Cardiology Procedures

Category 1 and Urgent Category 2

Intervention
Coronary Angioplasty - urgent
Coronary Angiography - urgent
Structural Heart Disease
Right heart catheterisation - if used to evaluate haemodynamic state in patients with severe heart failure or suspected primary pulmonary hypertension
Structural Heart Disease
TAVI
Percardiocentesis
TOE
TOE to assess for infective endocarditis - urgent
TOE to assess suitability of cardiac valves for urgent cardiac surgery
TOE guided cardioversion if AF is associated with haemodynamic compromise
Pacing / Devices
Device replacement for declining device battery longevity
Secondary prevention ICD
Pacemaker for symptomatic bradycardia - Sinus node dysfunction and/or AV block
Pacemaker for tachy-brady syndrome
CRT for chronic heart failure - urgent
Electrophysiology/Ablation/Cardioverion
AF ablation for chronic heart failure with reduced ejection fraction - refractory to medication
Atrial flutter if difficult to control rate and secondary complications of heart failure
VT ablation for haemodynamically significant VT or to prevent cardiomyopathy - urgent
Cardioversion if required < 30 days

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Cardiothoracic Surgery Procedures

Category 1 Procedures that are clinically indicated within 30 days	**Category 2** Procedures that are clinically indicated within 90 days ** The below procedures are a subset of Category 2 procedures considered urgent*
Lobectomy/wedge resection/pneumonectomy	Thymectomy (generally non urgent)
Pleurodesis (excluding chronic non acute pleural effusions)	
Urgent CABG for symptomatic disease	
Urgent valve surgery (eg endocarditis or symptomatic valve disease)	
Surgery for large or rapidly expanding aortic aneurysms	Surgery for symptomatic valve disease
Urgent aortic surgery	

AF ablation generally non urgent Cat 2/Cat 3

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Endoscopy Procedures	
Category 1	**Urgent Category 2**
Emergency	
Acute Upper GI bleeding	
Acute oesophageal obstruction – foreign bodies, food bolus, pinhole stricture/cancer where stenting is considered essential.	
Endoscopic vacuum therapy for perforations/leaks.	
Acute cholangitis/jaundice secondary to malignant/benign biliary obstruction	
Acute biliary pancreatitis and/or cholangitis with stone and jaundice	
Infected pancreatic collections/WON	
Urgent inpatient nutrition support – PEG/NJ tube	
Gastrointestinal obstruction needing urgent decompression/stenting	
Colonoscopy	
Rectal bleeding for >4 weeks	Change in bowel habits >6 weeks without alarm symptoms in patients with high pre-test probability of signficant pathology (eg age > 60 years, strong family history of bowel cancer etc)
Positive FOBT result	Abnormal imaging
Change in bowel habit: 6 weeks with alarm symptoms (persistent rectal bleeding, severe pain, iron deficiency anaemia, palpable mass, bloody diarrhoea)	Diarrhoea >6 weeks where endoscopy is indicated to progress management
Unexplained iron deficiency anaemia, in men or non-menstruating women	
Active inflammatory bowel disease where endoscopy is indicated to progress management	
Bloody diarrhoea with negative stool MC&S	
	Signs or symptoms suggesting a significant pathology where delayed diagnosis beyond 8 weeks would have a significant impact on clinical outcome.
Gastroscopy	
Unexplained upper GI bleeding	Unexplained recent dyspepsia in patients >55yr
Unexplained iron deficiency anaemia, in men or non-menstruating women	Reflux refractory to medical therapy
Unexplained recent dyspepsia in patients <55 with alarm symptoms	For duodenal biopsy following positive serology in suspected coeliac disease
Dysphagia/odynophagia	
Unexplained weight loss and upper abdo pain	
Upper abdominal mass and/or abnormal imaging	
Persistent vomiting and / or weight loss	
EUS - investigation of mass or abnormal imaging with high pretest probability of significant pathology	Signs or symptoms suggesting a significant pathology where delayed diagnosis beyond 8 weeks would have a significant impact on clinical outcome.

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ENT and Maxillofacial Procedures	
Category 1	**Urgent Category 2**
All cancer surgery/resection of primary/metastatic disease	Dental extraction as part of preparation for Radiotherapy or Cardiac Surgery
Complicated acute otitis media	Severe obstructive sleep apnoea confirmed by sleep study
Head and neck infections/abscess	Hearing loss leading to developmental delay
Mastoiditis	
Cholesteatoma - extensive or complications	
Chronic otitis media with acute complications	
Subglottic or tracheal stenosis, such as needing balloon dilatation	
Tracheostomy	
Complicated acute/chronic sinusitis, orbital complications/risk of intracranial complications, especially oncology patients	
Major bleeding	
Complications of recent surgery-bleeding or infection/abscess	
Severe sialadenitis requiring surgical management	
Muscle biopsy/temporal artery biopsy	
Posterior fossa decompression for haemorrhage, tumour or syrinx	
Pericoronitis requiring surgical tooth removal	
Acute tooth pulpitis/fracture requiring extraction of the tooth	
Maxillofacial or dentoalveolar trauma	
Severe oral infection/cellulitis	
Laryngo-tracheal stenosis - significant	

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General Surgical Procedures	
Category 1	**Urgent Category 2**
All cancer surgery/resection of primary/metastatic disease or suspected primary/metastatic disease	Surgery for severe reflux or aspiration
Trauma	Surgery for marginal ulcers
Cholecystectomy - acute cholecystitis, choledocholithiasis, biliary pancreatitis	Parotidectomy/submandibular gland – excision of
Hernia repair - obstructed/incarcerated/strangulated or highly symptomatic or at imminent risk of obstruction/incarceration	Thyroidectomy/hemi-thyroidectomy for significant obstructive/compressive symptoms
Parathyroidectomy for hypercalcaemia Ca > 3	Parathyroidectomy for symptomatic hyperparathyroidism (HPT)
Appendicetomy	
GIT obstruction/stricture	
Internal herniation	
Infusaport insertion. Infusaport removal (for infection / erosion etc)	
Gastric volvulus	
Haemorrhage	
Anastomotic leaks	

Bariatric Surgery, primary or revisional where the main indication is weight loss is considered Cat 3.

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Gynaecology Procedures	
Category 1	**Urgent Category 2**
Acute pelvic pain e.g. risk of ovarian torsion	Surgical management of significant menorrhagia or other gynaecologically caused acute blood loss (not responding to medical management, requiring transfusion/blood products)
Acute pelvic infection that requires surgical intervention due to acuity/non-response to medical treatment	
Ruptured tubal-ovarian abscess/mass	
Acute and severe per vaginal bleeding	
Viscus perforation	
Closed-loop bowel or colonic obstruction	
Incarcerated hernia with gynaecologic tumour	
Acute vulval, vaginal, uterine or pelvic haemorrhage	
Pelvic mass with torsion or causing urinary or intestinal obstruction	Urogynae to be assessed case by case (but potential examples include: surgery for significant prolapse/procidentia with complications; management of vesicovaginal fistula)
Post-menopausal bleeding with abnormal imaging – suspected gynaecological malignancy.	
High risk pre invasive disorders - Adenocarcinoma in situ (ACIS) identified on PAP smear	
Pelvic and/or abdominal mass on imaging – suspected gynaecological malignancy	
Suspicious masses - RMI >200.	
Suspicious masses – RMI <200 but history of other malignancy or family history of related malignancy, ascites or significantly concerning USS features	
Endometrial cancer	
Cervical and vulvar cancers—surgery with curative intent	

Gynaecology Procedures	
Category 1	**Urgent Category 2**
Cervical and vaginal malignancies requiring radiation applicators	Assessment and treatment associated with gynaecological cancers - LLETZ procedure for CIN, postmenopausal bleeding
Cervical AIS or inadequate colposcopy and concern for invasive cancer	
Advanced ovarian cancer, particularly interval CRS	
Patients with recurrent disease without non - surgical options	
Symptomatic patients with inoperable primary or recurrent cancer requiring palliative cancer procedures (e.g., diverting colostomy, venting PEG tubes, but not including exenteration	
Other cancer surgery/resection of primary/metastatic disease	
Symptomatic patients with inoperable primary or recurrent cancer requiring palliative cancer procedures (e.g., diverting colostomy, venting PEG tubes, but not including exenteration	
Other cancer surgery/resection of primary/metastatic disease	
Bartholin's abscess	Incomplete miscarriage
Curettage and evacuation of uterus	
Cone biopsy	
Ectopic pregnancy	

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Neurosurgical and Orthospinal Procedures	
Category 1	**Urgent Category 2**
All cancer surgery / resection of primary/metastatic disease or suspect primary / metastatic disease	Spinal disorders associated with cord compression or significant neurological compromise (with unambiguous findings on clinical examination)
Cerebral haematoma – evacuation of	Untethering of spinal cord
Craniotomy for ruptured aneurysm	Chronic and severe incapacitating pain with neurological deficiency (with unambiguous findings on clinical examination and severe functional impact on patient's ADLs to the extent that the patient could not manage their symptoms for a further 3-6 months.
Discectomy in the presence of foot drop	
Intracranial lesion (for example abscess/arteriovenous malformation) 1 – removal of	
Muscle biopsy / temporal artery biopsy	
Posterior fossa decompression for haemorrhage, tumour or syrinx	
Ventricular peritoneal shunt for obstructive hydrocephaly	
Unstable cervical, thoracic, lumbar fractures	
Surgical treatment of postoperative complications, other than planned revision surgeries	
Infections, unresolved by medical means with neurological or potential instability	
Acute neurological deficit eg cauda equina syndrome	

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Ophthalmology Procedures	
Category 1	**Urgent Category 2**
Intravitreal injections (subset)	Lid surgery for entropion/trichiasis
Retinal detachment	
Endophthalmitis	
Vitrectomy (excluding for the indication of floaters)	
Acute angle closure glaucoma	
Malignancy or suspected malignancy	
Moh's reconstruction	
Orbital decompression	
Trabeculectomy or tube glaucoma surgery (subset)	
Enucleation and evisceration	
Tarsorrhaphy	
Corneal graft surgery	

Most glaucoma surgery with iStents and MIGS are Cat 3

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Orthopaedic Procedures	
Category 1 Procedures that are clinically indicated within 30 days	**Category 2** Procedures that are clinically indicated within 90 days * The below procedures are a subset of Category 2 procedures considered urgent
Fractures	Conditions requiring significant/escalating opiods
Infection	Any procedure that cannot be safely postponed 90 days
Deep haematomas	
Wound breakdown	
Joint revision with impending fracture	
Malignancy	
Acute tendon injury/rupture	
Ligamentous Injury requiring acute repair	DMS & HOD Orthopaedics will discuss any cases of uncertainty
Acute rupture of Achilles tendon (that can not be treated non-operatively)	
Nerve injuries/compression	

Pain Procedures	
Category 1 Procedures that are clinically indicated within 30 days	**Category 2** Procedures that are clinically indicated within 90 days ** The below procedures are a subset of Category 2 procedures considered urgent*
Infected implanted devices	Patients only qualify as an urgent Category 2 case if they have pain not controllable with analgesics resulting in: - impairment of the patient to undertake activities of daily living - a severe impairment of mobility - the pain threatening to cause the patient to imminent job loss - a threat to the ability of the patient to function as a carer for another individual
Eroding IPGs	Pain which results in a substantial disturbance of sleep, sufficient to affect the patient's psychiatric status.
Exposed device wires	Significant psychiatric disturbance including depression as a result of the pain likely to impact on the ability of the patient to cope and placing them at risk of hospitalisation with regards to a psychiatric condition.
Replacement of an implant for severe facial pain where it is compromising the ability of the patient to maintain adequate nutritional intake.	Pain that has or will result in patients presenting to the emergency department due to the fact they cannot control the pain in their own environment.
Intractable sciatica requiring hospital admission, any severe spinal pain requiring hospital admission, current inpatients where the injection would substantially increase the chances of discharge, interventions for cancer pain.	Stimulator components which have not yet eroded but will potentially erode in the next 90 days (revision of stimulator only).
Vertebral crush fractures resulting in severe pain requiring hospitalisation, the pain status resulting in severe psychiatric disturbance with suicidal ideation.	

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Plastic Surgery

Guidelines for Category 1 and Urgent Category 2 Procedures

Skin and soft tissue cancers and suspected cancers, including malignant melanoma, SCC and urgent BCC
Soft tissue defects - wound debridements and flaps
Infections - debridement, removal of infected prostheses
Breast reconstructions if concurrent with breast cancer surgery
Trauma - lacerations, fractures
Nerve compression with proven motor compromise

**** For conditions outside this scope, please discuss with DMS ****

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Urology Procedures
(as per Urological Society of Australia and New Zealand)

Below is an indicative list of conditions which may warrant urgent surgical intervention during the COVID 19 crisis.
The list is not exhaustive but acts a guide for clinicians. ICU availability may be compromised at times and access to this level of care may be required in some cases.

Testis cancer
Inguinal orchidectomy, RPLND for progressive residual mass post chemotherapy (consider deferral if suggestive of slowly growing mature teratoma)
Renal cancer
Renal cell carcinoma > 7cm, or complicated with venous thrombus (consider immunotherapy/chemotherapy options as initial treatment in metastatic setting with secondary delayed cytoreductive nephrectomy), upper tract urothelial cancerrequiring nephroureterectomy (can consider neoadjuvant chemotherapy)
Prostate cancer
A proportion of high risk prostate cancers (viz., some select Gleason 8-10 cancers and high risk G4+3 or palpable cancers)
Intermediate and some high risk cancers may in many circumstances be safely managed with initial ADT and deferred definitive treatment
Low risk cancers should be initially managed with active surveillance
Bladder cancer
Cystectomy for MIBC (ideally prior neoadjuvant chemotherapy and delay surgery after discussion with medical oncology colleagues), surveillance on suspected cystoscopy +/-TURBT for high risk NMIBC only e.g., CIS and G3T1
Cystoscopy for macroscopic haematuria
It is recommended that a diagnostic cystoscopy should be undertaken with abnormal radiology or abnormal cytology. If these investigations are normal a delay of 1-2 months for a diagnostic cystoscopy is a low risk to the patient
Prostate biopsies
Only for suspicious prostate lesions or PIRADS 4/5 on prior MRI (not for lower PIRADS nor for protocol based AS evaluation which should be followed biochemically in 3 months) unless palpable suspicious lesion
TURP
For chronic or acute urinary retention if not suitable for self-catheterisation or indwelling IDC
Endourology
Symptomatic stones, obstructed or infected kidneys, stents in situ. Diagnosis of suspected upper tract urothelial cancer or endoscopic treatment of upper tract urothelial lesions
Scrotal
Testicular torsion
Trauma
Including penile, urethral
*** Note if the MDT recommends escalating a category, please discuss with DMS ** *

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Vascular Procedures

Category 1 and Urgent Category 2

Debridements/amputations toes/feet/legs or wounds
Renal access and venous access
Aortic and peripheral aneurysms pose a life and limb threat based on size/symptoms o ICU capacity will need to be considered prior to intervention o Generally AAA>5.5cm, CIAA>4cm, TAA>6cm, CFAA>3.5cm and Popliteal aneurysm >2.5cm would be considered appropriate for urgent treatment. (Noting Elective criteria usually less than above)
Recently symptomatic carotids (< 3 months) and crescendo TIAs (Asymptomatics, even >80% could be deferred up to 3 months on best medical therapy)
Critical limb ishchaemia o Vascular ischaemic rest pain or ulceration o Stable claudicants could probably be deferred up to 3 months with prioritization if symptoms progress despite best medical therapy o Exception - threatened open or endovascular interventions – ie. >75% in-stent or bypass stenosis – must be documented in notes/consent
Renal or mesenteric arterial intervention - symptomatic
Vascular tumours

Non urgent cases include any pelvic and lower limb varicose vein intervention - open or endovascular

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