Being an HBP Surgeon during COVID19 times

Barcelona has been hit very hard by COVID infection as nearly 6000 people have passed away so far in this region. In the last 2 months, cancer surgery has been delayed, liver transplantation has been limited to urgent cases and pancreas transplantation program has been suspended. Those of us who also work in emergency surgery have noticed that number of patients consulting for urgent problems has lowered, but we ended up receiving more severe cases as patients waited longer before attending hospitals.

There was a huge effort to optimize ITU beds availability: as HPB surgeons, we had to make decision on which patients had priority. We got at the stage where 85% of our hospital beds were COVID19 patients, and ventilators from elective surgery theaters were made available for ITUs. Lacking of a "score", our decisions were based on patients condition, tumor factors and patients preference too. We also had to share our decisions with other Surgical Specialties within the hospital and accept that sometimes there patients who had more priority than yours. The impact on patients health is - and will be - huge, and it is still too early to know exact numbers. This is a very sensitive issue and my personal view is that it should no be discussed in a forum.

At the moment, it is difficult to understand what we should do as surgeons to keep ourselves and our patients safe. There are plenty of forums with unsolved questions; in times of evidence-based medicine we need some proper literature to support our statements. And if you type on pubmed.gov "Covid 19" you will find some 10.000 articles: this huge literature has been generated just in 4 months. The quality of reported data is good, but the level of evidence of most studies is low. However, there is one key-word that has been always used during the last 2 months: "physical distance". This applied for instance to our relationship with patients: only one doctor and one nurse for the ward round, no physical contact with patient's family, communication and updates given by phone only. This also means calling patients relatives by phone at the end of the surgery - very hard sometimes on both sides. Outpatients clinic limited to new patients or need of clinical assessment only; no shaking hands with patients or relatives.

We had to change relationship with our colleagues too: MDTs and other meetings have completely moved to videoconferences. Many doctors were infected with CODID19, so we had fixed teams of two surgeon every week for elective and emergency surgery, to avoid exposure of too many surgeons at the same time. PCR and chest-CT are performed in all elective and emergency cases, and we all undergo weekly PCR.

I am sure it will take time to get some proper evidence on how we should change our daily practice: in the meantime, as a member of Communication Committee, I think "EA-HPBA family" is essential to support our decisions and to encourage collaborations amongst members.

Fabio Ausania, Hospital Clínic de Barcelona