ANZGOSA General Guidelines for managing Patients with Oesophageal and Gastric Cancer during COVID-19 pandemic

Version	1
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Approved by	ANZGOSA

This offers guidelines for managing oesophageal and gastric malignancy recognising that there will be variations dependent upon the jurisdictions, the hospital resources, the COVID admissions at the time of presentation or potential timing for surgery and recommendations at the multidisciplinary conference. The guidelines are likely to be modified according to the timing in the COVID crisis and the projected timelines once the peak has occurred. They assume that treating clinicians will be aware of appropriate PPE precautions and good clinical practice during this unprecedented pandemic. Members are referred to the ISDE Position Statement.

All decision making should include an evaluation of available resources incorporating: Surgical and junior medical staff, intensive care, ward nursing support, anaesthesia, peri-operative medicine, oncology/radiation oncology, nutrition, physiotherapy and rehabilitation services as well as outpatient follow up. Potentially, any of these key areas could be significantly impacted or unavailable.

The COVID crisis highlights the importance of multi-disciplinary care and these complex issues should be considered in multidisciplinary meetings. These meetings can be held via video conferencing. Surgical teams may wish to explore combining MDTs across hospitals or evaluating undertaking treatment or referral to less affected centres. There may be capacity for surgery to be performed in private facilities. These strategies require good communication at an early stage.

An individual assessment needs to be undertaken of each patient incorporating the age, co-morbidities, disease site and staging and wishes of the patient. This must be balanced against the capacity of the entire team and hospital system to deliver safe care.

Staging of Oeosophago-Gastric Malignancies

Gastroscopy for significant dysphagia maybe appropriate but are considered a high risk procedure for aerosolisation. Barium swallow may be an alternative screening investigation. Laparoscopy may also carry at an increased risk to the surgical and theatre team and its use should be limited to cases where imaging modalities demonstrate no distal disease but a bulky tumour meaning that peritoneal disease is more likely as this will change the management trajectory.

Patients of borderline fitness or physiological reserve may be better advised to undergo chemo-radiotherapy if possible or defer consideration of resectional surgery. Lung function testing may not be available. Basic tests of functional capacity (capacity to climb two flights of stairs) can be useful.

Oesophageal Cancer

Oesophagectomy should not proceed without availability of ICU support. Surgery should only proceed if deemed safe for the patient and staff, and the patient is considered to have a good survival prognosis from their oesophageal cancer. Consideration also needs to be given to the projected availability of resources in the weeks following surgery if complications occur.

Squamous Cell Carcinoma

Tumour stage	Recommendation
In situ	Surveillance
Invasive	Default definitive chemoradiation with subsequent surveillance Patients coming up for surgery during the crisis may be delayed

Adenocarcinoma

Tumour stage	Recommendation
T1a	Endoscopic therapy when considered appropriate -may be able to be deferred or performed in a non-COVID facility
T1b	Assess the role of surgery and capacity for that to be delivered referring to guidelines above or wait until safe. Alternatively, offer neoadjuvant therapy as a bridge to surgery 8-12 weeks later. Definitive CRT is an option with subsequent surveillance
cT2-4 – resectable *Options*	i)Neoadjuvant therapy. CRT – CROSS (5 weeks). There is evidence that surgery may be safely delayed for 12 weeks and this could potentially be longer if necessary during the pandemic
	ii)Patients who have had neo-adjuvant chemotherapy- consider for further chemotherapy as a bridge to surgery if surgery needs to be delayed. Alternatively, consider transfer to another centre for surgery if one is available locally.
	iii) Definitive CRT with subsequent restaging and surveillance. If persisting disease, resection after peak of crisis

Gastric Cancer

The potential to need an ICU bed will drive some of the decision making.

Tumour stage	Recommendation
T1	• Surgery while facilities not stressed **or** referral to other centre. • Consider delaying the surgery dependent upon the COVID situation in the hospital at the time.
cT2-4	• Perioperative chemotherapy FLOT – surgery 8-10 weeks following this (longer dependent upon the hospital situation) • Consider gastrectomy followed by adjuvant therapy if have access to requisite resources prior the COVID-19 crisis reaching its peak

GIST

- Principle to defer surgery for less biologically aggressive cancers unless symptomatic or bleeding, with the bleeding not controlled with PPI. Many GIST tumours can be safely deferred to weeks or months.
- Consider use of Glivec as a neoadjuvant therapy if appropriate
- Radiotherapy maybe considered

Other relevant guidelines

Members are directed to these other relevant guidelines that may help support decision making:

GESA	https://www.gesa.org.au/public/13/files/COVID-19/Triage_Guide_Endoscopic_Procedure_26032020.pdf
American College of Surgeons	https://www.facs.org/covid-19/clinical-guidance/elective-case/thoracic-cancer
GSA	https://www.generalsurgeons.com.au/media/files/News/DOC%202020-03-29%20COVID-19%20Guidelines%20for%20General%20Surgery_FINAL.pdf
ISDEA	Should be posted soon