

## Guidance for categorizing operations, found on APSA NaT COVID-19 for pediatric surgeons page

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APSA supports the guidance distributed by the American College of Surgeons regarding the scheduling of emergent, urgent and elective cases: <https://www.facs.org/covid-19/clinical-guidance/triage>

Specifically related to pediatric surgery the following case guidelines were included as examples.

### Guiding principles

- There is no substitute for sound surgical judgement.
- 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.
- 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 resources outpatient or short stay should be considered for uncomplicated appendicitis in order to maintain hospital beds; depending on 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

Repair of asymptomatic choledochal cyst