BRITISH ASSOCIATION OF ENDOCRINE & THYROID SURGEONS

BAETS statement on COVID-19 and Adrenal Services

CONFIDENTIAL ADVICE FOR HEALTH PROFESSIONALS TO CONSIDER WHEN PLANNING ADRENAL SURGCAL SERVICES March 2020

This document covers adrenal surgery. This is not a clinical guideline or Standard Operating Procedure, but is a distillation of expert opinion which clinicians may find useful when planning local services.

Introduction

- During the current period of exceptional demands on the UK and International health services as a result of the COVID-19 pandemic, it is expected that patients with both Adrenal Cancer and non-urgent / low risk adrenal pathologies will be impacted.
- Responsible clinicians may need to differentiate cases where management can be deferred with relatively low risk of patient harm (until there is less stress on the system) from those that require expedited treatment.
- Deferred cases may therefore require monitoring over a longer period than usual, or potentially be suitable for alternative interim medical management, more appropriately undertaken by, or in conjunction, with endocrinology colleagues.
- Any decisions re changes will need to be taken locally and supported by local governance structures. Local planning should take place at the earliest opportunity taking into account varying levels of anticipated disruption at different stages of the pandemic.

Secondary Care Referral;

- Triage should attempt to identify non-cancer or benign cases and defer/ reject these as appropriate. In England 2ww rules for referral still currently apply currently, but telephone consultations may help triage.
- In the absence of known or suspected malignancy, investigation of clinically and radiologically benign lesions (true incidentaloma) can be deferred where appropriate.
- Patients at high risk from COVID-19 (due to co-morbidities or age) that fulfil urgent cancer referral criteria should be identified and streamed to a clinical environment that minimises exposure risk

Diagnostic/ staging workup;

- Diagnostic strategies should be tailored to local expertise and available resources

- Limit diagnostic workup in those cases where there is low clinical suspicion of malignancy, but ensure that there are robust and tracked plans for ‘catch up’ in the future
- Record pre COVID-19 management plan i.e. what would have been recommended in normal circumstances, if different

MDT working;

- As per UK practice guidance (*Palazzo et al*) **all** cases undergoing adrenalectomy should be discussed in an MDT
- Normal MDT frequency and core members should be maintained where possible. Any reduction in core members attending or reduced frequency should be through mutual agreement within the MDT
- Utilise facilities for dial -in or electronic discussions where possible
- Record pre COVID-19 management plan (if this differs) as well as the agreed management plan for the patient in the current COVID-19 situation
- Should situation arise where MDT is not quorate;
    - Use electronic MDT forum
    - Follow national/international guidelines
    - Take advice on an individual patient basis from experienced colleagues in the relevant disciplines
    - Discuss retrospectively at MDT when able to

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Surgical Management;

- ***Location -*** Adrenalectomy should be performed only in high volume centres (currently defined as > 6 per year, but ideally more) within a multi-disciplinary setting to minimise complications and length of stay, and make the most efficient use of available operating theatre time

- ***Prioritisation -*** Patients will require adrenalectomy as soon as this can be safely performed in the following order

    - Urgent Adrenalectomy – Priority 1 Confirmed Adrenal Cancer or Highly Suspicious Masses. Adrenal cancer is usually very aggressive with surgical resection the only effective treatment and therefore should be prioritised as such. This includes malignant phaeochromocytoma

    - Urgent Adrenalectomy – Priority 2 Indeterminate Masses > 6cm especially those that have been shown to be increasing in size or hot (and non-functional) on PT scan

    - Benign adrenal pathology may occasionally present in such a form as to also require urgent surgical management (eg refractory Cushing's syndrome, phaeochromocytoma presenting with heart failure). Due consideration should also be given to urgent adrenalectomy in these rare circumstances

    - Semi-urgent Adrenalectomy –

        - Adrenal Metastases - Rescan at 3 months and re-prioritise if progressing

        - Phaeochromocytoma
            - Block to highest degree that patient can tolerate and maintain independent living
            - Patients presenting with multi organ failure should be managed medically and surgery deferred if they can be safely managed on medication in the community until it is safer to admit them

        - Indeterminate Masses < 6cm
            - Consider PET scanning if not already undertaken

        - Cushings with difficult to manage related co-morbidities
            - Consider medical treatment with metyrapone (monitor cortisol to avoid hypocortisolaemia and be aware management of associated co-morbidities such as hypertension and diabetes may improve and require medication adjustment)

    - Deferred Adrenalectomy
        - Sub-clinical Cushings - Pragmatic endocrine monitoring for early detection, and treatment, of developing complications

- Primary Hyperaldosteronism (Conns) - On-going management is best supervised by experienced endocrinologist (as cardiovascular complications are greater in this group compared to age / sex / blood pressure matched populations)

- ***Vulnerability*** - The relatively few patients who will require critical care admission following adrenalectomy also need to have taken into consideration their likelihood of succumbing to COVID-19 were they to contract this peri-operatively. Those who are extremely likely to succumb to COVID infection and would not ordinarily receive invasive ventilation in that eventuality may not be considered for resection even if priority 1 during this pandemic.

- **Follow up**
  - Post-operatively in the unfortunate event of complication, clear discharge instructions of who to contact will reduce emergency department attendance
  - Strategies to minimise face to face follow up should be adopted (reviewing new urgent referrals through the MDT may also reduce the need for clinic attendance)
  - Utilisation of Virtual and telephone consultations
  - Discussion with local primary care providers for monitoring of blood pressure and diabetic control to reduce hospital visits.
  - Collaboration with endocrinologists to minimise duration of hydrocortisone replacement

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