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March 23, 2020: Gynecologic Oncology Considerations during the COVID-19 Pandemic

Given the challenges presented by the COVID-19 pandemic, the following considerations are provided to enable practitioners to deliver cancer care while protecting the health and safety of both patients and members. The current understanding of COVID-19 is continually evolving and its impact on the care of gynecologic oncology patients is rapidly changing. Data are limited at this time, and these considerations will need to be modified as more information emerges about COVID-19 or further resource stratification becomes necessary as the crisis evolves. The considerations provided may not be applicable in all clinical settings or may need to be modified as different locoregional situations arise. The discussion points presented are not meant to take the place of institutional or government agency recommendations.

Oncology patients at highest risk for severe events during this pandemic include the following:

- Patients \geq 65 years old [1]
- Patients at any age with significant co-morbidity (particularly cardiovascular disease, pulmonary disease and diabetes mellitus) [2]
- ECOG status \geq 2
- Patients receiving cytotoxic chemotherapy [3]

General outpatient considerations:

- Pre-screen patients via telephone/patient portal for COVID-19 symptoms the day before clinic appointment, repeat screening at patient check in. Consider checking their temperature at screening if possible.
- Prioritize newly diagnosed cancer and recurrent cancer patients with symptoms needing treatment/end-of-life discussion.
- Limit to one or completely restrict visitors to the appointment if possible.

- Encourage physical distancing in waiting areas and schedule patients to facilitate maintaining fewer people in the waiting area.
- Minimize clinic/hospital/laboratory visits and the number of staff members who interact with each patient. Evaluate patients utilizing telehealth visits and home or local collection of labs.
- Reschedule asymptomatic surveillance visits and conduct routine postoperative visits and discussion of pathology with telehealth.
- Educate patients on the symptoms of COVID-19 infection and on best practices including hand washing and physical distancing.

General inpatient considerations:

- Minimize traffic between inpatient sites and clinics by delegating who goes where and consolidate services as much as possible.
- Reduce traffic on wards by having designated inpatient providers on your service and allow only one trainee/APP and attending to enter the room to examine and interview the patient.
- Avoid inpatient chemotherapy when possible.

Patients who should continue to be evaluated and treated:

- Newly diagnosed cancer with priority given to high grade disease (including ovarian cancer, sarcomas, gestational trophoblastic neoplasia and type II endometrial cancers).
- Recurrent cancer patients with symptoms needing urgent treatment or end of life discussion.
- Chemotherapy patients who are ECOG 0-1 and have normal lab values for chemotherapy (ANC > 1.5 and no lymphopenia), and no major clinically significant co-morbidity (particularly cardiovascular disease and pulmonary disease); patients with no concerns should be considered for evaluation by telemedicine and proceed directly to infusion without an office visit to minimize the number of contacts.
- Consider utilization of chemotherapy regimens that will avoid frequent patient visits.
- Evaluate enrollment and treatment on clinical trials based on availability of clinical and research support.
- Second opinions may be accomplished with the use of telemedicine as resources allow.

Ovarian cancer:

- Neoadjuvant chemotherapy may be effective in delaying surgery and inpatient hospitalization.
- Consider chemotherapy agents and dosing carefully to limit lymphopenia/neutropenia to avoid hospitalization.
- Maintenance therapy can be continued if well tolerated with normal labs and can be monitored utilizing telemedicine.
- The use of growth factor support should continue based on current guidelines and can be considered in elderly or those with significant co-morbidities.

Endometrial cancer:

- If patients are considered high risk for perioperative morbidity or if health system resources do not allow for a timely surgical intervention, consider alternate treatment strategies such as hormonal therapy for endometrial intraepithelial neoplasia (atypical hyperplasia)/low-grade endometrial adenocarcinoma.
- Patients requiring chemotherapy should be treated with the same considerations as mentioned for ovarian cancer.

Cervical cancer:

- Early cervical cancer patients who are considered candidates for surgery may be scheduled as usual or delayed as appropriate.
- Locally advanced cancers can be treated with standard protocols, and chemoradiation for curative intent should be prioritized.
- Management of pre-invasive disease can be deferred.

References:

[1] CDC COVID-19 Response Team. MMWR Morb Mortal Wkly Rep. 2020 Mar 18.

[2] Cascella M, Rajnik M, Cuomo A, Dulebohn SC, Di Napoli R. Features, Evaluation and Treatment Coronavirus (COVID-19). StatPearls. Treasure Island (FL) 2020.

[3] Liang W, Guan W, Chen R, Wang W, Li J, Xu K, et al. Cancer patients in SARS-CoV-2 infection: a nationwide analysis in China. *Lancet Oncol.* 2020;21(3):335-7.