgery in order to provide quick, early, senior decision maker assessment early in the journey of the emergency surgery patients, as well as provide support to the already busy A&E department by re-directing this group of patients away from the A&E into the ASAU.



Team Members:

The team currently consists of the following members:

- 1- 4 Consultant Acute care surgeons.
- 2- 3 Registrars.
- 3- 2 SHOs.
- 4- 3 Interns.
- 5- 2 Nurses (running the ASAU)
- 6- CNM2 Surgical ward.
- 7- CNM2 Emergency Theatre.

With the support of other healthcare professionals to include surgical dieticians, wound care nurses, pain management nurses, stoma care nurses, physiotherapists, etc.. and we currently have a great reputation in the CUH being there all the time when someone needs an urgent surgical consult.

Achievements:

After implementation, we have shown evidence of high quality results in the following points:

- There was objective evidence of early assessment of the acute surgical patient by a senior member of the team; a consultant/registrar review was achieved in 92% of the cases.
- There was objective evidence of significant increase of the number of procedures done in the emergency theatre/month compared to the previous era of no dedicated emergency surgery service.
- There was objective evidence of improvement in the starting time of the 1st case in the emergency theatre compared to the previous era of no dedicated emergency surgery service.
- There was objective evidence of improving the weekly utilization of the emergency theatre from around 40% pre-ACS to 80% in the first 6 months post ACS.
- The development of the ASAU Acute Surgical Assessment Unit in 11/2017 was a high quality result of the successful implementation of the whole ACS program, with the addition of 2 dedicated nursing staff in charge of the ASAU, which in itself stands as another successful project under the umbrella of the ACS team.
- My team was nominated as a FINALIST for the Irish Healthcare Centre Awards 2019, a highly competitive annual event, and although we didn't win that, we were all extremely proud to be in the 3 finalists across all Ireland.





In June 2019 we received the National Accreditation of our ASAU for a 1 year duration, having met all the requirements for it, and it is indeed a great achievement we at CUH are all proud of.

During the COVID-19 pandemic, we were affected by all the restrictions, pressure and re-direction of services, but currently with the NEW-NORMAL, we are continuing to expand and improve the service with many quality improvement projects underway, and our ultimate goal is to make ACS team the best in the Republic of Ireland.



Surgical Research Society October Virtual Meeting 2020 Schedule of Events from Postponed March meeting



Tuesday 6th October

- 18:00-19:00 Poster Parallel Session 1
- 18:00-19:00 Poster Parallel Session 2
- 18:00-19:00 Poster Parallel Session 3

Thursday 8th October

- 18:00-19:15 RCS(Eng) Research Fellows Symposium

Tuesday 13th October Parallel Sessions

- 18:00-19:15 Basic Sciences
- 18:00-19:15 Database Research
- 18:00-19:15 Systematic Reviews/Meta Analyses

Thursday 15th October Parallel Sessions

- 18:00-19:15 Translational Research
- 18:00-19:15 Surgical Education and Training
- 18:00-19:00 Cohort Studies

Tuesday 20th October

- 18:00-19:30 PATEY PRIZE SESSION 1

Thursday 22nd October

- 18:00-19:30 PATEY PRIZE SESSION 2

Tuesday 27th October Parallel Sessions

- 18:00-19:00 Experimental Human Research
- 18:00-19:00 Qualitative Research
- 18:00-19:00 Breast

Thursday 29th October

- 18:00-19:15 RESEARCH COLLABORATIVES DRAGONS DEN
- 19:15-19:45 Presentation of Prizes

Presenters will be contacted directly by the SRS Secretariate.
Details on how to register will be posted shortly on the SRS
Website <http://surgicalresearch.org.uk/>



ASGBI & NFAS present The Emergency General Surgery Symposium 2020

Miss Gill Tierney
Director of Emergency General Surgery ASGBI

The ASGBI Emergency General Surgery Symposium 2020 is taking place virtually on **9th September**. This meeting has been a sell out for the past two years so for those who haven't been able to attend in previous years, it's an opportunity to join us on-line. Chaired by Miss Gill Tierney, ASGBI EGS Director and Professor Pete Sagar it promises to be a fast-paced and stimulating day.

Experts from all branches of general surgery will give a state-of the art snapshot of the management of the acute surgical conditions which present to the general surgical emergency service.

This day will be of practical use to experienced clinicians delivering care to our patients and also of use to our trainees preparing for examinations.

A focus on joint decision making and the frail surgical patient will be part of the meeting.

The day will be divided into clinical subsections and also political and managerial subsections.

Colorectal topics will include:

- The acute anus
- Pseudo-obstruction
- Emergency surgery in colitis
- Sigmoid volvulus

Upper GI Emergencies including:

- The use of laparoscopy in emergency settings
- Complex biliary diseases and pancreatitis

Difficult Clinical Decisions will be covered by

Dr Sarah Hare, NELA Clinical Lead and Sarah Liptrot.

Managerial and political situations including best practice tariff will be discussed by Dr Dave Murray and Mr Arin Saha.

Inevitably there will be mention of COVID-19 in a presentation by Miss Sonia Lockwood.

There will be the opportunity to ask questions and partake in live polling. This will be fast-paced and relevant. Further details are available via the ASGBI web site [here](#).

Speakers include:



Mr John Abercrombie
Member of Council, RCS
England



Dr Sarah Hare
NELA Clinical Lead



Mr Paul Leeder,
Director of Education, ALSGBI



Miss Nicola Fearnhead
Past President, ACPGBI



Dr Dave Murray
NELA Chair



Mr Arin Saha
National Clinical Lead,
Surgical Ambulatory
Emergency Care Network



Mr Richard Guy
EGS Consultant,
Wirral University
Teaching Hospital



Miss Sonia Lockwood
NELA Surgical Lead



Mr Andy Smith,
Education, Training &
Research Lead, AUGIS



REGISTRATION IS FREE FOR ASGBI MEMBERS





ASGBI WEBINAR SERIES

We are running a series of webinars on topical issues. Past webinars are available to view through the web site.



Future webinar topics include:

- Troublesome testicles
- Practice-changing published evidence from NELA
- Modern management of rib fractures - who, where and how?
- Modern management of head injuries - who, where and how?
- Paediatric emergencies in general surgery

The webinars will take place from 24th September.

EMERGENCY GENERAL SURGERY Committee



ASGBI is committed to developing excellence in emergency general surgery through evidence-based sharing of good practice. Through it's Director of Emergency Surgery (Miss Gill Tierney) and the Emergency General Surgery Board (Chaired by Professor Pete Sagar), ASGBI works with all four surgical Colleges, trainee representatives and specialty associations to improve matters in this area.

ASGBI and EGS

The Association:

- Produces guidelines and standards on EGS services in conjunction with ACPGBI, AUGIS, ALSGBI and NFAS
- Works closely with NELA (National Emergency Laparotomy Audit) to produce reports, drive change and share best practice.
- Liaises with the SAC;
- Shares best practice in ambulatory EGS tariff implications

If you would like to be part of the evidence-based development of excellence in UK Emergency Surgery why not join ASGBI, attend the annual emergency surgery one day meeting, our annual surgical congress and share with and learn from like-minded colleagues.

www.asgbi.org.uk



cores

Feedback

Surgical Safety Update: Cases from the Confidential Reporting System for Surgery (CORESS)

CORESS is an independent charity, supported by the Federation of Surgical Specialty Associations (FSSA)

Professor Frank CT Smith, Programme Director, on behalf of the CORESS Advisory Board.

This series of reports illustrates a variety of cases in which systems errors were involved. Injection errors remain a perennial problem, and a useful reference article classifying psychological causes of medication errors is cited. A problem arising from pooled lists is illustrated. Attention is drawn again to the value of team briefs and effective use of WHO checks in reducing operative error.

We are grateful to those who have provided the material for these reports. The online reporting form is on the website (www.cores.org.uk), which also includes all previous Feedback reports. Published cases will be acknowledged by a Certificate of Contribution, which may be included in the contributor's record of continuing professional development, or may form part of appraisal or annual review of competence progression portfolio documentation. Trainee contributions are particularly welcome.

Professor Frank CT Smith
On behalf of the CORESS Advisory Board

Thoracic Outlet Surgery Complications

(Case ref: 260)

A 38 year-old woman underwent first rib resection and scalenectomy with pectoralis minor tenotomy for neurogenic Thoracic Outlet Syndrome (NTOS). Preoperatively, the procedure and potential complications were discussed in detail with the patient, whilst obtaining informed consent. Surgery was uneventful and the first rib was excised via a supraclavicular approach. Scalenus anterior was detached from the scalene tubercle on the first rib and a substantial portion excised, relieving compression of the subclavian artery and brachial plexus. The operating surgeon searched for the phrenic nerve which lies on the anterior border of scalenus anterior, beneath the scalene fat pad, but was unable to identify the nerve.

The patient made a satisfactory recovery and was discharged on the first post-operative day. Four weeks later she attended her GP, unwell with a cough and a fever. She was referred to hospital where she was diagnosed with pneumonia. On auscultation of her heart, a mitral valve murmur was noted. Blood cultures were obtained and the patient underwent chest X-ray which showed consolidation in the base of the right lung and an elevated right hemidiaphragm. Echocardiography confirmed mitral valve regurgitation with the suggestion of vegetations on the valve.

She was treated with intravenous antibiotics but remained breathless and unwell. Eventually the cardiac surgery team intervened, in the presence of normal blood cultures, to undertake mitral valve annuloplasty and debridement via median sternotomy. Six months post-surgery, on long-term antibiotics, the patient remains well with improvement of her NTOS symptoms and normal cardiac function.

Reporter's comments:

(Surgery for NTOS represents a small niche in surgical practice. The procedure involves decompression of the scalene triangle by resection of the scalenus anterior and scalenus medius muscles, to decompress the roots of the brachial plexus and subclavian artery, with resection of the first rib. During surgery, the brachial plexus, phrenic nerve and long thoracic nerve to serratus anterior, are at risk (Figure 1). As

operating surgeon, I had discussed the potential risks with the patient in detail, and had documented these on the consent form. Nonetheless, having failed to identify the phrenic nerve, despite looking for it, and documenting this in the operation note, it would appear that the nerve was injured during the procedure giving rise to the elevated hemidiaphragm. Subsequent development of a pneumonia predisposed to septicaemia and the resultant endocarditis. This was not a complication previously encountered. Identification and protection of the phrenic nerve during dissection in this procedure is paramount. The elevated hemidiaphragm subsequently recovered, suggesting nerve paresis.

CORESS comments:

The Advisory Board accepted the reporter's comments. The anatomy relating to this procedure is illustrated in Figure 1.

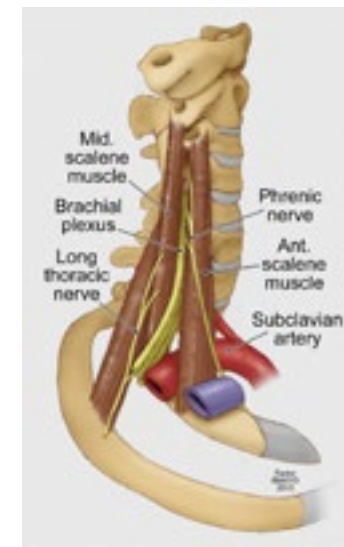


Figure 1. The anatomy of the Thoracic Outlet illustrating nerves at risk during surgical decompression. The clavicle is not illustrated in this diagram. (Reporting Standards of the Society of Vascular Surgery for Thoracic Outlet Syndrome, Illig KA et al, J Vasc Surg 2016)

Missed breast tumour in pooled case.

(Case Ref: 263)

A 50-year old lady presented through the Breast Screening Programme, with a right breast cancer. At the time of assessment, the tumour was easily palpable as a 2cm mass. She was listed for wide local excision and sentinel lymph node biopsy.

During pre-assessment she required cardiac investigations prior to surgery, leading to a delay in the procedure. She was therefore commenced on primary hormonal therapy, as she was oestrogen receptor positive. Her surgery was undertaken approximately 6 weeks later.

On the day of surgery, the patient was examined by a different surgeon, and the tumour was no longer palpable. The consultant who carried out the initial assessment was on leave and the operating list was undertaken by another experienced surgeon. The surgeon spoke to the on-site breast radiologist, who placed a skin mark over the site of the tumour under ultrasound control. Uneventful surgery was undertaken.

At the post-surgery MDT, it was reported that no tumour was present in the excised breast specimen. The patient was re-assessed radiologically and the persistent tumour was identified adjacent to the surgical bed. A second procedure under wire-guidance was undertaken, and the tumour was successfully removed.





Reporter's Comments:

This case highlights the pressure to use operating capacity to its maximum. It was complicated by an unusually fast response of the tumour to hormone therapy, such that it became impalpable. Despite efforts to localise the tumour with a skin mark, this was ineffective. A protocol has now been introduced, dictating that in similar circumstances, a guide wire needs to be placed under imaging control prior to surgery.

CORESS & Reporter Comments:

Where cases are pooled, standards need to be protected through use of common protocols. Options here might have include placement of a coil or clip, under radiological control, prior to chemotherapy, to aid tumour localisation. Placement of a guide wire to aid dissection, under ultrasound control, remains an effective method of localising an impalpable tumour prior to surgical resection.

Abscess Confusion

(Case Ref: 264)

A 45-year old man presented to the Emergency Department on a Friday, with a left buttock abscess of two weeks duration. He was seen and consented for incision and drainage by the surgical SHO who marked the side and site with a large arrow pointing towards the abscess from laterally. In the event the emergency list ran late and the patient was cancelled for surgery that night. He was sent home and told to come back after the weekend. When he reattended, he was listed for incision and drainage of a pilonidal abscess. The skin was re-marked over the site of the still visible inked arrow, and he was consented for drainage of a buttock abscess, but he was not seen by the registrar due to undertake the procedure, who was already operating.

The patient was brought to theatre and placed in the left lateral position, with the marked arrow and abscess obscured. With the patient draped and anaesthetised, the registrar was unable to find a pilonidal abscess. He called in the consultant who thought he felt some localised induration and undertook an exploratory incision in the natal cleft, which he left open and packed. No sample was sent for microbiology. When the patient returned to the recovery area and was awoken, he was disturbed to find that the symptoms from his undetected, and untreated, left buttock abscess persisted. He subsequently required a further procedure and a formal complaint was submitted.

Reporter's Comments:

Confusion arose between the classification of the various abscesses that arise around the buttocks, perineal and natal cleft regions. The patient was inappropriately listed for the wrong operation, and was not seen prior to surgery by the operating surgeon, who positioned the patient according to the procedure described on the list. In this position, neither the abscess or the marked arrow could be seen.

CORESS Comments:

Multiple errors contributed to this adverse event. There was failure to apply the correct nomenclature to the pathology, which was described differently on consent form and operating list. Of paramount importance was the fact that the operating surgeon did not examine the patient and confirm the site of pathology prior to anaesthesia.

The site of the marked abscess was not visible in the position in which the patient was placed. A preoperative brief and a formal WHO check should have prevented this occurrence. This is a systemic problem compounded by individual failures, referred to by the Advisory Board Psychologist as "organisational amnesia".

Injection error 1.

(Case Ref: 265)

On a routine GI operating list, the anaesthetist, keen to ensure rapid patient turnover and completion of the list, drew up three separate prophylactic antibiotic doses of intravenous cefuroxime 1.5 g for the first three patients, as discussed with the surgeon. On administration of the antibiotics the first patient was noted to twitch, but otherwise the procedure was completed uneventfully. When the prophylactic antibiotics were administered to the next case, however, the patient fitted. Review of the administered drugs revealed that the cefuroxime powder had inadvertently been reconstituted with 1% lignocaine solution, which was kept in the same drawer as the water for injection, in a similar ampoule. The patient recovered with no adverse effects but had to be awakened and the operation was not completed.

Injection error 2.

(Case Ref: 266)

In a separate incident, an anaesthetist prepared two syringes of Alfentanil 500 mcg/ml for the first two patients on the operating list. On completion of the first case, he administered what he thought was Ondansetron 2mg/ml, drawn up from a similar sized ampoule, to reduce postoperative nausea. Inadvertently, however, the drug given was the Alfentanil drawn up for the second patient, who sustained temporary laryngospasm and respiratory depression causing prolonged recovery from anaesthesia.

CORESS Comments:

Medication errors can occur in:

- choosing a medicine—irrational, inappropriate, and ineffective prescribing, under-prescribing and over-prescribing;
- writing the prescription—prescription errors, including illegibility;
- manufacturing the formulation to be used—wrong strength, contaminants or adulterants, wrong or misleading packaging;
- dispensing the formulation—wrong drug, wrong formulation, wrong label;
- administering or taking the drug—wrong dose, wrong route, wrong frequency, wrong duration;
- monitoring therapy—failing to alter therapy when required, erroneous alteration.

Aronson¹, has classified medication errors according to four broad categories:

- Knowledge-based errors (through lack of knowledge)
- Rule-based errors (using a bad rule or misapplying a good rule)
- Action-based errors (called slips)
- Memory-based errors (called lapses)

The Advisory Board were grateful to the anaesthetist who contributed these reports. Two separate mechanisms were involved in these injection errors. In the first, the antibiotics were reconstituted with the wrong fluid for injection. In the second, the wrong syringe was picked up. These were both action-based errors. The anaesthetist commented that drawing up multiple drugs for different operations contravened good practice. Coloured sticky labels applied to syringes may help, but are not always standardised. Keeping drugs with similar packaging and appearance next to each other in a store cupboard constitutes a systems error. Checking each drug, ampoule and date, prior to administration is a mandatory action prior to injection.

1. Medication errors: what they are, how they happen, and how to avoid them

J.K. Aronson QJM: An International Journal of Medicine, 2009;102 (8) 513-521,

<https://doi.org/10.1093/qjmed/hcp052>





Fall from grace

(Case Ref: 267)

An anaesthetised patient, due to undergo a gynaecological procedure, was placed on the operating table with her legs up in stirrups, and her bottom over the edge of the table. The anaesthetist, keen to reduce the risk of pulmonary aspiration, tilted the table head-up with the consent of the operating surgeons. Unfortunately, despite prior removal of the transfer slide sheet, the patient slid off the table and fell to the floor. The procedure was abandoned. The patient had to be awakened from anaesthesia and transferred to the emergency department to undergo a full trauma survey and imaging to exclude spinal and cranial injury. Litigation was successful.

CORESS Comments:

Falls from operating tables constitute serious risk to the patient and may be under-reported. Removal of the slide sheet forms part of the WHO check. Certain procedures may be more prone to risk of patient slippage particularly where an operating table needs to be angled (neurosurgery; laparoscopic surgery; gynaecological and colorectal procedures). Where there is increased risk, securing straps can be employed, and a high degree of awareness of the potential risk is the responsibility of the operating surgeon.

Atypical thromboses

(Cases 268, 269, 270)

Case 1

A 42-year old lady presented to her GP with rapid onset pain and pallor of her right leg. The GP was unable to feel pulses and referred her to the Emergency Department of the local hospital. She was transferred to the care of the vascular team who obtained a duplex scan and CT angiogram confirming occlusion of the superficial femoral artery with the appearance of embolism causing acute leg ischaemia. A femoral embolectomy was undertaken that night, at which the vascular registrar removed a quantity of recent clot. The patient was placed on intravenous heparin.

The leg survived overnight but remained dusky and further thrombectomy was necessary the following morning. Due to the odd appearance of the clot, some was sent for histological examination. The histology report commented on the appearances of myxomatous material. The patient underwent transthoracic echocardiography and chest CT scans confirming the presence of a left atrial myxoma. She was subsequently referred to the cardiac surgeons, who undertook surgical resection of the tumour, and the patient made a full recovery.

Case 2

Following hysterectomy for bleeding, a 46-year old woman presented with a warm swollen left leg. Duplex scan suggested iliofemoral thrombosis and the patient was treated for a postoperative DVT. She was anticoagulated, but at 3-month follow-up duplex scanning, imaging suggested propagation of the clot with abnormal appearances, and she underwent abdominal and pelvic CT scans. CT imaging revealed fleshy tissue, or clot invasion of the left pelvic and iliac veins, propagating into the inferior vena cava. The vascular surgery team became involved and eventually undertook open venous exploration, removing a large quantity of abnormal thrombus from the IVC and iliac vein. Postoperatively the patient remained anticoagulated.

Histological examination of the clot revealed cellular features of intravenous leiomyomatosis, a rare benign smooth muscle tumor, of uterine origin, that may grow into pelvic veins. On continued anticoagulation the patient remained well at 6-month follow-up with no significant recurrence.

Case 3

A 54-year old non-smoking man with minimal risk factors for vascular disease presented with a dusky painful swollen left calf of 48 hours onset. Duplex scanning suggested the probability of a calf vein DVT with an associated haematoma in the calf muscles adjoining the veins. The haematoma was explored and drained of dusky clot, and the patient was anticoagulated. However, the swelling persisted over the next two weeks and there was further bloody discharge from the calf incision. An MRI scan showed an irregular oedematous appearance of the calf muscles and the wound was re-explored with biopsy of the indurated muscle. Histological examination of the excised muscle demonstrated the presence of an invasive rhabdomyosarcoma. The patient required amputation of the affected leg shortly after.

CORESS Comments:

These atypical presentations of arterial and venous thromboses don't represent surgical mishap or adverse incidents. However, the Advisory Board noted that if there is no obvious source of embolus, then it is reasonable to ask for histological examination of thrombus, to rule out an atypical pathology. Arterial or venous thrombosis with no obvious cause may be the first manifestation of occult neoplasia.





Journal of the Association of Surgeons of Great Britain & Ireland

We would greatly appreciate your feedback to further enrich the content and format of the JASGBI!

Please complete the survey (link below) to tell us what you think

<https://www.surveymonkey.co.uk/r/X26JQC7>



Journal of the Association of Surgeons of Great Britain & Ireland

Contributor Guidance

(As at Summer 2017)

The Association welcomes and encourages contributions from Fellows and asks that potential contributors take the following guidelines into consideration.

Aims

The Journal of the Association of Surgeons of Great Britain and Ireland (JASGBI) is a regular publication that has evolved from the previously named Newsletter. It aims to publish material of topical or general interest to members of the Association, which will promote and advance the reputation and functions of the Association to a wider professional audience.

JASGBI is not a peer reviewed, academic publication, and is not intended as a vehicle for conventional academic papers. We nevertheless welcome a wide range of subject matter which may include:

- Articles of national and strategic relevance in relation to surgical training, teaching, career development, and issues in national politics, as they bear upon surgical and professional practice.
- Articles of topical debate.
- News from the Regions, and from affiliated Specialty Associations and Societies.
- Articles on international surgical practice, as observed by members of the Association on their travels, attachments and secondments.
- Historical articles of interest and relevance to surgeons.
- Personal experiences, parallel careers, hobbies, activities and achievements which are out of the ordinary, or which would fit our popular 'Secret Lives' series.

This list is not exclusive. JASGBI is keen to encourage and help develop standards in professional writing and to act as a vehicle for new and original material.

Publication Standards

Although JASGBI is not a conventional, peer reviewed academic publication, we subscribe wholeheartedly to the highest standards in respect of Publication Ethics and the elimination of the various forms of publication malpractice, as set out by the Committee on Publication Ethics (COPE) and the World Association of Medical Editors (WAME). Material submitted to JASGBI should thus be original to

the author(s). The editors reserve the right to submit any manuscript to peer review and to seek any amendments which are deemed to improve the presentation or content of the article to meet the standards and style of JASGBI.

Article length

Each page of JASGBI can accommodate around 750 words with a small picture. While we are flexible as to content, articles should usually be of 2,000 words or less, with up to four original images and/or figures. In general terms, PowerPoint graphics detract from the quality of presentation and should be avoided.

Images and Copyright

We support full colour pictures. Please only submit pictures for which you own the copyright, or have the written permission to reproduce from the person who holds the copyright. If the source requires attributing, please include this in the article. Number the images and state the appropriate figure title in the correct location in the text. Please ensure images are high resolution (minimum resolution 640 x 840 pixels) and submitted in JPG format if possible.

You retain the copyright of your published material. Where multiple authors have contributed to an article, please submit written authority and agreement of all authors to the publication.

JASGBI reserves the right to use published material in the advancement of the interests of the Association, and to distribute such material both in hard copy in the printed journal and by other electronic means, as through the Association's website, to secure the widest possible readership.

Authors must provide a 'for correspondence' email address with any article submitted. This will be published alongside your article.

References

JASGBI is not a journal of reference and we can neither encourage nor support long lists of references. In general terms, we will publish no more than ten relevant references.



Surgical Life

The Journal of the ASGBI

JASGBI IS PUBLISHED BY

The Association of Surgeons of Great Britain and Ireland
35-43 Lincoln's Inn Fields, London WC2A 3PE

Tel: +44 (0) 207 973 0300 | Email: admin@asgbi.org.uk

A Company Limited by guarantee, registered in England: 6783090. VAT number: GB 944 3070 34

EDITORIAL BOARD

Editor: Professor Vassilios Papalois, Director of Communications & Informatics

Editorial Advisors: Professor Iain Anderson & Ms Vicki Grant

JASGBI is an educational publication, distributed free to members of the Association.

The opinions expressed in this Journal are those of the individual authors, and do not necessarily reflect the policy of the Association of Surgeons of Great Britain and Ireland.

ASGBI STRATEGIC BUSINESS COLLABORATORS



Association of Surgeons of Great Britain and Ireland
35-43 Lincoln's Inn Fields, London WC2A 3PE | Tel: +44 (0) 207 430 9235

www.asgbi.org.uk