Prioritisation of Colorectal Surgery during COVID-19

Intercollegiate advice on relative prioritisation across all surgical specialties has been published by the British and Irish Royal Surgical Colleges and the full list is available on our website

Download the list

This guidance covers the elective surgical priority levels:

- P2 for surgery that should take place within 4 weeks
- P3 for surgery that should take place within 3 months
- P4 for surgery that can be delayed for more than 3 months.

Delay in treatment may still result in adverse outcomes. Good administrative tracking will be essential to ensure patients do not get "lost" in the system. Regular scheduled remote updates through clinical nurse specialists will help mitigate against harm from disease progression or clinical deterioration.

Some procedures originally listed in Priority level 4, such as pelvic exenteration and multivisceral colorectal cancer resections, were assigned largely due to the significant requirements for critical care, blood transfusion, multiple clinical teams, long operating times and length of hospital stay incurred in providing such services, and also because most patients will have alternative treatment options such as pelvic radiotherapy or systemic anticancer treatments. As resources allow, these patients have been moved to Priority 3.

Salvage surgery for recurrent anal cancer has been assigned to Priority 3 as there is no other cancer treatment available for these patients and the tumour biology tends to be more aggressive than locally advanced primary or recurrent rectal cancer.

Surgery intended solely for quality of life purposes was previously considered as reasonable to defer during the recovery phase. Relevant cases mainly fall into the Priority 4 category. However, note that we are reaching a stage where such procedures have already been waiting a significant time. When Priority 4 cases have been waiting 6 months in total they should be reviewed and, if appropriate, moved to a higher priority level. There is also the recommendation to review and potentially upgrade individual patients based upon risk to function and worsening disability, pain and/or physical symptoms.

A specific case has been made for full thickness rectal prolapse where there is often a substantial disability with a known functional benefit to surgery and often low risk operations available. These patients can be considered as Priority 3 provided there is MDT direction and consideration given to any potential effect on local NHS resources.

The following table lists the priorities for elective colorectal procedures:

Surgical Priority Category during COVID-19	**Colorectal Procedures**
Priority 2	Stricturing or fistulating luminal Crohn's disease not responsive to endoscopic or medical treatments after optimisation of medication and nutritional status MDT directed resection/diversion for highly symptomatic cancer
Priority 3	MDT directed resection of colon cancer MDT directed resection of rectal cancer MDT directed resection of colorectal cancer liver metastases MDT directed resection of neuroendocrine tumour Salvage surgery for recurrent anal cancer Pelvic exenteration Seton insertion for symptomatic anal fistula (including perianal Crohn's disease) Colectomy and proctectomy for colitis refractory to medical treatment (excluding acute severe colitis treated urgently) MDT directed full thickness rectal prolapse surgery
Priority 4 (see notes above)	Transanal or rectal resection for benign rectal polyp Colonic resection for benign colonic polyp Completion proctectomy for IBD Ileoanal pouch surgery Uncomplicated incisional hernias Abdominal wall reconstruction Reversal of Hartmann's procedure Closure of diverting ileostomy Non-urgent proctology procedures Pelvic floor conditions (neuromodulation/sphincter repair etc)