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Recommendations for the Management of Colon and Rectal Cancer during the COVID-19 Pandemic



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The Illinois Cancer Collaborative (ILCC)

The Illinois Cancer Collaborative (ILCC) is a first-of-its kind, multidisciplinary statewide partnership of Illinois hospitals working together to improve the safety and quality of care for cancer patients across Illinois during, and after, the COVID-19 pandemic. Our vision is to engage providers to deliver patient-centered, high-quality cancer care across Illinois. If you are interested in joining the ILCC, please visit our webpage at ilcancer.org and contact us at info@ilcancer.org.

The ILCC COVID-19 Working Groups and Consensus Guidelines

Providers and institutions throughout Illinois are experiencing difficulty with the lack of evidence and recommendations from numerous sources for cancer care during the COVID-19 pandemic. In response, the ILCC convened three multidisciplinary working groups of experts to pool their experience, expertise, and knowledge in regard to safe and optimal care of cancer patients during the pandemic. The results are the ILCC Consensus Guidelines for COVID-19 Cancer Care in three areas: Colorectal Cancer, Lung Cancer, and Visitor Policies for Ambulatory Cancer Care. The goal of these guidelines is to provide a single source for hospitals, clinics, and practices to support safe and optimal care for cancer patients statewide during this unprecedented pandemic.

These guidelines represent the consensus recommendations of the members of the Illinois Cancer Collaborative COVID-19 Operations Working Group and do not represent endorsement or approval by their individual institutions.

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Evidence Review

Risk of delayed surgical treatment of colon cancer

- A single center study showed that a 30, 60, 90, or 120-day period from diagnosis to surgical treatment of colorectal cancer was not associated with worse survival.[5]
- A systematic review of 5 studies with diagnosis-to-surgery intervals up to 56 days concluded that there was no association between delay in surgery and survival in colon cancer.[6]
- A study showed that patients with stage I to III colon cancer who had primary elective surgery >40 days after diagnosis experienced reduced survival. Each 14-day increase in the interval from diagnosis to surgery was associated with a 6% increase in the hazard of death.[7]

Risks of delayed surgical treatment of rectal cancer

- A delay of >60 days from onset of symptoms to radiation or surgical treatment was associated with lower survival.[8]
- A review suggested that no association was seen between treatment delay and survival among patients with rectal cancer.[9]
- An interval of >6-8 weeks from the completion of neoadjuvant therapy to surgery was associated with improved rates of pathologic complete response but not with overall survival.[10]
- A watch-and-wait approach for patients with rectal cancer who had complete clinical response to neoadjuvant therapy was shown to result in worse survival than total mesorectal excision but can be considered in selected patients.[11]

Neoadjuvant regimens for colon and rectal cancer

- The feasibility phase of the FOxTROT trial suggested that neoadjuvant chemotherapy is safe for locally advanced, operable (T3-T4a, N0-2, M0) colon cancer.[12] The preliminary results of the multicenter trial showed that neoadjuvant therapy reduced surgical complications but did not affect survival at 2 years.[13]
- Neoadjuvant chemoradiation is the standard of care for high-risk clinical stage II-III rectal cancer.[14]
- Three clinical trials have demonstrated no difference in outcomes for short vs. standard course neoadjuvant radiotherapy for rectal cancer.[15-17]

Recommendations

Management of locoregional colon cancer if surgical resources are limited

ASYMPTOMATIC PRIMARY

CLINICAL STAGE I-II

- Consider delaying all therapy if inpatient resources are expected to become available within 4 weeks.
- In select cases, particularly T3-4a disease, neoadjuvant chemotherapy may be considered. The length of therapy should be tailored to the clinical stage and anticipated ability to offer surgical resection. The total length of therapy can be modified based on pathologic stage. A capecitadine/oxaliplatin (CAPOX) regimen is preferable to leucovorin/5-fluorouracil/oxaliplatin (FOLFOX).

CLINICAL STAGE III

- Consider neoadjuvant chemotherapy. The length of therapy should be tailored to the clinical stage and anticipated ability to offer surgical resection. The total length of systemic therapy can be modified based on pathologic stage and CAPOX is preferable to FOLFOX.

SYMPTOMATIC PRIMARY

- If hospital resources are severely limited, consider alternatives to definitive resection in patients at high risk of complications, need for intensive care, or prolonged hospitalization. Alternatives should be determined on a case-by-case basis but may include endoluminal stent placement in left-sided tumors, fecal diversion, or resection without immediate anastomosis.
- If symptoms are not amenable to a temporizing intervention, definitive surgery should be offered.

Management of locoregional rectal cancer if surgical resources are limited

ASYMPTOMATIC PRIMARY

CLINICAL STAGE I

- Consider delaying all therapy if inpatient resources will become available within 4 weeks.
- In select cases, neoadjuvant chemoradiation may be considered.
- The duration of chemotherapy should be tailored to the clinical stage and anticipated ability to offer surgical resection. The total length of therapy can be modified based on pathologic stage, and CAPOX is preferable to FOLFOX.
- Short course radiation (5 doses of 5 Gy) should be considered to minimize hospital exposure.
- At experienced centers, a watch-and-wait approach for select patients with complete clinical response to neoadjuvant chemoradiation can be considered.

CLINICAL STAGE II-III

- Neoadjuvant chemoradiation should be administered prior to surgical resection for stage II-III rectal cancers.
- The length of therapy should be tailored to the clinical stage and anticipated ability to offer surgical resection. The total length of therapy can be modified based on pathologic stage.
- CAPOX is preferable to FOLFOX and should be administered prior to radiation.
- Short course radiation (5 doses of 5 Gy) should be considered to minimize hospital exposure.
- At experienced centers, a watch-and-wait approach for select patients with complete clinical response to neoadjuvant chemoradiation can be considered.

SYMPTOMATIC PRIMARY

- If hospital resources are severely limited, consider alternatives to definitive resection in patients at high risk of complications, need for intensive care, or prolonged hospitalization. Alternatives should be determined on a case-by-case basis but may include fecal diversion or resection without immediate anastomosis.
- If symptoms are not amenable to a temporizing intervention, then definitive surgery and/or radiation should be offered.
- Stenting is not recommended as a temporizing measure for rectal cancers.

Management of metastatic colorectal cancer if surgical resources are limited

- If curative intent surgery is possible (e.g., isolated metastatic liver and/or pulmonary disease, peritoneal disease), decisions about treatment should incorporate the extent of disease, expected surgical morbidity, risk of disease progression without intervention, and availability of inpatient resources.
- If surgery is not indicated, less invasive alternative therapies including Y-90 radioembolization or stereotactic body radiation therapy should be considered.

Patient Care Coordination

Patients with colorectal cancer should have initial telehealth appointments with the following providers to ensure that (1) treatment can proceed quickly after care is resumed, and (2) patients will be known to their providers if emergent intervention is needed:

- Primary care practitioner
- General surgeon, colorectal surgeon, or surgical oncologist
- Gastroenterologist
- Medical oncologist (*if applicable*)
- Radiation oncologist (*if applicable*)
- Medical geneticist (*if applicable*)

A protocol should be developed to ensure that patients with newly diagnosed colorectal cancer are scheduled for initial appointments with these providers.

If no immediate treatment is planned, a process should be developed to maintain contact with each patient to ensure that they are not lost to follow-up and can resume treatment when resources permit.

Patients should be instructed how to perform simple tasks, such as disconnecting their chemotherapy pump at home, to minimize the need for healthcare encounters which risk exposure.

Appendix

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