Surgical Priority Update in Oesophageal and Gastric Cancer

21st April 2020

SURGICAL PRIORITY UPDATE IN OESOPHAGEAL AND GASTRIC CANCER

STATEMENT

The impact of the COVID 19 pandemic is being felt across the UK with major disruption of cancer services. The majority of the Oesophago-gastric Units in the UK are now running a restricted surgical service. This update aims to deliver a clear AUGIS position on acceptable standards of care to protect clinicians during this difficult time. It is imperative that we continue to treat these cases with the highest standards available to us.

Major resectional surgery may be limited for the following reasons;

1) Risk of post-operative COVID 19 infection;
2) Limited availability of post-operative intensive care beds;
3) Reduced availability of intensive care beds and support services for managing post-operative complications.

In some centres, major resectional surgery is continuing, but some of the more challenged networks have identified ‘Cancer Hubs’ in order to continue with cancer surgery. The majority of cases being performed in these units, are low risk and each case has to go through a central vetting process, with the result that not all cases will be prioritised for surgery. The clinician needs to be aware of this when discussing management options. It is crucial that patients are low-risk as post-operative COVID infection is still possible.

In the current climate, it is the view of AUGIS that alternative treatment strategies can be offered to patients, despite the lower chance of a complete cure. For example, patients with adenocarcinoma of the distal oesophagus, may be offered definitive chemoradiotherapy or prolonged neoadjuvant chemotherapy, with resection being delayed or offered as salvage surgery. All patients should be informed that their treatment has been affected by the pandemic and transparent documentation of the discussion should be kept.

It is now crucial that units start to plan for the return of surgical services. There is likely to be limited resources initially and cases will still have to be prioritised. Support staff have been reassigned and many allied professionals have been relocated to other departments. The reintroduction of resectional surgery will need to be carefully planned with realistic expectations during the initial period.

The Royal College of Surgeons and NHS England have published guidelines on managing patients during a coronavirus pandemic: www.england.nhs.uk/coronavirus/secondary-care/other-resources/specialty-guides/#cancer. It is important that units share information and support each other during this difficult time. Please let us know if AUGIS can do anything further to help.

Best Wishes

James Gossage (AUGIS OG Lead) Nick Maynard (AUGIS President Elect)
Tim Underwood (AUGIS OG Research Lead) Giles Toogood (AUGIS President)
GUIDANCE

Surgical Priority

This guidance should be considered in the context of previous AUGIS / NICE Guidelines.

- All patients should be discussed as currently by the MDT.
- Staging tests may be limited.
- Laparoscopy is not appropriate in a hospital treating patients with COVID or where there is a risk of infection for the patient or staff.
- Clinical and preoperative assessment of all patients is important in treatment planning but patient contact should be minimal and telephone consultation used where possible.

There are likely to be situations where there is a restriction on critical care support which will require difficult decisions on selection for surgery.

1. Priority 1 - Emergency Cases

- Emergency surgery is rare in OG cancer, endoscopic and interventional radiology options should be used where possible.

- Oesophageal Perforation - Acceptance and management of this condition should be considered on a case by case basis depending on patient co-morbidity and available critical care services. If critical beds are limited due to a high volume of COVID 19 positive patients, then a local conservative approach maybe more appropriate.

- Postoperative complications - Patients requiring return to theatre or critical care support are more common in this specialty. If these facilities become limited then elective surgical resection should be limited to patients where this risk is low.

2. Priority 2 - Elective Cases

- There is variation in the postoperative care requirements for OG patients. Where level 1 facilities are required, each facility will need to assess their critical care bed status and services available for post-operative care. If this is limited or unavailable then alternative treatment should be considered.

- When the pressure on level 2/3 is modest it may be appropriate to continue with surgery in low risk patients.

- If there is pressure on level 2/3 beds, then priority should be determined by symptoms, performance status and tumour biology.

- In patients where there is a prediction of prolonged recovery based on performance score, consideration should be given to non-surgical treatment. In many cases patients will have received neoadjuvant chemotherapy and this should be considered as an option to continue in discussion with the MDT.
• Chemoradiotherapy should be considered either as definitive treatment or as a neoadjuvant.

• In both oesophageal and gastric cancer, T1a and T1b disease could be potentially treated by endoscopic therapies. In addition, a delay in treatment of up to 3 months could be considered for early oesophageal / gastric cancer (which includes N1 disease).

• Post neoadjuvant stage II and III disease should, if possible, continue to be treated surgically but priority can be determined based on likely nodal involvement and poorly differentiated histology.

GIST Tumours

• The treatment plan should be discussed by both the OG and Sarcoma MDT.
• Delay in surgery should be considered for those GISTs < 5cm.
• Those presenting with bleeding can also be considered for delay but this should be supplemented with endoscopic assessment, high dose PPI and risk assessment.
• Larger tumours require consideration for oncological treatment or surgery depending on available facilities.

Comment

These measures are intended to guide surgical priority planning but it is fully recognised that there will be local pressures which will contribute to the decision processes. Decisions should be made through an MDT process and patients should be made aware of the additional surgical risk posed by COVID 19.