

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. If there are inadequate resources to manage potential complications, then surgery may need to be delayed or, if necessary, referred to centers with resources to perform the procedure. Discussion of cases at multi-disciplinary tumor board (virtual or otherwise performed in a setting limiting exposure) remains critical to discuss priorities, resources, and personalized treatment plans based on hospital, patient, and tumor specifics in this environment.

Gastric and esophageal cancer

- cT1a lesions amenable to endoscopic resection may preferentially undergo endoscopic management where resources are available
- cT1b cancers should be resected
- cT2 or higher and node positive tumors should be treated with neoadjuvant systemic therapy.
- Staging laparoscopy with peritoneal washings is often utilized for patients being considered for neoadjuvant treatment. Given the recent concerns of laparoscopic surgery in COVID-19 patients and the additional use of resources, consideration may be given to proceeding straight to neoadjuvant treatment in COVID-19 positive patients, and if staging laparoscopy is decided to be performed, efforts to minimize PPE utilized and staff involved / exposed in the procedure should be made using appropriate pneumoperitoneum risk reduction strategies.
- Patients finishing neoadjuvant chemotherapy may stay on chemotherapy if responding to and tolerating treatment, and resources do not support proceeding to resection. If patients are not responding to systemic treatment, resection and/or referral may be considered.
- Patients with gastric outlet obstruction or hemorrhage may be treated with endoscopic measures to allow for enteral nutrition/ control of bleeding and proceed to surgery if these measures fail.

- Surgery may be considered for short-term deferral in 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.

- In cases where systemic chemotherapy is indicated in addition to surgery, consider neoadjuvant chemotherapy as a means of postponing surgery.
- 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.

Defer surgery for asymptomatic PNET, duodenal and ampullary adenomas, GIST, and high risk IPMN's, unless delay will affect resectability.

Use ablation or stereotactic radiosurgery instead of resection for liver metastases where possible. Consider ablation or embolization over surgical resection for HCC.