

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

HPB malignancies are typically biologically aggressive and not considered “elective” operations. The decision on performing an operation during the COVID-19 pandemic, needs to be considered in the context of the hospital resources, multi-disciplinary providers, symptomatology of the presentation, and biology of the disease. The following factors should also be weighed in the decision-making process: hospital resources of PPE, bed/ICU/ventilator capacity and utilization, number of COVID-19 patients and the projected trajectory of COVID-19 patient influx.

Phase I. Semi-Urgent Setting (Preparation Phase) as defined by the ACS

Cases to be done as soon as feasible

- Symptomatic and asymptomatic duodenal adenocarcinoma
- Symptomatic and asymptomatic ampullary adenocarcinoma
- Symptomatic and asymptomatic extra-hepatic cholangiocarcinoma
- Symptomatic and asymptomatic intra-hepatic cholangiocarcinoma
- Symptomatic and asymptomatic gallbladder adenocarcinoma
- Pancreatic adenocarcinoma patients completing the projected course neoadjuvant therapy where more therapy may be detrimental to their health status
- Pancreatic neuroendocrine carcinomas (small/large cell) completing the projected course neoadjuvant therapy where more therapy may be detrimental to their health status
- Metastatic colorectal cancer to the liver completing the projected course neoadjuvant therapy where more therapy may be detrimental to their liver
- Symptomatic low grade tumors (see below)*

Cases to consider alternative therapies to safely delay surgery to a more stable time

- Consider neoadjuvant chemotherapy for large intra-hepatic cholangiocarcinoma that will require a major liver resection
- Consider ablation, regional therapy procedures, or neoadjuvant therapy for hepatocellular carcinoma
- Consider neoadjuvant therapy for all newly diagnosed pancreatic adenocarcinoma patients and extending planned neoadjuvant to total upfront therapy if patient tolerating regimen
- Consider adding radiation to neoadjuvant chemotherapy protocols to delay surgery if warranted for biology by multi-disciplinary tumor boards
- Staging/margin operations in incidentally detected gallbladder cancers on final pathology
- Consider somatostatin analogues or regional therapy in newly identified liver metastasis in well-differentiated neuroendocrine in previously resected patients even if resectable

Cases that should be deferred

- Asymptomatic pancreatic or duodenal well-differentiated neuroendocrine tumors
- Asymptomatic duodenal and ampullary adenomas with or without high grade dysplasia
- Asymptomatic GIST
- Asymptomatic high risk IPMN or MCN pancreatic cysts
- Hepatic adenomas, gallbladder confined polyps/masses, or indeterminate low-grade appearing neoplasms
- Choledochal cysts
- Metastatic renal cell cancer to pancreas or liver

*Low grade tumors that are symptomatic due to bleeding, obstruction, perforation, or hormonal activity that cannot be temporized by non-surgical methodology and pose a health threat.

Phase II. Urgent Setting as defined by the ACS

Cases to be done as soon as feasible

- Peri-ampullary tumors causing gastric outlet obstruction where endoscopic stenting is not a good option
- Bleeding tumors that cannot safely be managed with interventional radiology, endoscopy, or radiation
- Hormonally active neuroendocrine tumors, like insulinomas, that pose a major health threat untreated
- If extended delay would potentially make an advanced tumor become unresectable and all other forms of therapy have been maxed out
- Management of surgical complications if interventional approach not feasible

Cases that should be deferred

- Same cases from Phase 1
- All asymptomatic tumors from Phase 1

Alternative treatment approaches recommend

- All delayed approaches suggested in Phase 1
- Consider neoadjuvant chemotherapy in tumors that you otherwise would not give chemotherapy upfront if could do so safely
- Consider adding radiation to tumors that you otherwise would not give radiation to if could do so safely
- SBRT to liver metastasis
- Consider regional liver therapy for extended indications to bridge to a later surgery
- Consider neoadjuvant hormone therapy where appropriate
- Observation in low grade tumors

Phase III. (Local Resource Scarcity) as defined by the ACS

Cases to be done as soon as feasible

- Management of surgical complication if interventional approach not feasible

- Bleeding tumors that cannot safely be managed with interventional radiology, endoscopy, or radiation
- Any tumor with acute perforation that can be salvaged operatively

Cases that should be deferred

- All HPB tumors

Alternative treatment approaches recommend

- Same as above