

Resource for Management Options of GI and HPB Cancers During COVID-19

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SSO supports the need for treatment decisions to be made on a case-by-case basis. The surgeon's knowledge and understanding of the biology of each cancer, alternative treatment options, and the institution's policies at the time the patient will be scheduled for surgery all need to be taken into consideration.

The information below is based on the opinions of individuals who are experts within the field of gastrointestinal and hepato-pancreato-biliary cancers and are members of the Society's Gastrointestinal and Hepato-pancreato-biliary Disease Site Work Groups.

Upper Gastrointestinal Cancer

Most gastrointestinal cancer surgery is not elective.

Gastric and esophageal cancer

- cT1a lesions amenable to endoscopic resection should preferentially undergo endoscopic management.
- cT1b cancers should be resected.
- cT2 or higher and node positive tumors should be treated with neoadjuvant systemic therapy.
- Patients finishing neoadjuvant chemotherapy can stay on chemotherapy if responding and tolerating treatment.

Defer surgery for less biologically aggressive cancers, such as GIST unless symptomatic or bleeding.

Hepato-pancreato-biliary Cancer

Operate on all patients with aggressive HPB malignancies as indicated.

- Pancreas adenocarcinoma, gastric cancer, cholangiocarcinoma, duodenal cancer, ampullary cancer, metastatic colorectal to liver
- If responding to and tolerating neoadjuvant chemotherapy, then continue and delay surgery.

Use ablation or stereotactic radiosurgery instead of resection for liver metastases where possible. Consider ablation or embolization over surgical resection for HCC. Defer surgery for asymptomatic PNET, duodenal and ampullary adenomas, GIST, and high risk IPMN's, unless delay will affect resectability.