Condition	Recommended Surgeries	Rationale	Average Length of Stay
ENDOUROLOGY/STONE DISEASE			
Stones	For obstruction/infection: • Ureteral stent insertion • Consideration for awake, bedside ureteral stent under local • Consideration for nephrostomy tube	• When possible, stents can be placed at the bedside which spares a ventilator [26] • Nephrostomy tubes can be placed under local anesthesia, sparing a ventilator. • If neither option is possible, an obstructed or infected upper tract is an emergency requiring intervention.	• Outpatient procedure (unless concurrent infection)
Indwelling ureteral stent	• Delay most procedures	• Most stents left in place even up to 6-12 months can have simple stent removal, and endoscopic management of stents is possible in most patients up to 30 months of indwelling time.[27]	• Outpatient procedure
BPH	• Delay BPH procedures (TURP,HOLEP, PVP Laser, etc)	• Urinary obstruction can be adequately treated via urethral or suprapubic catheter without need for a procedure under anesthesia	• TURP: 1-2 days[28]
FEMALE UROLOGY/INCONTINENCE			
Stress urinary incontinence, interstitial cystitis, overactive bladder, neurogenic bladder	• Delay all procedures		
Nerve Stimulator In Place	• Second stage nerve stimulator placement or removal	• Nerve stimulators with externalized leads may have a high rate of infection if left in place and should be either internalized via second stage or removed, either of which can be performed under local anesthesia.	Outpatient Procedure
RECONSTRUCTIVE SURGERY			
Fistula with pelvic sepsis	• If systemic symptoms, diversion either with catheters/drains, or formal fecal stream diversion • Delayed definitive repair unless clinical conditions would require immediate repair.	• Fistula repairs are resource intensive and should be delayed when possible.	• Variable
Artificial Urinary Sphincter Explants	• Infected explants, only	• Infected sphincters may progress rapidly to systemic infection and should be addressed emergently	• Variable
URETHRAL STRICTURE			
Urethral Obstruction	• Delay all procedures	• Suprapubic tube placement or Foley catheter placement in association with urethral dilation or incision is urgent in those with impending or complete lower urinary tract obstruction.	• Outpatient Procedure
PROSTHETIC SURGERY			
Erectile dysfunction	• Infected explants only	• Infected implants may progress rapidly to systemic infection and should be addressed emergently.	• Variable
GENERAL UROLOGY			
Soft tissue infection	• Acute infections only; scrotal abscesses, Fournier's gangrene		• Variable
Ischemia	• Shunting for Priapism • Testicular Detorsion / Orchidopexy		• 1-3 days
Hemorrhage	• Clot evacuation for refractory gross hematuria		• 1-3 days
Trauma	• Penile / testicular fracture repair • Ureteral injury • Bladder Perforation		• Outpatient Procedure • 1-3 days
TRANSPLANT			
Renal transplant	• Deceased donor transplants only	• Deceased donor transplants should proceed without delay.	• 4-8 days[29]
	• Live donor transplants delayed	• Live donor transplants should be delayed, both to spare resources and to delay the requisite immunosuppression on the recipient, which may lead to a greater impact of COVID-19 infection.	
PEDIATRICS			
Acute torsion	• Scrotal exploration, orchidopexy		• Outpatient Procedure
GU obstruction	• Foley catheter / suprapubic tube placement		• Outpatient Procedure
INFERTILITY			
	• Delay all procedures		

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INFERTILITY			
	• Delay all procedures		

ONCOLOGY			
Condition	Recommended Surgeries	Rationale	Average Length of Stay
Bladder cancer	• Cystectomy for MIBC, regardless of receipt of neoadjuvant chemotherapy	• Delaying cystectomy for MIBC by 90 days increases pN+ rate[3], decreases overall and progression free survival [4], and higher pathologic stage[5]	• 5-8 days (US) [6,7]
	• Cystectomy for CIS refractory to 3rd Line therapy		
	• TURBT for suspected cT1+ bladder tumors	• cT1 tumors are understaged in up to 50% of cases, presenting significant risk of missed MIBC[8]	• Outpatient procedure
Testicular cancer	• Orchiectomy for suspected testicular tumors	• Limited data on survival with delay to orchiectomy[9]; however, orchiectomy is an outpatient procedure with potential overall survival benefit and should be prioritized[10]	• Orchiectomy: outpatient procedure
	• Post-chemotherapy RPLND		
	• Favor chemotherapy or radiation rather than RPLND when clinically appropriate	• To spare a ventilator and inpatient stay (RPLND), radiation post-orchiectomy can be encouraged when surveillance is not an option. Chemotherapy use should be balanced by concern for immunosuppression and increased risk of COVID-19 infection/sequelae	• RPLND: 4-6 days (open) [11] 1-3 days (minimally invasive)[12]
Kidney cancer	• Nephrectomy for cT3+ tumors, including all patients with renal vein and/or IVC thrombi	• More advanced renal tumors, particularly with associated vein thrombi, may progress rapidly and create more complicated surgeries and adversely affect survival and/or surgical morbidity.[13]	• Nephrectomy: 3 days[14]
	• Planned partial or radical nephrectomy for cT1 masses should be delayed or other forms of ablative approaches should be considered in selected patients		• IVC Thrombectomy: 5-10 days[15]
	• Planned partial or radical nephrectomy for cT2 should be considered for delay based upon patient specific considerations, such as age, morbidity, symptoms, and tumor growth rate	• For cT1-2 (stage I-II) masses, delaying surgery by 3 months has not been associated with decreased CSS or OS.	• 1-2 days (minimally invasive) or 2-4 days (open) [16]
Prostate cancer	• Most prostatectomies should be delayed	• Surgery for NCCN high risk may be considered depending on patient age and disease risk. However, given the availability of other treatment modalities, these surgeries may receive lower prioritization than others on this list (as delay of treatment up to 12 months, even for high risk disease, may not alter operative outcomes, cancer specific mortality, or other outcomes).	• 0-2 days[20]
	• Shared decision making to consider radiation therapy for NCCN High risk disease	• Biochemical recurrence rates may be higher in high risk men who delay definitive treatment, but there is not a clear cut-off time for this treatment benefit.[17–19]	
	• Surgery for NCCN high risk if patient is ineligible for radiation		
	• Selected high risk patients as well as those with intermediate or low risk cancer should be delayed		
UTUC	• Nephroureterectomy for high grade and/or cT1+ tumors	• 3 month delay to surgery for UTUC has been associated with disease progression for all patients, and with CSS for patients with muscle invasive disease.[9,21]	• 1-4 days[23]
		• Early stage, particularly invasive, has a high risk of being understaged.[22]	
Adrenal tumors	• Adrenalectomy for suspected ACC, or tumors >6cm	• Adrenal masses larger than 6 cm are much more likely to harbor carcinoma.	• 0-1 days[25]
	• Consider delay of adrenalectomy for less suspicious adrenal masses (<6cm, favorable imaging characteristics)	• ACC progresses rapidly, and achieving R0 at surgery provides the best chance of survival. Delay may decrease resectability and affect survival. [24]	
Urethral / Penile Cancer	• Clinically invasive or obstructing cancers	• Data for these rare tumors are limited. Preventing lymph node metastases may spare significant morbidity from patients. Further,	• Outpatient procedure