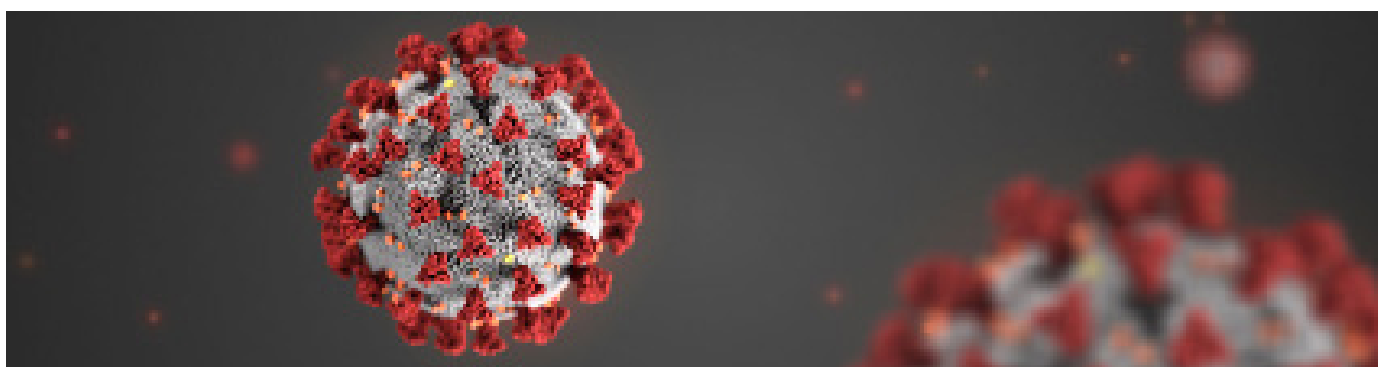




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**Recommendations of the Gynecological Oncology and Breast Disease Section of SEGO on management of gynecological tumors during the COVID-19 pandemic**



The situation that has arisen as a result of the COVID-19 pandemic has radically changed the approach to health care in Spain and to gynecological oncology in particular. Consequently, many doubts must be resolved and decisions taken in the best possible manner to provide optimal outcomes for patients with cancer during this period.

Our objective must be to preserve the resources of the health service to the best of our ability and to be prepared for the consequences of a continuous increase in the number of persons affected by COVID-19.

The objective of this document is to provide alternatives for the management of gynecological tumors during the pandemic and thus to help our members with decisions on diagnosis and therapy in their respective geographic areas and taking into account local epidemiology. These measures can be revised in line with the developing epidemiological situation and the recommendations of the Ministry of Health and Consumer Affairs and the Health Councils of the Autonomous Communities. Teams working in gynecological oncology should implement the measures according to their individual circumstances.

The current and future scenario for many centers is the limitation on surgical procedures, for the following reasons:

- Congestion of the vast majority of intrahospital circuits.
- Centralization by intensive care units of most available respirators and intensive care beds.
- Surgical risks for patients and health care personnel:
  - An estimated 30% of staff are expected to be on sick leave or in quarantine, which in our case affects cancer specialists.
  - Surgical procedures carry a risk of formation of aerosols (eg, general anesthesia, surgical smoke).
- Limitations of time and physical space for carrying out standard procedures.

Decisions on treatment must be made on an individual basis, taking into account the characteristics of the patient, the tumor, and the capacity of the center. Given current uncertainty surrounding the progress of the pandemic in the coming months, decisions on delay/nonprovision of treatment may lead to severe complications or progression and affect the survival of patients.



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Therefore, the Gynecological Oncology and Breast Disease Section of SEGO would like to provide useful guidelines based to the greatest extent possible on scientific evidence (limited as this is) that offer medical-surgical alternatives for postponing/replacing standard treatment of tumors. These alternatives should be discussed with patients and covered in the definitive informed consent document.

### **General measures**

- Patients are advised to attend health care centers unaccompanied, even at admission, except where this is completely unavoidable.
- Social distancing should be facilitated.
- Patients should take their own temperature or report any symptom that is suggestive of infection by COVID-19 before reaching the center, irrespective of whether they are attending for surgery or an outpatient visit.
- Channels of communication (telephone, e-mail) should be facilitated to ensure continuous electronic/online contact with the patient.
- Patients should be informed of the situation and of the change in diagnostic and treatment strategy. This should be set out in the informed consent.
- Measures should be adapted to the epidemiological situation and to the capabilities of the individual center.

### **Endometrial cancer**

- In the case of low-risk tumors, the approaches to be considered include hormone treatment until definitive surgery can be performed (medroxyprogesterone acetate 400-800 mg/d or megestrol acetate 160-320 mg/d), together with an antithrombotic agent (acetylsalicylic acid 100 mg/d) or a levonorgestrel intrauterine device. Aromatase inhibitors such as anastrozole, letrozole, or exemestane can be prescribed as alternatives.
- In the case of intermediate- or high-risk tumors, we recommend vaginal hysterectomy with double adnexectomy or minimally invasive surgery with hysterectomy and sentinel node biopsy. In cases with no bilateral migration, reinjection is an acceptable option.
- In the case of advanced tumors, chemoradiotherapy and hormonal treatment should be taken into account.

### **Ovarian cancer**

- When an early ovarian tumor is suspected, we recommend minimizing surgery, that is, removal of the ovarian tumor(s) without intraoperative histology and, in cases of a definitive positive result, staging by imaging or deferred staging, with the objective of selecting future adjuvant treatment.
- In the case of patients with advanced ovarian tumors, it is necessary to weigh the possibility of surgical treatments (lack of physical space for surgery, risk of need for intensive care that is already congested, surgical complications, anesthesia with ventilation) with chemotherapy (immunosuppressive status) and the patient's general status, as well as comorbid conditions. When a stay in intensive care and/or a lack of physical space for surgery is expected, neoadjuvant chemotherapy should be started.
- Treatment should be selected based on imaging studies and diagnosis based on directed biopsy. Laparoscopy and use of physical spaces for surgery should be avoided.
- In the case of patients already receiving neoadjuvant treatment, cycles can be prolonged on an individual basis according to the response as assessed using imaging techniques, tumor markers, and the extension of interval debulking surgery (complete debulking).



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## **Cervical cancer**

Procedures with spinal anesthesia should be considered. Patient age and the high survival rate in initial stages should also be taken in to consideration in extreme hospital management situations. When an operating room is not available, radiotherapy should be considered for these patients.

- Tumors <2 cm, especially in the case of infiltrative tumors with no gross lesions and histopathology findings that are not unfavorable (eg, G3, unusual histopathology findings) can be managed with wide conization/trachelectomy and delay of definitive surgical treatment, providing that free surgical margins can be ensured in the interest of a rapid procedure, with locoregional and outpatient anesthesia. If the situation allows, every attempt will be made to detect the sentinel node.
- Given the high associated survival rate, IB1-IIA1 tumors should be managed based on radical hysterectomy with sentinel node biopsy. However, in the current situation, radiotherapy can be taken into consideration as curative treatment.
- Locally advanced cervical cancer should be staged using physical examination and imaging techniques.

## **Vulvar cancer**

- Consider delaying treatment (individual basis).
- Where possible, vulvar tumors <2 cm should be managed with radical excision under local/locoregional anesthesia.
- When the characteristics of the tumor require standard surgery, the approach to be adopted should be radical excision and selective biopsy of the sentinel node. Where possible, ultraradical procedures and lymphadenectomy that increase morbidity and hospital stay should be avoided.
- When the size of the tumor or the proximity to sphincters necessitates complex reconstruction techniques, neoadjuvant chemoradiotherapy should be considered.
- In accordance with the characteristics of the tumor and of the patient, and given the current situation of limited operative time, definitive chemoradiotherapy can be considered.

## **Breast cancer**

In areas where the epidemic is severe, patients with breast cancer should be recommended to postpone surgery after diagnosis, with priority given to neoadjuvant treatment. Electronic/online contact should be reinforced to provide psychological support.

In general terms, it is important to consider the following:

- Hospital diagnoses and treatments should be postponed as long as possible.
- If surgery is necessary, it should be performed in the outpatient setting, without admission to hospital. Priority should be given to less aggressive procedures that can be performed with local anesthesia and sedation. If mastectomy is necessary, reconstruction surgery should be performed at a later date.
- In the case of luminal tumors, neoadjuvant hormone therapy with aromatase inhibitors should be prescribed. In premenopausal women, this should be combined with LH-RH analogues.
- In Her2+ and HR– tumors, as well as in triple-negative tumors, the preferred option is neoadjuvant treatment, after consultation with the medical oncology department.
- Neoadjuvant treatment should be evaluated in triple-negative tumors.
- In the case of patients who require chemotherapy, schedules involving the least number of hospital visits possible should be applied.



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- For more information from the Spanish Society of Breast Disease, please see: <https://www.sespm.es/nuevo-coronavirus-diagnostico-y-tratamiento-del-cancer-de-mama-en-pacientes-con-neumonia/>

### **Newly diagnosed cases**

- Patients should be informed of the extreme nature of the current health care situation. The situation to be accepted by the patient must be defined in the informed consent documents.
- Where possible, management should always be by electronic communication/online, although at least one physical examination will be necessary. This should be performed with the means available in the clinic.
- Where possible, clinical advice should be based on physical examination and on ultrasound, abdominal, and vaginal examination in order to avoid overloading other hospital circuits.

### **Follow-up**

- For the duration of the pandemic, or at least during the period where transmission is most likely, the number of in-person visits should be minimized. Routine follow-up visits should be postponed.
- Every attempt should be made to ensure that follow-up is electronic/online, except where symptoms indicate a recurrence of the tumor.
- Where possible, additional tests should be avoided until the end of the pandemic, except where the patient's symptoms require these to be performed or for monitoring of treatment.

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