



100+years

AMERICAN COLLEGE OF SURGEONS

*Inspiring Quality:  
Highest Standards, Better Outcomes*

# COVID-19: Guidance for Triage of Non-Emergent Surgical Procedures

## Pediatric Surgery

### Guiding principles

- The goal is to provide timely surgical care to children with emergent and urgent pediatric surgical issues while optimizing patient care resources (e.g. hospital and intensive care unit beds, personal protective equipment, ventilators) and preserving the health of caregivers.
- There is no substitute for sound surgical judgement
- Surgery should be performed only if delaying the procedure is likely to prolong hospital stay, increase the likelihood of later hospital admission or cause harm to the patient.
- Children who have failed attempts at medical management of a surgical condition should be considered for surgery to decrease the future use of resources (e.g. recurrent infections in a branchial cleft cyst following course of antibiotics).
- Multidisciplinary shared decisions regarding surgical scheduling should be made in the context of available institutional resources that will be variable and rapidly evolving.
- Telemedicine and teleconsult services should be used for patient and physician interaction when available.

(The following list contains examples and is not meant to be comprehensive.)

### Emergency cases

Delay is life threatening

- Acute intestinal obstruction
  - Abnormalities of intestinal rotation
  - Incarcerated inguinal hernia
  - Pyloromyotomy for hypertrophic pyloric stenosis
  - Intussusception reduction not amenable to radiographic reduction
- Extracorporeal life support
- Intestinal perforation
  - Necrotizing enterocolitis with perforation
- Trauma with uncontrolled hemorrhage or penetration
- Ischemia
  - Testicular torsion
  - Ovarian torsion
  - Limb ischemia from trauma or iatrogenic
- Most congenital anomalies
  - Esophageal atresia with tracheoesophageal fistula
  - Symptomatic congenital diaphragmatic hernia
  - Intestinal atresia
  - Intestinal diversion for anorectal anomalies
  - Intestinal diversion for Hirschsprung disease not improved with irrigations

- Appendectomy for acute appendicitis (depending on institutional resources outpatient or short stay should be considered for uncomplicated appendicitis in order to maintain hospital beds; depending on available resources patients with complicated appendicitis should receive parenteral antibiotics and percutaneous drainage if an abscess is present)
- Esophageal or tracheal foreign body ingestion (special note should be made of higher risk of COVID-19 for endoscopic procedures)

## Urgent cases

Delays of days to weeks may be detrimental

- Most cancer surgery
  - Solid tumors (initial biopsy, resection following neoadjuvant therapy; consideration should be given for continuing chemotherapy in patients who will require postoperative intensive care or ventilation)
- Portoenterostomy for biliary atresia with jaundice
- Abscess incision and drainage
- Resection or diversion for acute exacerbation of inflammatory bowel disease not responsive to medical management
- Vascular access device insertion  
Consideration should be given to peripherally inserted central catheters
- Repair of symptomatic inguinal hernia
- Cholecystectomy for symptomatic cholelithiasis
- Gastrostomy if required for discharge

## Elective cases

Delay results in minimal patient risk

- Vascular access device removal (not infected)
- Chest wall reconstruction
- Asymptomatic inguinal hernia
- Anorectal malformation reconstruction following diversion
- Hirschsprung disease reconstruction following diversion
- Inflammatory bowel disease reconstruction following diversion
- Enterostomy closure
- Breast lesion excision (i.e. fibroadenoma)
- Branchial cleft cyst/sinus excision
- Thyroglossal duct cyst excision
- Fundoplication
- Orchiopexy
- Bariatric surgery
- Splenectomy for hematologic disease
- Cholecystectomy for biliary colic
- Repair of asymptomatic choledochal cyst

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