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Brazilian Society of Surgical Oncology considerations on gynecologic cancer management during COVID-19 pandemic

Considerações da Sociedade Brasileira de Oncologia Cirúrgica (SBCO) sobre o manejo de câncer ginecológico durante a pandemia de COVID-19

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ABSTRACT

The present proposal aims to support and help clinicians how to manage gynecologic cancer patients during the COVID-19 pandemic. It is based on the opinions of surgical oncologists of the Brazilian Society of Surgical Oncology (BSSO) and not necessarily evidence-based instructions.

Keywords: COVID-19 pandemic; surgical oncology; gynecologic cancer.

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RESUMO

A presente proposta tem como objetivo apoiar e ajudar os médicos a manejar as pacientes portadoras de câncer ginecológico durante a pandemia de COVID-19. É baseada nas opiniões de cirurgiões oncológicos da Sociedade Brasileira de Cirurgia Oncológica (SBCO) e não necessariamente em instruções baseadas em evidências.

Descritores: Pandemia de COVID-19; Cirurgia Oncológica; Câncer Ginecológico; SBCO.

INTRODUCTION

The present proposal aims to serve as a tool and help clinicians for oncologic treatment during COVID-19 pandemic. It is based on the opinions of individuals who are experts within the field and not necessarily evidence-based instructions[1-5]. We recognize that the management strategies are dynamic and should be determined individually depending on the equipment/resources, staff, space, and systems available for oncologic treatment at each institution. Also, its application will vary according to the severity of the COVID-19 epidemic in the region. Uncontrolled extrapolation or using it not to offer the best treatment available in a non-epidemic area must be avoided.

Outpatient

a) Restrict outpatient visits to new patients during diagnosis and oncologic treatment.

b) The number of involved professionals should be restricted to the minimum necessary for attendance.

c) Restrict the accompanying family members to one person.

d) Postpone the routine consultations for asymptomatic patients.

e) Postpone laboratory and imaging exams for asymptomatic patients.

f) Consider “telemedicine” or “telehealth” and input the considerations in the medical records.

Oncologic Management

1. Cervical cancer

1.1. Pre-malignant lesions: patients with diagnosed CIN II/III should receive a re-evaluation and treatment postponed within 3 months.

1. 2. Early Stage Cervical Cancer (Ia1-Ib2)

- Early disease should be confirmed by imaging (CT, MRI), if evaluable.
- Stage Ia1 without LVSI after conization and negative margins: re-evaluation within 3 months if fertility-sparing is not desired and/or adenocarcinoma histology.
- Stage Ia1 with LVSI after conization and negative margins: re-evaluation within 2 months or sentinel lymph node protocol (SLN), if evaluable.
- Stage Ia2 after conization and negative margins: re-evaluation within 2 months or SLN, if evaluable.
- Stage Ia2 after conization and positive margins: consider re-conization or type B radical hysterectomy/trachelectomy + SLN (or pelvic lymph node dissection (LND), if SLN not evaluable).
- Stage Ib1: type B radical hysterectomy/trachelectomy + SLN (or pelvic LND, if SLN not evaluable).

  • If diagnosis after conization with negative margins and absence of LVSI and depth of stromal invasion of <10mm, consider re-evaluation within 2 months or SLN, if evaluable.

  • Consider definitive radiotherapy or neoadjuvant chemotherapy if surgical treatment is not evaluable within 2 months.
- Stage Ib2: type B or C1 radical hysterectomy + SLN ± LND.

  • Consider definitive radiotherapy or neoadjuvant chemotherapy if surgical treatment is not evaluable within 2 months.

1.3. Locally Advanced Cervical Cancer (≥Ib3)

- Treatment with chemoradiotherapy and consider hypofractionation.
- If loco-regional recurrent or persistent disease after radiotherapy, consider neoadjuvant chemotherapy if radical surgery is not available at the moment, but still feasible.

2. Endometrial cancer

2.1. Polyps and Abnormal Endometrial Thickness

- Asymptomatic: re-evaluation within 3 months.
- Symptomatic cases (bleeding): D&C or diagnostic hysteroscopy.

2.2. Endometrial Cancer – Low Risk (Stage Ia, endometrioid G1 or G2)

- Early disease should be confirmed by imaging (CT, MRI), if evaluable.
- Total Hysterectomy (TH) + Bilateral Salpingo-oophorectomy (BSO) ± SLN.
- An alternative to surgery, hormonal treatment (megestrol or medroxyprogesterone), or levonorgestrel IUD should be considered, especially in grade 1 histology.

2.3. Endometrial Cancer – Intermediate and High Risk (Stage Ib, endometrioid G3 or non-endometrioid histologies)

- Early disease should be confirmed by imaging (CT, MRI), if available.
- Total Hysterectomy (TH) + Bilateral Salpingo-oophorectomy (BSO) + SLN ± pelvic LND.
- If surgical treatment is not evaluable within 2 months, consider neoadjuvant hormonal therapy (megestrol or medroxyprogesterone) for endometrioid G1 and G2 and neoadjuvant chemotherapy for high-grade histologies.

3. Ovarian cancer

- Should be considered for decision-making: age, family history, presence of symptoms, imaging findings, and tumor markers (Ca125).
- Cysts and adnexal tumors without suspicion of malignancy and normal Ca125: re-evaluation within 3-6 months.
- Reinforce genetic evaluation for all confirmed ovarian carcinoma, except for mucinous type.

3.1. Presumed Early Stage Ovarian Cancer

- Adnexal tumors with characteristics suspicious of malignancy (imaging and Ca125) should proceed to diagnosis.
- The laparoscopic approach should be preferred (with surgical team adequate protection) for appropriate diagnosis and staging.
- If surgical diagnosis and staging are not possible within 2 months, re-evaluate with imaging and Ca125.

3.2 Advanced Stage Ovarian Cancer (Stages III-IV)

- If infrastructures for primary cytoreduction are available (ICU, surgical team) and the patient is suitable for surgery (ECOG, age, comorbidities), proceed with laparoscopic evaluation for disease extension and cytoreduction when laparoscopic score (Fagotti) <8.
- If infrastructures for primary cytoreduction are not available (ICU, surgical team) or the patient is suitable for surgery (ECOG, age, comorbidities), proceed with neoadjuvant chemotherapy after imaging-guided biopsy (preferred) or positive cytology associated with CA125/CEA > 25.
- Stage IV: proceed with neoadjuvant chemotherapy after imaging-guided biopsy (preferred) or positive cytology associated with CA125/CEA > 25.
- Patients that already have neoadjuvant chemotherapy after 3-4 cycles: consider going through the 6 cycles if infrastructures for interval cytoreduction are not evaluable.
- Recurrent ovarian cancer: chemotherapy. Consider re-evaluation within 2-3 months if asymptomatic.

4. Vulvar cancer

4.1. Early Stage Squamous Cell Carcinoma (tumor size <4cm and cN0)

- Wide local excision with intended surgical margins of 2cm + SLN (or inguinofemoral LND if SLN not evaluable).
- Consider neoadjuvant radiotherapy if access to surgery is not possible.

4.2. Advanced Stage Squamous Cell Carcinoma (tumor size >4cm or cN1)

- Wide local excision or radical vulvectomy with intended surgical margins of 2cm + inguinofemoral LND.
- Consider neoadjuvant radiotherapy if access to surgery is not possible.
- If the patient has already finished the neoadjuvant radiotherapy and partial response, consider neoadjuvant chemotherapy if access to surgery is not possible.
- In the case of locoregional recurrence and previous radiotherapy, consider neoadjuvant chemotherapy if access to radical surgery is not possible.

AUTHOR'S CONTRIBUTION

Glauco Baiocchi: Collection and assembly of data, Conception and design, Data analysis and interpretation, Final approval of manuscript, Manuscript writing.

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