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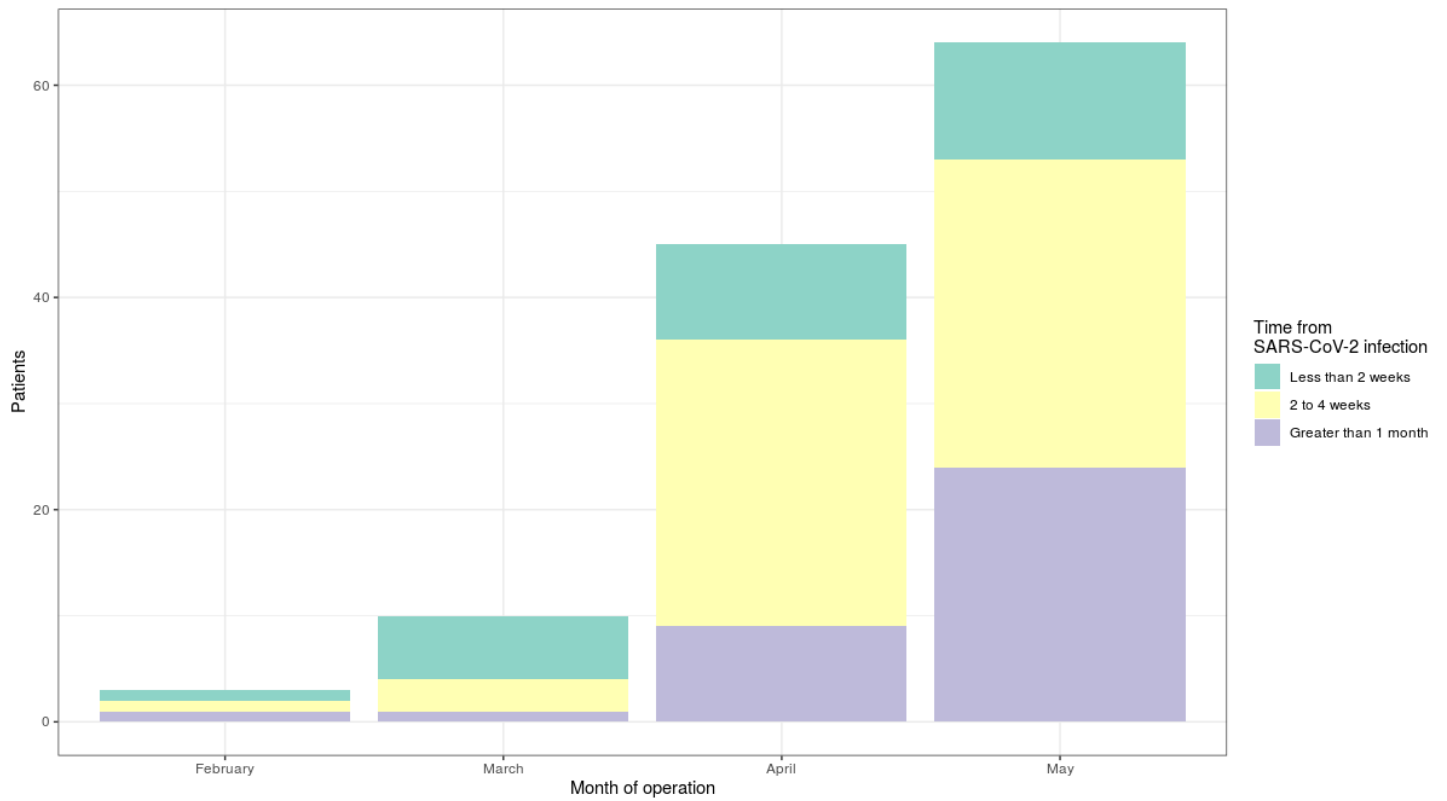
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Supplementary Figure 1. Accrual of patients operated after previous SARS-CoV-2 infection between February and May 2020

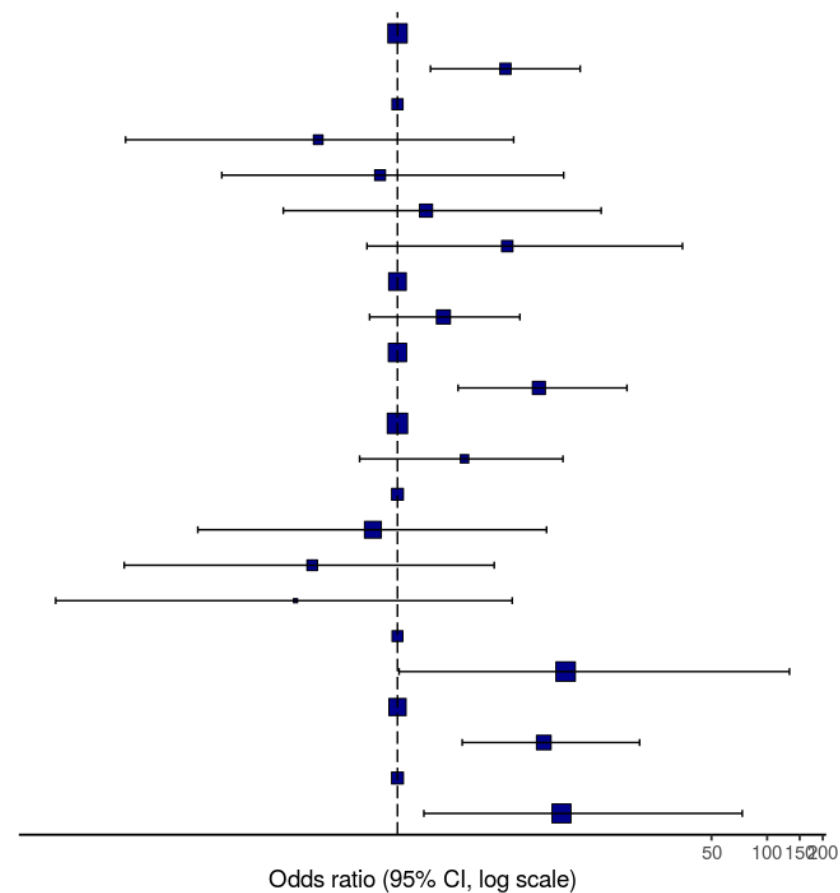


Timing from previous SARS-CoV-2 positive swab was defined as the weeks from notification of a positive nasopharyngeal swab (qRT-PcR) result. For the purpose of analysis, this was divided into three groups: less than 2 weeks; 2 to 4 weeks; greater than 1 month. Within this study, we did not collect whether a confirmatory repeat 'negative' SARS-CoV-2 swab test had been performed preoperatively.

Supplementary Figure 2. Propensity score matched model for factors associated with postoperative pulmonary complications.

Pulmonary Complications: OR (95% CI, p-value)

Previous SARS-CoV-2	No	-
	Yes	3.84 (1.51-9.74, p=0.004)
Age	<50 years	-
	>80 years	0.37 (0.03-4.25, p=0.399)
	50-59 years	0.81 (0.11-7.93, p=0.836)
	60-69 years	1.43 (0.24-12.65, p=0.714)
	70-79 years	3.93 (0.68-34.84, p=0.158)
Sex	Female	-
	Male	1.77 (0.71-4.59, p=0.226)
ASA Grade	ASA grade 1-2	-
	ASA grade 3-5	5.82 (2.13-17.45, p=0.001)
Pre-existing respiratory condition	No	-
	Yes	2.31 (0.62-7.86, p=0.190)
RCRI	0	-
	1	0.74 (0.08-6.41, p=0.776)
	2	0.35 (0.03-3.34, p=0.356)
	>=3	0.28 (0.01-4.18, p=0.373)
	Operation grade	Minor
	Major	8.12 (1.02-132.05, p=0.088)
Disease stage	Early disease	-
	Advanced/nodal disease	6.19 (2.24-20.42, p=0.001)
Hospital type	COVID-19 free surgical pathway	-
	No defined pathway	7.72 (1.39-73.37, p=0.038)



Data included from 112 patients with previous SARS-CoV-2 infection propensity score matched with 448 patients with no preoperative or perioperative SARS-CoV-2 infection. ASA=American Society of Anaesthesiologists. RCRI= Revised Cardiac Risk Index. Please See *Appendix* for full definitions. Area under the Receiver Operating Characteristic curve for model: 0.88 (excellent discrimination).

Supplementary Table 1. Characteristics of patients with a previous positive SARS-CoV-2 test.

Factor	Levels	Less than 2 weeks N=27	2 to 4 weeks	Greater than 4 weeks	P-Value
Age	<50 years	6 (22.2)	9 (15.0)	8 (22.9)	0.561
	50-59 years	4 (14.8)	13 (21.7)	9 (25.7)	
	60-69 years	5 (18.5)	19 (31.7)	8 (22.9)	
	70-79 years	8 (29.6)	15 (25.0)	5 (14.3)	
	>80 years	4 (14.8)	4 (6.7)	5 (14.3)	
Sex	Female	20 (74.1)	38 (63.3)	19 (54.3)	0.277
	Male	7 (25.9)	22 (36.7)	16 (45.7)	
ASA Grade	Grade 1-2	15 (57.7)	44 (73.3)	26 (74.3)	0.285
	Grade 3-5	11 (42.3)	16 (26.7)	9 (25.7)	
Pre-existing respiratory condition	No	21 (77.8)	50 (83.3)	31 (88.6)	0.522
	Yes	6 (22.2)	10 (16.7)	4 (11.4)	
Revised cardiac risk index	0	4 (14.8)	17 (28.8)	8 (22.9)	0.015
	1	15 (55.6)	29 (49.2)	24 (68.6)	
	2	5 (18.5)	13 (22.0)	3 (8.6)	
	>/=3	3 (11.1)	0 (0.0)	0 (0.0)	
Operation grade	Minor	1 (3.8)	16 (27.6)	4 (11.4)	0.016
	Major	25 (96.2)	42 (72.4)	31 (88.6)	
Cancer stage	Early disease	18 (66.7)	34 (57.6)	22 (64.7)	0.662
	Advanced/nodal disease	9 (33.3)	25 (42.4)	12 (35.3)	
Hospital type	COVID-19 free surgical pathway	7 (25.9)	14 (23.3)	10 (28.6)	0.85
	No defined pathway	20 (74.1)	46 (76.7)	25 (71.4)	

COVID-19=Coronavirus disease 2019. ASA=American Society of Anaesthesiologists. See *Appendix* for full definitions. Percentages calculated as a proportion of column total. Differences between groups tested with Chi² test for grouped data, with Fisher's exact modification where required.

Supplementary Table 2. Characteristics of propensity score matched groups

Factor	Levels	Previous SARS-CoV-2 diagnosis	No previous or perioperative SARS-CoV-2 diagnosis	P-Value
Age	<50 years	22 (19.6)	86 (19.2)	0.87
	>80 years	13 (11.6)	60 (13.4)	
	50-59 years	21 (18.8)	80 (17.9)	
	60-69 years	30 (26.8)	135 (30.1)	
	70-79 years	26 (23.2)	87 (19.4)	
Sex	Female	72 (64.3)	286 (63.8)	1
	Male	40 (35.7)	162 (36.2)	
ASA Grade	Grade 1-2	77 (68.8)	317 (70.8)	0.764
	Grade 3-5	35 (31.2)	131 (29.2)	
Pre-existing respiratory condition	No	97 (86.6)	411 (91.7)	0.136
	Yes	15 (13.4)	37 (8.3)	
Revised cardiac risk index	0	27 (24.1)	101 (22.5)	0.888
	1	61 (54.5)	258 (57.6)	
	2	21 (18.8)	74 (16.5)	
	>/=3	3 (2.7)	15 (3.3)	
Operation grade	Minor	21 (18.8)	81 (18.1)	0.978
	Major	91 (81.2)	367 (81.9)	
Cancer stage	Early disease	68 (60.7)	270 (60.3)	1
	Advanced/nodal disease	44 (39.3)	178 (39.7)	
Cancer type	Breast	16 (14.3)	63 (14.1)	0.996
	Colorectal	37 (33.0)	162 (36.2)	
	Gynaecological	13 (11.6)	43 (9.6)	
	Head or neck	13 (11.6)	47 (10.5)	
	Hepatopancreatobiliary	8 (7.1)	40 (8.9)	
	Intracranial	3 (2.7)	12 (2.7)	
	Lung	5 (4.5)	16 (3.6)	
	Oesophagogastric	8 (7.1)	36 (8.0)	
	Sarcoma	4 (3.6)	12 (2.7)	
	Urological	5 (4.5)	17 (3.8)	
Hospital type	COVID-19 free surgical pathway	30 (26.8)	100 (22.3)	0.381
	No defined pathway	82 (73.2)	348 (77.7)	

112 patients with previous SARS-CoV-2 positive swab were matched to 448 with no previous and no perioperative SARS-CoV-2 infection (10 were missing at least one matching variable). COVID-19=Coronavirus disease 2019. ASA=American Society of Anaesthesiologists. See *Appendix* for full definitions. Percentages calculated as a proportion of column total. Differences between groups tested with Chi² test for grouped data, with Fisher's exact modification where required.

Appendix

Timing of SARS-CoV-2 testing

Previous SARS-CoV-2 infection was defined as a diagnosis of SARS-CoV-2 made with a nasopharyngeal swab (qRT-PcR) greater than 7 days before the date of surgery.

Timing from previous SARS-CoV-2 positive swab was defined as the weeks from notification of a positive nasopharyngeal swab (qRT-PcR) result. For the purpose of analysis, this was divided into three groups: less than 2 weeks; 3 to 4 weeks; greater than one month. Within this study, we did not collect whether a repeat confirmatory 'negative' SARS-CoV-2 swab test had been performed preoperatively.

Perioperative SARS-CoV-2 infection was defined as diagnosis of SARS-CoV-2 within the 7 days before surgery up to the 30th day after surgery, with the day of surgery as Day 0.

Data variables

American Society of Anesthesiologists physical status classification (ASA) is a validated system used to assess and communicate a patient's pre-anaesthesia medical comorbidities. The classification system alone does not predict the perioperative risks but can be used with other factors (grade of surgery, ECOG performance status) to stratify risks of postoperative complications. The following grades were defined in the study protocol: Grade 1: Healthy person; Grade 2: Mild systemic disease; Grade 3: Severe systemic disease; Grade 4: Severe systemic disease that is a constant threat to life; Grade 5: A moribund person who is not expected to survive without the operation.

Pre-existing respiratory condition was defined pragmatically as a past medical history of asthma, chronic obstructive pulmonary disease, and/or any other obstructive or restrictive pulmonary disease diagnosed by a physician.

Revised Cardiac Risk Index (RCRI) represents a multifactorial approach to assessing the cardiac risk of non-cardiac surgery. It was calculated as a composite of procedural risk (intraabdominal/intrathoracic versus other), history of ischemic heart disease, myocardial infarction, congestive heart failure, cerebrovascular disease, diabetes mellitus, and/or chronic kidney disease. This gave an attributable risk score from 0 (lowest risk) to 6 (highest risk).

Grade of surgery was categorised based on the Clinical Coding & Schedule Development Group as either Minor (minor/intermediate) or Major (major/complex major).

To account for different tumour grading and staging systems across solid cancer types, disease status was classified as early stage (organ confined, non-nodal, non-metastatic, fully resectable) or advanced stage (growth beyond organ, nodal, metastatic with curative intent, debulking with life prolonging intent).

For each patient, the hospital status at the time of their operation was classified either providing a COVID-19 free surgical pathway or no defined pathway. This provided a dynamic assessment that could change if hospitals chose to establish a dedicated COVID-19 free pathway. COVID-19 free surgical pathways were defined as complete segregation of operating room, critical care, and inpatient ward areas for elective cancer surgery, away from patients being treated for COVID-19. This included both hospital sites which were opened during the pandemic specifically to provide COVID-19 free surgical care (e.g. independent providers, or satellite hospitals) and major, acute hospital sites which treated COVID-19 patients during the study period but in completely separate areas of the hospital with no mixed areas or staff working between areas. Hospitals where there was mixing of patients undergoing treatment for COVID-19 and elective surgical patients in any operating theatre, critical care, or inpatient ward areas were classified into the 'no defined pathway group'. Where hospitals had no defined pathway, but coincidentally were treating no COVID-19 patients in their surgical pathway at the time of surgery, they were still classified as having 'no defined pathway'.

Outcome measures

The primary outcome measure was postoperative pulmonary complications defined as pneumonia, acute respiratory distress syndrome or unexpected ventilation within 30-days of surgery with the day of surgery as Day 0. The secondary outcome measure was mortality within 30-days of surgery.

Postoperative pneumonia was defined as recommended by international consensus on outcome measures for perioperative care, the US Centers for Disease Control (CDC) definition of pneumonia was used within 30 days after surgery, modified to accommodate limited availability of radiological facilities:

- Fever ($>38^{\circ}\text{C}$) with no other recognised cause
- Leucopaenia (white cell count $<4 \times 10^9 \text{ L}^{-1}$) or leucocytosis (white cell count $>12 \times 10^9 \text{ L}^{-1}$)
- For adults >70 years old, altered mental status with no other recognised cause;

AND at least two of the following:

- New onset of purulent sputum or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements
- New onset or worsening cough, or dyspnoea, or tachypnoea
- Rales, crackles or bronchial breath sounds
- Worsening gas exchange (hypoxaemia, increased oxygen requirement).

Wherever possible, the diagnosis was confirmed with a chest radiograph. The following findings were considered to confirm pneumonia:

- New or progressive and persistent infiltrates
- Consolidation
- Cavitation

Unexpected post-operative ventilation was defined as either an episode of non-invasive ventilation, invasive ventilation, or extracorporeal membrane oxygenation after initial extubation following surgery, or unexpected failure to extubate following surgery.

Statistical analysis

The study was reported according to SAMPL (Statistical Analyses and Methods in the Published Literature) guidelines. Non-parametric data were summarised with medians and interquartile ranges and differences between groups were tested using the Mann-Whitney U test. The χ^2 test was used for categorical data. Missing data were included in flowcharts and summary tables, allowing denominators to remain consistent in calculations.

Propensity score matching (PSM) was conducted to explore differences in outcomes between patients with previous SARS-CoV-2 infection and patients with no previous and no perioperative SARS-CoV-2 infection. This involved building a binary logistic regression model to derive predictors of 30-day postoperative pulmonary complications using a 3-step approach. Firstly, propensity scores were developed by including age, sex, ASA grade, operation grade, preoperative testing for SARS-CoV-2, ECOG performance score and community SARS-CoV-2 risk in a binary logistic regression model. Secondly, this logistic regression model was then combined with the PSMATCH2 command in Stata (Version 16.0; Statacorp, College Station, TX) to calculate propensity scores representing the estimated probability of 30-day postoperative pulmonary complications on each participant's characteristics. Participants in previous SARS-CoV-2 infection were matched to participants with no previous and no perioperative SARS-CoV-2 infection with the closest propensity score on a ratio of 1:4 using a nearest-neighbour algorithm with no replacement, and matching was restricted to within the common support region. Thirdly, to ensure that the matching was

effective, we checked the balance of covariates between groups after the matching process (*Supplementary Table 2*).

Multivariable logistic regression was then used to explore the association between previous SARS-CoV-2 infection and postoperative pulmonary complications, summarised using adjusted odds ratios and 95% confidence intervals. Clinically plausible patient, disease, operation and location specific factors were selected a priori for inclusion in adjusted analyses, in order to identify independent predictors of postoperative pulmonary complications. Models only included factors that occurred before the outcome of interest. Analyses were carried out using the R Foundation Statistical Program version 3.1.1 (packages: finalfit, tidyverse).