



AMERICAN COLLEGE OF SURGEONS

*Inspiring Quality:
Highest Standards, Better Outcomes*

100+years

COVID 19: Elective Case Triage Guidelines for Surgical Care

Thoracic Cancer Surgery

Phase I. Semi-Urgent Setting (Preparation Phase)

Few COVID 19 patients, hospital resources not exhausted, institution still has ICU vent capacity, and COVID trajectory not in rapid escalation phase

Surgery restricted to patients likely to have survivorship compromised if surgery not performed within next 3 months

Cases that need to be done as soon as feasible (recognizing status of hospital likely to progress over next few weeks):

- Solid or predominantly solid (>50%) lung cancer or presumed lung cancer >2cm, clinical node negative
- Node positive lung cancer
- Post induction therapy cancer
- Esophageal cancer T1b or greater
- Chest wall tumors of high malignant potential not manageable by alternative therapy
- Stenting for obstructing esophageal tumor
- Staging to start treatment (mediastinoscopy, diagnostic VATS for pleural dissemination)
- Symptomatic mediastinal tumors – diagnosis not amenable to needle biopsy
- Patients enrolled in therapeutic clinical trials

Cases that should be deferred

- Predominantly ground glass (<50% solid) nodules or cancers
- Solid nodule or lung cancer < 2 cm
- Indolent histology (e.g. carcinoid, slowly enlarging nodule)
- Thymoma (non-bulky, asymptomatic)
- Pulmonary Oligometastases - unless clinically necessary for pressing therapeutic or diagnostic indications (i.e. surgery will impact treatment)
- Patients unlikely to separate from mechanical ventilation or likely to have prolonged ICU needs (i.e. particularly high-risk patients)
- Tracheal resection (unless aggressive histology)
- Bronchoscopy
- Upper Endoscopy
- Tracheostomy

Alternative treatment approaches to be considered (assuming resources permit):

- Early stage esophageal cancer (stage T1a/b superficial) managed endoscopically
- If eligible for adjuvant therapy, then give neoadjuvant therapy (e.g. chemotherapy for 5cm lung cancer)
- Stereotactic Ablative Radiotherapy (SABR)
- Ablation (e.g. cryotherapy, radiofrequency ablation)
- Stent for obstructing cancers then treat with chemoradiation
- Debulking (endobronchial tumor) only in circumstance where alternative therapy is not an option due to increased risk of aerosolization (e.g. stridor post obstructive pneumonia not responsive to antibiotics)
- Nonsurgical staging (EBUS, Imaging, Interventional Radiology biopsy)
- Follow patients after their neoadjuvant for "local only failure" (i.e. salvage surgery)
- Extending chemotherapy (additional cycles) for patients completing a planned neoadjuvant course

Phase II. Urgent Setting

Many COVID 19 patients, ICU and ventilator capacity limited, OR supplies limited or COVID trajectory within hospital in rapidly escalating phase

Surgery restricted to patients likely to have survivorship compromised if surgery not performed within next few days

Cases that need to be done as soon as feasible (recognizing status of hospital likely to progress over next few days):

- Perforated cancer of esophagus – not septic
- Tumor associated infection – compromising, but not septic (e.g. debulking for post obstructive pneumonia)
- Management of surgical complications (hemothorax, empyema, infected mesh) – in a hemodynamically stable patient

Cases that should be deferred:

- All thoracic procedures typically scheduled as routine/elective (i.e. not add-ons)

Alternative treatment approaches RECOMMENDED (assuming resources permit):

- Transfer patient to hospital that is in Phase I
- If eligible for adjuvant therapy then give neoadjuvant therapy
- Stereotactic Ablative Radiotherapy (SABR)
- Ablation (e.g. cryotherapy, radiofrequency ablation)
- Reconsider neoadjuvant as definitive chemo-radiation, and follow patients for "local only failure" (i.e. salvage surgery)

Phase III.

Hospital resources are all routed to COVID 19 patients, no ventilator or ICU capacity, OR supplies exhausted.

Surgery restricted to patients likely to have survivorship compromised if surgery not performed within next few hours

Cases that need to be done as soon as feasible (status of hospital likely to progress in hours)

- Perforated cancer of esophagus – septic patient
- Threatened airway
- Tumor associated sepsis
- Management of surgical complications – unstable patient (active bleeding not amenable to nonsurgical management, dehiscence of airway, anastomotic leak with sepsis)

All other cases deferred

Alternate treatment recommended

- Same as above

General Recommendations

The Society of Surgical Oncology have recommendations for a number of additional cancer types.

Case status (i.e. risk of death time frame) determination made by Division, ideally in a multi-clinician setting (case review conference)

Consent language: You are being offered surgery now, because at this time we feel that your risk of being harmed by infections, including coronavirus, within the hospital is low, and that delaying surgery could reduce your chances of being cured of cancer. It is not possible to know either the risk of delaying surgery or the chance of getting an infection with perfect accuracy, but I did consult my colleagues and it is our group's opinion that surgery is a reasonable thing to do.

Released March 24, 2020