



## **GOC POSITION STATEMENT FOR THE COVID-19 PANDEMIC SITUATION**

### **TREATMENT AND MANAGEMENT FOR WOMEN WITH GYNECOLOGIC CANCER**

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#### **CONTEXT**

In the current context of the COVID-19 pandemic, we are experiencing a drastic drop in access to the operating rooms and supporting facilities imposed by government authorities in order to prepare and deal with this public health crisis. Consequently, delays to access surgery for women with gynecological cancer will inevitably be encountered. Some of these delays could be detrimental to the patient's health and significantly impact survival.

#### **GOC POSITION**

In these circumstances, we believe it necessary to establish criteria for prioritizing gynecological cancers in order to facilitate and standardize the selection of operative cases in each jurisdiction within the Canadian context as other international societies have established recommendations (1-3). These criteria must be established according to the aggressiveness of the pathology, the patient's symptomatology as well as the chances of survival if addressed by a surgical procedure. In addition, the availability of resources and safety of our immunocompromised patients will need to be taken into account when we order chemotherapy. A prioritization process for our patients requiring chemotherapy will also need to be implemented as the strain on our system increases for the duration of the pandemic and the lengthy recovery period after.

#### **GYNECOLOGIC CANCER MANAGEMENT DURING THE COVID19 PANDEMIC**

Every active cancer pending surgery or on chemotherapy should be discussed at a team conference with multidisciplinary involvement as needed to determine urgency and resources



that may impact treatment modality. Criteria based on the aggressiveness of the disease AND the possibility of a curative treatment, regardless of the age of the patient, should be assessed to determine the best course of action. ECOG performance status and level of medical intervention and surgical complexity should be taken into consideration. An **advanced care plan** needs to be in place with a code discussion for all active gynecologic oncology patients in light of the possibility of infection. Within our resources, the gynecologic oncology teams should continue to triage and see new consults during the pandemic, using virtual visits when appropriate for all appointments.

Our cancer population needs supporting resources to continue to provide care appropriately and avoid compromising our patients' health. GOC strongly recommends that **access to interventional radiology for biopsy of metastatic deposits** in advanced cancers needs to be preserved to allow for expedited treatment triage. Radiation oncology requires access to curative intent radiation procedures during the crisis. Palliative care access needs to be maintained for pain and symptom management and end-of-life care.

In a pandemic, for the proper use of operating, anesthetic and intensive care resources, hyperthermic intraperitoneal chemotherapy is strongly discouraged. We should also avoid performing surgeries that would require ICU resources and also recommend alternative treatment plans in patients with medical comorbidities that would make surgical intervention a high-risk procedure.



In all cases where a decision is necessary to postpone surgical treatment, women should be reassessed periodically to ensure there is no cancer progression. Delayed patients can be triaged according to this statement.

***This document makes suggestions for therapy and includes measures that may require definitive therapy post pandemic. Local and provincial resources and pandemic directives need to be taken in context when applying this information.***

#### **ACTIVE COVID-19 INFECTION AND SURGERY**

Any surgery should be postponed until the end of symptoms in the patients who test positive for COVID-19 according to provincial mandates with possible lung imaging (4) based on the clinical scenario and possible negative testing unless there is a life-threatening emergency. The risks of post-operative complications are markedly increased in the COVID-19 population and moreover in an oncology context (5). Every precaution required should be taken in order to maintain a safe environment with minimal risk of contamination for the entire surgical and anesthetic team.

The concern has been raised about the possible risk of aerosolization of the COVID19 during minimally invasive surgery however there is no evidence that this is the case. The AAGL has released a joint position statement and can be referenced (6). The statement encourages controlled venting of the pneumoperitoneum into a closed smoke evacuation system with Ultra Low Particulate Air Filtration capability and avoiding rapid desufflation during times of tissue extraction or instrument change to prevent gas venting into the operating room. Proper personal protective equipment should always be worn based on the requirements of each facility.



**PRIORITIZATION – THE FOLLOWING PATIENTS WITH GYNECOLOGICAL CANCER WHICH SHOULD BE PRIORITIZED FOR ACCESS TO SURGERY:**

**EMERGENT - Immediate**

A. Significant symptoms regardless of the primary malignancy and in the context where surgery offers the most appropriate care:

- Hemorrhage with unstable vital status, refractory to transfusion.
- Refractory symptoms to medical management requiring surgical attention (e.g. pain).
- Viscus perforation.
- Signs of bowel obstruction refractory to conservative treatment - closed loop bowel or large bowel obstruction.
- Hydatiform mole.
  - Curettage or hysterectomy.

**URGENT - 1 TO 4 WEEKS** depending on team conference recommendations

B. Criteria based on the aggressiveness of the disease AND the possibility of a curative treatment, regardless of the age of the patient. ECOG performance status and level of medical intervention and surgical complexity should be taken into consideration. Due to the delay in surgery, these conditions are at risk of deterioration with a deleterious impact on the patient's survival. In women with metastatic disease or significant co-morbidities a medical approach should be considered.

- OVARIAN CANCER
  - Suspicious ovarian masses with elevation of tumor markers and or ascites.
  - Timely access to interval debulking surgery after maximum benefit from neoadjuvant chemotherapy.



- Primary debulking for ovarian cancer unlikely to respond to neoadjuvant chemotherapy (such as low grade serous, clear cell, mucinous).
- ENDOMETRIAL AND UTERINE CANCER
  - High grade endometrial cancer (FIGO grade 3 endometrioid/ grade 2 p53 mutated/serous / carcinosarcoma / undifferentiated/clear cell).
  - Known/suspicion of high grade uterine sarcoma.
- CERVICAL CANCER
  - Non-microinvasive (FIGO 2019 stage IB1, IB2) appropriately treated by surgery.
  - FIGO 2019 stage IB3 and greater should be evaluated for concomitant chemoradiation.
- VULVAR CANCER
  - Large volume tumor (Stage IB and higher).
  - If involvement of sphincters, should be considered for chemoradiotherapy.

#### **SEMI-URGENT**

C. Although surgical management is preferable within 28 days as required by the standards for access to oncologic surgery, the following patients will be postponed after individual assessment:

- OVARIAN TUMOR
  - Ovarian mass with adverse features with normal tumor markers
- OVARIAN CANCER
  - Advanced ovarian cancer with the possibility of initiating neoadjuvant chemotherapy or continuing chemotherapy.



- ENDOMETRIAL CANCER
  - EIN/atypical hyperplasia and low-grade endometrial cancer
    - Progestin hormone therapy should be offered pending surgery.
    - If a patient reaches 12 weeks on progestin treatment and still has persistent disease on endometrial biopsy, the priority level should be upgraded to urgent.
  - Advanced stage endometrial cancer could be treated with neoadjuvant chemo.
  
- CERVICAL CANCER
  - FIGO 2019 stage IA1, IA2
    - These cases could be offered LEEP under local anesthesia with imaging assessment of lymph nodes.
  
- VULVAR CANCER
  - Presumed stage 1a tumors could be addressed by wide local excision under local anesthesia.

## **CONSIDERATIONS FOR SYSTEMIC THERAPY**

### **ACTIVE COVID-19 INFECTION AND CHEMOTHERAPY**

All patients with a diagnosis of active COVID 19 infection will not be eligible for chemotherapy until their symptoms have resolved and they test negative depending on resources. Further immuno-compromising these patients during an active infection, even if their symptoms are mild, would be significantly increasing their risk of complications and mortality (5). In addition, these patients should be self-isolating until symptom resolution so as to not propagate COVID19. There should be consideration for chemotherapy regimens that require fewer hospital visits and are less immunocompromising. Discussions involving the care teams and the



patients should be made about withholding IV maintenance chemotherapies during the crisis. PARP inhibitors are also immunocompromising (7,8) and can cause anemia requiring blood transfusion therefore patients should consider delaying the start of a new maintenance PARP inhibitor during the crisis. Those currently on PARP inhibitors may wish to continue their use if there has been stability of their immune system, however, these patients should be informed of their increased risk for developing severe symptoms if they acquire COVID19 and should take exposure precautions.

## **PRIORITIZATION OF SYSTEMIC THERAPY**

### **URGENT - immediate**

- A. Patients with a new diagnosis and/or significant burden of disease anticipated to get overall survival or significant progression free survival benefits from the timely administration of chemotherapy
- Gestational Trophoblastic Neoplasia
  - Germ Cell tumours
  - Patients receiving chemotherapy with curative intent
  - Neoadjuvant chemotherapy for ovarian malignancies
  - Curative intent chemoradiation for cervical or vulvar cancer

### **SEMI-URGENT - 1-3 MONTHS START**

- B. The following patients could start chemo within 1-3 months depending on symptomatology, comorbidities and anticipated gained benefit:
- New diagnosis of recurrent disease requiring chemotherapy for symptom management
  - Adjuvant treatment (chemotherapy or radiotherapy) after curative intent surgical management (endometrial, cervical or vulvar cancer)
  - Platinum sensitive recurrent ovarian cancer



## **CONCLUSION**

GOC will remain vigilant and work actively with our stakeholders to provide information resources to our members and our cancer population. These recommendations apply during this current period of COVID-19 pandemic and the recovery period afterwards as cancer care resources are fully re-established. As this situation is rapidly changing on a day-by-day basis, this statement may be subject to modification as the need requires.



## REFERENCES

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