Ever since its widespread outbreak, the COVID-19 pandemic has challenged health care systems worldwide. Allocation of resources in an effort to contain the spread of the virus, along with the reluctance of many patients to seek health care because of restrictions and social isolation, have severely disrupted preventive screenings and cancer care worldwide. Beds were needed for critically ill patients with COVID-19, and staff were required to care for those patients. Therefore, a resource transfer led to a prohibition on elective surgery for varying lengths of time in every state in the US and elsewhere in the world, generally between March and May 2020. There have been numerous publications in the past 2 years reporting the association of the COVID-19 pandemic with the diagnosis and treatment of colon and rectal cancer.

We read with great interest the comprehensive work by Eklöv et al1 in which they retrospectively reviewed 1140 patients who received a diagnosis of colorectal cancer and were treated in 8 hospitals in the greater Stockholm region, the area in Sweden most affected by COVID-19. The authors compared 550 patients with colorectal cancer treated between March and August 2020 with a control group of 590 patients treated between March and August 2019.1 The authors reported that more patients during the pandemic presented with advanced stage cancers, mostly a higher proportion of T4 tumors, compared with the control patients in 2019. This finding is consistent with other publications from around the world, including our own institutional experience.2 Furthermore, a multicenter comparative cohort study3 from Italy has reported that patients operated on during the first 8 months of the pandemic were more likely to be symptomatic, present with advanced stage disease, and have multiple liver metastases. These findings appear to be a direct result of delays in screening and diagnosis of colon and rectal cancer due to the restrictions imposed by the pandemic. In England for example, a population-based study4 showed a 92% reduction in the number of colonoscopies performed during the first wave of the pandemic. Interestingly, a report5 from Singapore showed no delay in presentation of colorectal cancer and no change in oncological or operative outcomes after lockdown measures. This laudable result was made possible because of the adequate preparation of resources and contingency plans formed by Singapore's local health care system as lessons learned from previous airborne pandemics.5 Moreover, the geographical and population size of Singapore may have been uniquely helpful factors.

The pandemic taught us a valuable lesson about the substantial impact of the delays in screening and diagnosis of colorectal cancer on oncological outcomes and survival. Eklöv et al1 noted that time to surgery had not changed, contrary to findings seen in other studies. For example, Dong et al6 reported that the COVID-19 pandemic significantly prolonged the mean interval between surgery and the last radiation session for rectal cancer. Our own institutional experience showed that time from diagnosis to initiation of any treatment modality for rectal cancer was significantly prolonged in patients operated on during the first year of the pandemic.2 Eklöv et al1 also reported that the number of patients with colon cancer who received an ostomy during the pandemic nearly doubled compared with the same time period before the pandemic. In contrast, The COVIDSurg Collaborative, which analyzed 2073 patients in 40 countries operated on during the first wave of the pandemic, found that only 1.3% had a defunctioning stoma and only 3.0% had an end stoma instead of an anastomosis.7 This finding is interesting and may, as the authors mention, indicate that our Swedish colleagues may have decided during that time to opt for the procedure with the lowest risk of complications to avoid potential complications that may overload their overwhelmed intensive care units. This finding is another example of how colorectal surgeons
had to adapt their practices and surgical decision-making to cope with the new reality set by the pandemic. It is interesting to note that in our own institutional experience, we saw a significant increase in abdominoperineal resection rates for rectal cancer in patients operated on during the first year of the pandemic. However, we can explain our results by the fact that, as was the case in the Stockholm region, more patients who were operated on during the first year of the pandemic presented to us with more locally advanced disease. Conversely, Eklöv et al noted that even in the COVID-19–free Ersta hospital, the rate of stoma creation significantly increased.

We were pleased to read that Eklöv et al reported no differences in the number of laparoscopic colorectal surgical procedures during the outbreak of the pandemic, because initially there had been great concern regarding possible viral transmission during laparoscopic surgery. This fear was subsequently mitigated as studies began to show that, when the necessary precautions are used, elective laparoscopic colorectal surgical procedures can be safely performed. Unfortunately, it seems that in some centers around the world, this initial concern had already taken its toll. A recent study from China reported that the rate of laparoscopic surgery for rectal cancer had decreased by nearly 20% in patients operated on during the pandemic. However, other reports, including our own recently published institutional experience, have fortunately demonstrated no significant differences between the rate of minimally invasive and open surgery for rectal cancer during the first year of the pandemic. As Eklöv et al mention, this result is probably due to the strict adherence to the guidelines and recommendations published by the American College of Surgeons, the Society of American Gastrointestinal and Endoscopic Surgeons, and the European Association of Endoscopic Surgery. Moving forward, we believe this debate has been settled and that we can continue to offer our patients the advantages of minimally invasive surgery while maintaining the safety and health of the patient and the hospital staff.

In addition to potential adverse outcomes to the patients, such as greater likelihood of an ostomy, hospital staff also experienced negative sequelae. One example of the hazards of the pandemic was the significant decrease in the participation of residents in colorectal surgery described by Eklöv et al. Clearly, physical distancing hindered surgical education; operative volumes are estimated to have been decreased by over 50% during the first wave of the pandemic. As we have learned that we can safely operate during the pandemic, we have also realized that resident education need not be compromised. We hope that these lessons learned will become practice used during the next pandemic or future waves of COVID-19. It would be interesting if Eklöv et al followed up with data analysis from March to August 2021 and again from March to August 2022 to assess any changes during and, hopefully, after the pandemic.

ARTICLE INFORMATION
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