Management of Cancer Surgery Cases During the COVID-19 Pandemic: Considerations

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Management of Cancer Surgery Cases During the COVID-19 Pandemic: Considerations

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The SSO supports the need for treatment decisions to be made on a case-by-case basis.

Breast cancer (BC)

Defer surgery for at least 3 months

Atypia

Prophylactic/risk-reducing surgery

Reconstruction

Benign breast disease.

BC Ductal Carcinoma In Situ

Defer for 3–5 months.

Treat ER+ DCIS with endocrine Tx

Monitor monthly for progression

ER- DCIS ➔ high priority for surgery

ER+ invasive BC (stage I-III)

Neoadjuvant endocrine or chemotherapy by multidisciplinary tumor board recommendations

Triple-Negative/HER2+ BC

Neoadjuvant chemotherapy for T2+ and/or n1+ disease

OP if unable to chemotherapy

OP if no adequate information by biopsy

BC post-neoadjuvant C/T

Delay post-chemotherapy surgery 4~8 weeks if adjuvant chemotherapy is noted indicated

BC Special consideration

Progressive disease on systemic therapy

Angiosarcoma

Malignant phyllodes tumors

should not be delayed

Colorectal cancer

Operate if

Obstructed, perforated, or acutely bleeding

Non-metastatic colon cancer

Colorectal cancer

Defer surgery for all cancers in polyps

Consider neoadjuvant chemotherapy for locally advanced and metastatic colon cancer.

Colorectal cancer

For rectal cancer, neoadjuvant radiation component, highly consider a short-course (5*5 Gy) regimen

Delay surgery for locally advanced rectal cancer post- neoadjuvant therapy for 12–16 weeks

Thyroid surgical indication

Cancer with local invasion or aggressive biology

Medical-failure Graves' disease

Symptomatic Goiter

Open biopsy for anaplastic cancer or lymphoma

Parathyroid

Hyperparathyroidism with life-threatening hypercalcemia that cannot be controlled medically

Adrenal surgical

OP if

(Highly suspected) adrenocortical cancer

Medical failure Pheochromocytoma or paraganglioma

Medical failure Cushing's syndrome

Neuroendocrine tumor NET

OP if

Symptomatic small bowel NET

Medical failure pancreatic NET

Lesions with significant growth

Cytoreductive operations and metastasectomy should generally be delayed

Gastric and esophageal cancer

cT1a → endoscopic resection

cT1b → OP

≧ cT2 or N1 → Neoadjuvant C/T

Gastric and esophageal cancer

Post neoadjuvant chemotherapy → stay on chemotherapy if response to treatment

GIST → OP if symptomatic

Hepato-pancreato-biliary cancer

Operate on all patients with aggressive hepato-pancreato-biliary malignancies as indicated

Defer operation if Neoadjuvant C/T is indicated

Hepato-pancreato-biliary cancer

Defer surgery for asymptomatic pancreatic NETs, duodenal and ampullary adenomas, GISTs, and high-risk IPMN, unless delay will affect resectability.

Melanoma

Delay wide local excision of in situ disease for 3 months and, as resources become scarce, all lesions with negative margins on initial biopsy

Melanoma

Surgical management of T3/T4 melanomas (> 2 mm thickness) should take priority over T1/T2 melanomas ($\leqq$ 2 mm thickness).

The exception is any melanoma that is partially/incompletely biopsied

Melanoma

Sentinel lymph node biopsy is reserved for patients with lesions > 1 mm

Manage clinical stage III disease with neoadjuvant systemic therapy.

Peritoneal surface malignancy

Defer CRS/HIPEC for low-grade appendiceal mucinous neoplasms

Peritoneal surface malignancy

Neoadjuvant C/T from

High-grade appendiceal cancer
Gastric cancer

Colorectal cancer,

High-grade mesothelioma

Ovarian cancer

Desmoplastic small round cell tumors

Sarcoma

A primary soft tissue sarcoma without metastatic disease on staging that needs surgery will be prioritized for the OR

Sarcoma

Alipomatous tumors (ALTs)

Classic dermatofibrosarcoma protuberans without fibrosarcomatous degeneration,

Desmoid tumors

can be deferred for 3 months or more

Sarcoma

Indolent behavior (e.g. retroperitoneal well-differentiated liposarcoma) and low metastatic risk (e.g. myxoid liposarcoma, low-grade fibromyxoid tumor) can be deferred for short intervals