Dear Colleagues,

The world is passing through a critical phase of uncertainty in public health which is of a magnitude which we have never faced before. This pandemic of the deadly Corona virus was totally unprecedented, catching even the most developed countries in total unpreparedness. We stand today on the frontline of the battlefield and we must be prepared to deal with our patients most effectively. Needless to say, we are in a huge shortfall of resources and manpower.

Cancer is also a life threatening condition which should be dealt with very early and treated holistically with all the armamentarium of different Oncological disciplines based on certain evidence based guidelines for best possible outcomes. The problem in the present days is we have to weigh the benefits of cancer treatment against the risks of getting infected with corona virus, which can be more lethal. There are obviously no clear guidelines and different Oncological societies in the developed worlds have tried to create some which are mostly based on their own resources and their profile of patients. Not all of these can be applicable in a country like India where Healthcare infrastructure, the Manpower and the patient profiles are all very heterogenous.

IASO has taken inputs from many Experts of the fraternity and has tried to formulate some guidelines applicable for next 3 wks of Curfew and may be revised from time time. It will be the final prerogative of the clinician, based on his scientific understanding to make
decisions in the best interest of the patient and the whole nation in general. The decisions must be made on a case-by-case basis based upon your knowledge and understanding of the biology of each cancer, with the help of a multidisciplinary team, and institutional policies. Any suggestions from our side will be overruled by any Orders or diktats which may come from the local or national government authorities from time to time.

Let us remind everyone that our nation

- is particularly short of protective supplies, such as N95 masks, PPE gowns, gloves and other protective materials.
- has the potential shortage of hospital manpower in general and may be due to Covid-19 sickness, quarantine and duties at home. We need to avoid adding self-inflicted shortage to the already small workforce.
- is short of dedicated Infectious disease units and we may be called for backup.
- has severe shortage of hospital beds, ICU beds and ventilators. The nation has just around 25000 ventilators which is way behind the required 1 million needed in case of a disaster.
- has a need to maximize social distancing amongst our patients, colleagues and staff which is difficult in a country like India given its dense population and lack of awareness.
- has difficulty and uncertainty in transport due to the curfew of manpower and material.
- has general public which is prone to be affected by rumours, unauthentic therapy and gullible to get cheated.
- where social and local issues should be kept in mind during decision taking. Different areas are likely to be affected differently.
- where if authorities demand, they can take manpower and material, especially ventilators, from other Healthcare facilities as per local need for Covid-19 patients.
- where availability of Blood and blood products has become a challenge
Broad guidelines.

**General.**

All emergency must be attended even in the present circumstances like tracheostomy, obstruction, bleeding, perforation, sepsis, mechanical respiratory emergencies like Pneumothorax/pleural effusion etc.

All terminal care treatment must be optimised

Semi-elective cancer Surgeries, if planned, must be simple and short and with low morbidity with minimal blood loss.

Prioritise Surgeries with high chances of cure when given early treatment.

Avoid surgery with doubtful benefits and for poor prognostic diseases.

Avoid surgical time and manpower associated with extensive surgery like micro vascular reconstruction, laparoscopic lengthy procedures, breast reconstruction, major Liver Resection etc.

Choose surgeries associated with morbid conditions and requiring prolonged ICU care with due diligence

Anytime, the need for ventilators for Covid-19 patients may arise. In those times of crises, the ventilators shouldn't be blocked by Surgical Oncology patients.

**Universal Precautions**

All patients should be considered as potentially Covid-19 infected and managed with due protection to staff and appropriate medical isolation from other individuals.

Due care should be given to manage the biomedical waste, and the body tissues, solid waste and fluids from each other.

All staff must be informed about new precautions and new risks.

Keep communicating.

**Biopsies:** being the 1st step in confirming the diagnosis, and being a minor procedure, should be considered early. Management decisions can be based on these reports.
**Breast cancer**

ER, PR positive patients can be delayed with Neoadjuvant hormonal therapy.

Locally advanced cases may be offered neoadjuvant chemotherapy if they are Hormone Receptor negative.

Very early cancers can be delayed till crises subsides.

Surgery may be justified in poor responders to Neo-adjuvant treatment or where Chemotherapy and Hormone therapy are not an option (e.g. elderly ER negative patient), or Malignant Phyllloides, sarcomas.

**Head and Neck**

Emergencies like Stridor, bleeds, dysphagia need to be treated appropriately. Procedures like Tracheostomy, Carotid Artery ligation, Endoscopic NG tube insertion/stenting need to be considered in such cases.

Advanced and palliative patients should be counselled to remain at home with minimal therapy ensuring adequate symptomatic medical treatment.

Surgeries when done should be simple involving minimal manpower and material. Cosmetic reconstruction can be delayed.

T1, T2 lesions can be operated with minimal hospitalisation.

Cases which have equivalent results with radiation should be given.

Anyone who is a candidate for neoadjuvant therapy must be dealt with accordingly.

Slow cancers like Thyroid, Parotid, Basal cell Carcinoma can be delayed.

However, Thyroid cancers which are locally aggressive and has local invasion or airway compression should be taken up for early surgery.

Uncontrolled Hyperparathyroidism may also be a candidate for early surgery.

**Thoracic malignancies**
It is prudent to avoid surgery which is likely to require ventilators for long periods and can have high risks of chest complications.

Esophagus cancers are preferably given Neo-adjuvant radiotherapy and or chemotherapy and those who have already completed Neo-adjuvant treatment, surgery can be delayed for another 3 weeks.

Lung cancers are mostly inoperable and get Non-surgical treatments like Chemotherapy, Radiotherapy, Targeted therapy. A multidisciplinary decision should be taken after full work up to rationalise surgery versus Non-surgical Neo-adjuvant treatment in Stage I-III Cancers.

Thymomas are mostly slow growing and can be delayed.

Metastatic resections are preferably deferred.

**Upper GI, Hepatopancreatico biliary Cancers**

All obstruction, bleeding and perforations need to be operated on without delay.

Neo-adjuvant Chemotherapy should be considered in Gastric malignancies.

Stenting can be done in patients with Oesophageal stricture or gastric outlet obstruction in advanced cases for palliation.

Complex Cases like Whipples and Segmental Liver resections should preferably be done only at high volume Centrein otherwise uncomplicated cases.

Surgeries for Gallbladder cancer should be done sooner rather than later for its aggressive nature.

RFA may be considered to treat small HCCs and Colo-rectal Liver metastases (upto 3 cms). For larger lesions, systemic therapy should be considered.

Embolization may be also be considered for treating HCC.

GIST can be treated with neo-adjuvant TKIs unless they are bleeding actively which will necessitate surgery.

Treatment for PNET, IPMN, etc. can be delayed.

**Colorectal cases.**

Rectum cases will preferably be radiated preoperatively. Surgery can be planned 8-12 wks. after completion of RT patients. In obstruction lesion a stoma has to be considered.
Colonic obstructions, bleeding and impending perforation should be relieved early with a resection/stoma. Definitive surgery may be delayed by Endoluminal stenting for obstructing lesion.

Neo-adjuvant chemotherapy may be considered for locally advanced colonic cancers.

Colectomies should be done early as delay may significantly affect the outcome.

**Sarcomas and Bone Cancers**

Low grade sarcomas (eg Low grade Retro-peritoneal Liposarcoma) can be deferred therapy.

Those cases which need Radiation and Chemotherapy, are preferably given in the Neo-adjuvant setting especially in the extremities.

Aggressive malignant sarcomas are to be operated upon without much of delay.

**Peritoneal surface malignancy**

Consider Chemotherapy for all fresh cases.

Those who are responding to chemotherapy may be further delayed with additional chemotherapy.

Those due for surgery or those not responding to chemotherapy must be delayed by minimum 2 weeks. Those with surgical complications like obstructions need to be operated immediately.

Avoid extensive surgical therapy. Trade off better survival with minimal therapy possible as per your acumen.

**Cancer cervix/vulva**

Select young patients who can undergo surgery with minimal morbidity. Prefer early discharge with Telephonic support.

**Renal cancers**
Renal cancers are relatively slow growing and can be delayed for 2-3 weeks, unless associated with any complications or bleeding.

Adrenal Tumours:

Surgery may be deferred unless the patient is having uncontrolled symptoms in Pheochromocytomas/Paragangliomas/Cushings.

**Testicular cancers/ CA Penis**

Simple procedures to be done on day care basis. RPLND to be delayed or avoided in favour of chemotherapy. Elective groin dissections to be delayed.

**Melanoma**

Early surgery should be considered in Stage I & II.

Neo-adjuvant therapy should be considered in Stage III.

**Pre malignant cases.**

Avoid therapy for now.

**Words of caution for Surgeons and Anaesthetists:**

The experience strongly suggests high risks of Corona infection amongst the Surgeons and Anaesthetists when operating on a confirmed/suspected Covid 19 case. Full protection with PPEs are strongly recommended for all OT staff. Special care should be taken during Intubation by the Anaesthetists or Head & Neck surgeons and Endoscopists. Laparoscopic surgeries should be avoided as much as possible. Electrocautery should be used in a minimal setting and should be accompanied by suction. Avoid needle stick and stab injuries. After the surgery is over the OT should be cleaned with PerOxyacetic acid. High efficiency filter should be changed and OT should be closed for at least 2 hrs thereafter.

**Follow up.**
Keep the morale of patients and Healthcare workers high. Delay follow up visits and communicate online.

Keep patients aware of Covid-19 and their responsibilities. Refer them to nearest healthcare facility for smaller issues.

**General suggestions for surgical units.**

Keep staff with extended duty day/hours and limit manpower mobility.

Keep Operation theatres working on limited days only.

Work in teams which don’t mix with other teams.

The Healthcare workers also should take adequate precaution not to carry infection to the outside world including their own homes.

_Please once again remember these are only guidelines created taken into consideration the risks-benefits of Cancer treatment during the Corona Virus Pandemic/Curfew. Ultimate decisions have to be taken after discussion in MDTs on a case-to-case basis by the treating Oncologist, taking into account the local resources. This may not have any validity in the Court of Law._

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Hon Secretary

Indian Association of Surgical Oncology

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