Surgical Management for Oncologic Patients during COVID-19 outbreak

- SICO Practical Recommendations -

Part 1 - General considerations

Patients selection

- Surgical delay should not affect oncological prognosis
- Possibly do not postpone
  1. After neoadjuvant
  2. High biological aggressiveness
  3. No therapeutic alternatives

COVID-19+ without emergent problems
-> postpone at the end of pandemic

Multidisciplinary Tumor Board

- Fundamental for shared clinical decisions
- Prefer videoconference meeting
- Use telemedicine for follow-up

Pre-operative screening

- T < 37.3 (WHO indications)
- Respiratory symptoms, cough, sore throat?
- Relatives or close contacts COVID-19+ or suspected?
- Residence in higher risk area for COVID-19?
- SARS-CoV-2 PCR-test negative before surgery

Anastomosis & Stoma

- Prefer intra-corporeal vs open anastomosis
- Prefer mechanical vs hand-sewn anastomosis
- Consider direct anastomosis vs loop protective ostomy vs terminal colostomy
- Consider PPE for caregivers during stoma management

Laparoscopy & Surgical Smoke

- Little evidence for risk specific to COVID-19
- Appropriated skin incisions & trocars with balloon
- Low pressure pneumoperitoneum
- Minimize time in Trendelenburg position
- Use filters & closed suction systems for SS
- Limit use of energy devices
- Prefer approach with minor risk for staff
- Avoid training programs with COVID-19+ patients

Personal Protective Equipment

- All staff trained with specific courses on PPE use
- FFP2/N95 mask
- Goggles/full face mask, double gloves

SICO COVID-19 Working Group. April 2020

Full Recommendations are available at *www.sicoweb.it*

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Part 2 - Specific considerations

Upper-GI

Esophagus

- Stage I: postpone endoscopic/surgical procedure
- Stage II-III: neoadjuvant therapy
- Stage IV: multimodal therapies

Stomach

- cT1a/b: postpone endoscopic/surgical procedure
- cT2-4N+: neoadjuvant therapy
- Post neoadjuvant: consider to continue therapy, if tolerated
- Low aggressiveness: postpone surgery

HPB

Liver & Biliary tract

- Marginally resectable, no effective alternatives, high aggressiveness: do not postpone surgery
- For others patients: consider Loco-regional treatments, start/ continue neoadjuvant therapy
- Transplantation only for high MELD or HCC

Pancreas

- Consider neoadjuvant chemotherapy

Sarcoma

- Primary soft tissue sarcoma cM0: possibly do not postpone (save for ALT of the extremities/superficial trunk and DFSP than can be safely postponed)
- In radiosensitive tumours, consider neoadjuvant radiation therapy
- High risk soft tissue sarcoma: consider neoadjuvant chemotherapy or chemo/radiotherapy
- Localized GIST: consider neoadjuvant with Imatinib in sensitive kit/ pdgfra mutated tumours

Colon & Rectum

- Malignant polyps: postpone endoscopic/surgical procedure
- Colon cT3-4N+: consider neoadjuvant chemotherapy
- Rectum locally advanced: Total neoadjuvant therapy
- Rectum post-neoadjuvant: consider to wait > 8 weeks

Breast

- High grade (≥T2, G3, ↑Ki67, HER2+, triple -, N1, IBC): consider neoadjuvant chemotherapy
- *High priority* (30 days): high grade in premenopausal patients; non-responding to neoadjuvant, pregnancy; T2 > 3cm; early local recurrence; bleeding tumours
- *Medium priority* (60 days): cT1, N0, Luminal A; after Neo-adjuvant
- *Low priority* (90 days): Luminal A in postmenopausal patients; in situ

Endocrine system

Thyroid & Parathyroid

- Tir 4-5 infiltrating, N+; M+; needing totalization: possibly do not postpone
- Calcium >12 mg/dl; carcinoma infiltrating other organs: possibly do not postpone

Adrenal gland

- Metabolic syndromes, suspicion of malignancy: possibly do not postpone

Peritoneum

- Low grade: consider to postpone 2-4 months
- High grade: consider neoadjuvant
- PIPAC: possibly do not postpone
- After neoadjuvant: surgery in 4-6 weeks
- Use high level PPE for HIPEC & PIPAC

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