See Article page 597 in the August 2020 issue.

Commentary: Collaboration is key to saving as many lives as possible

Mara B. Antonoff, MD

In the August 2020 issue of the *Journal*, Chen and colleagues¹ share insights from the Chinese experience with Coronavirus Disease 2019 (COVID-19) for the benefit of improving thoracic surgical outcomes worldwide during this unprecedented time. This article is certainly timely, and at this moment, the information shared is likely of greater relevance to the majority of surgeons in our field than any other previous publication. This pandemic affects us all—all of our practices, all of our patients, all of our colleagues and communities. Based on Peng and colleagues’² cohort study of perioperative COVID-19 outcomes, as well as additional experience from the Chinese thoracic surgical workforce, this article¹ shares wisdom in attempts to lessen the global wreckage from the coronavirus.

Among Chen and colleagues’¹ suggestions, the first is aimed to minimize the spread of the virus from asymptomatic carriers, specifically with the use of universal precautions. However, the recommendation for treating all patients who come to the hospital for surgery with universal precautions is accompanied with the caveat that there is a presumption of adequate supplies. This, of course, is a challenging assumption, because it will vary on the basis of location, population density, financial resources, and phase of the surge, among many additional variables. In order to heed the advice provided here with regard to use of universal precautions, more work is currently needed to explore the challenges and potential solutions for addressing critical shortages of personal protective equipment (PPE).³

Chen and colleagues¹ go on to provide specific recommendations for common thoracic diseases, which are overall quite helpful. While these recommendations are geared

Mara B. Antonoff, MD, FACS

CENTRAL MESSAGE

Sharing our successes, failures, and lessons learned with the thoracic surgical community is imperative to saving as many lives as possible during this pandemic.

toward the general thoracic surgeon, certainly, this is a time when similar guidance is being proposed to steer adult and congenital cardiac surgeons.^{4,5} In terms of disease processes, Chen and colleagues¹ recommend cessation of operating for ground-glass lesions; first, because ground-glass predominant malignancies typically exhibit an indolent and favorable course, and second, because of challenges in discerning COVID-19–related imaging findings from those of pure ground-glass adenocarcinomas. With regard to N2–IIIA non–small cell lung cancer, Chen and colleagues¹ recommend consideration of induction therapy to delay surgery or deferral to definitive chemoradiation followed by immunotherapy, depending on additional patient factors. Moreover, for assessing the stage of non–small cell lung cancer patients, we are urged to rely on positron emission tomography, despite its inherent limitations, to reduce additional procedures of endobronchial ultrasound and mediastinoscopy, especially considering risk of aerosol generation with the former. For esophageal cancer, the suggestion is made to consider, for select patients, bimodal rather than trimodal therapy, with the caveat that salvage resection could be offered as needed after the pandemic. Finally, for patients with COVID-19 who require urgent or emergency surgical procedures, Chen and colleagues urge us not to abandon our patients in the greatest need, but also not to forget the importance of protecting ourselves and our teams with adequate PPE. These are all excellent recommendations and, for the large part, correspond with those recommendations made by the Thoracic Surgery

From the Department of Thoracic and Cardiovascular Surgery, University of Texas MD Anderson Cancer Center, Houston, Tex.

Disclosures: The author reported no conflicts of interest.

The *Journal* policy requires editors and reviewers to disclose conflicts of interest and to decline handling or reviewing manuscripts for which they may have a conflict of interest. The editors and reviewers of this article have no conflicts of interest.

Received for publication April 21, 2020; accepted for publication April 22, 2020; available ahead of print May 1, 2020.

Address for reprints: Mara B. Antonoff, MD, 1400 Pressler St, Unit 1489, Houston, TX 77030 (E-mail: mbantonoff@mdanderson.org).

J Thorac Cardiovasc Surg 2020;160:e237-8
0022-5223/\$36.00

Copyright © 2020 by The American Association for Thoracic Surgery
<https://doi.org/10.1016/j.jtcvs.2020.04.069>

Outcomes Research Network (ThORN) regarding triage of operations for thoracic malignancies during this pandemic.⁶

However, one of the strengths of the ThORN consensus statement is that all recommendations are based on the hospital's phase within the surge in terms of prevalence of patients with COVID-19 within the institution, availability of hospital resources, and rate of change.⁶ Although the advice from Chen and colleagues¹ is outstanding, it does not take into consideration the various phases of the pandemic that may be facing the readership. In addition, one might note that many of the recommendations made by Chen and colleagues¹ are based on less than robust oncological evidence; however, this is actually very appropriate given that the recommendations are based on the best data that we have available and guidance is in high demand during this challenging time. As stated by infectious disease specialist Dr Annie Antar, "All of us want to practice evidence-based medicine, but the timeline for this might not allow us to wait for that."⁷

Chen and colleagues¹ have taken a humbling and altruistic approach, sharing information that will be of great benefit to our thoracic surgical community. In times such as this, there exists much uncertainty regarding best practices, outcomes, and consequences of the challenging decisions with which we are all faced. However, one thing is

absolutely certain: Such sharing of experiences—successes, failures, and lessons learned—is imperative to enable us all to save as many lives as possible.

References

1. Chen KN, Gao S, Liu L, He J, Jiang GN, He J. Insights from China: improving thoracic surgery outcomes during the COVID-19 pandemic. *J Thorac Cardiovasc Surg*. 2020;160:597-600.
2. Peng S, Huang L, Zhao B. Clinical course of coronavirus disease 2019 in 11 patients after thoracic surgery and challenges in diagnosis. *J Thorac Cardiovasc Surg*. April 10, 2020 [Epub ahead of print].
3. Rowan NJ, Laffey JG. Challenges and solutions for addressing critical shortage of supply chain for personal and protective equipment (PPE) arising from Coronavirus disease (COVID19) pandemic - case study from the Republic of Ireland. *Sci Total Environ*. 2020;725:138532.
4. Mahmud E, Dauerman HL, Welt FG, Messenger JC, Rao SV, Grines C, et al. Management of acute myocardial infarction during the COVID-19 pandemic. *Catheter Cardiovasc Interv*. April 20, 2020 [Epub ahead of print].
5. Shah PB, Welt FGP, Mahmud E, Phillips A, Kleiman NS, Young MN, et al. Triage considerations for patients referred for structural heart disease intervention during the Coronavirus Disease 2019 (COVID-19) pandemic: an ACC/SCAI consensus statement. *JACC Cardiovasc Interv*. April 3, 2020 [Epub ahead of print].
6. Thoracic Surgery Outcomes Research Network, Inc. COVID-19 guidance for triage of operations for thoracic malignancies: a consensus statement from Thoracic Surgery Outcomes Research Network. *Ann Thorac Surg*. April 4, 2020 [Epub ahead of print].
7. Begley S. Desperate for Covid-19 answers, U.S. doctors turn to colleagues in China. *STAT Health*; 2020. Available at: <https://www.statnews.com/2020/03/24/covid-19-answers-doctors-turn-to-china/>. Accessed April 21, 2020.