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**VIEWPOINT**

# Management of Non Metastatic Colo-Rectal Cancers during the COVID-19 Pandemic: Viewpoint

Fadila Kouhen <sup>a</sup> , Meriem Chihabeddine <sup>a</sup>, Mohammed Afif <sup>b</sup>, Nadia Errafiy <sup>c</sup><sup>a</sup> Department of Radiotherapy, International University Hospital Sheikh Khalifa. Mohammed VI University of Health Sciences (UM6SS). Casablanca, Morocco.<sup>b</sup> Department of Radiotherapy, National Institute of Oncology. Mohammed V University In Rabat, Morocco.<sup>c</sup> National Reference Laboratory (LNR). Mohammed VI University of Health Sciences (UM6SS). Casablanca, Morocco.**ABSTRACT**

Recently, an ongoing outbreak of pneumonia caused by a novel coronavirus, known as severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), has spread throughout Morocco and the rest of the world with more than 4.5 million confirmed cases and 300,000 deaths in 188 countries.

As oncologists, it's difficult to choose between delaying oncological treatment which increases the risk of progression and death from the disease and increasing the risk of contamination by Covid 19 Virus for patients who are very vulnerable.

Colorectal cancer is a real public health problem, it represents the third most commonly diagnosed cancer in males and the second in female.

The purpose of the present work is to review the recommendations from the international evidence-based guideline for managing patients with Non metastatic colo-rectal cancers during the COVID- 19 crisis.

**KEYWORDS:** Covid-19; Non Metastatic Colo-Rectal Cancers; Guidelines**Correspondence:** Dr Fadila Kouhen : Department of Radiotherapy, International University Hospital Sheikh Khalifa. Casablanca, Morocco. Email : [fadila10m@hotmail.com](mailto:fadila10m@hotmail.com)

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Recently, an ongoing outbreak of pneumonia caused by a novel coronavirus, known as severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), has spread throughout Morocco and the rest of the world with more than 4.5 million confirmed cases and 300,000 deaths in 188 countries.

Cancer patients are considered as a highly vulnerable group in the current COVID-19 pandemic. According to a recently published Chinese cohort, patients with cancer had a higher risk of developing severe events defined by admission to the intensive care unit (ICU), mechanical ventilation, or death compared with patients without cancer (39 % vs 8%, p = 0.0003) [1].

As oncologists, it's difficult to choose between delaying oncological treatment which increases the risk of progression and death from the disease and increasing the risk of contamination by Covid 19 Virus for patients who are very vulnerable. However, the risks related to COVID-19 should be balanced against tumour control and discussed on a case-by-case basis.

Colorectal cancer is a real public health problem, it represents the third most commonly diagnosed cancer in males and the second in female, with an estimated 1,4 million cases and 693,900 deaths occurring in 2012 [2].

According to the Cancer Registry of Rabat, colorectal cancer represents the first gastro-intestinal cancer, and the fourth most common cancer, with an incidence of 8,4/100 000 habitants in 2008 with a significant increase in incidence these last years due to considerable progress in the detection, diagnosis and treatment of cancer [3].

In rectal cancer, an international panel of cancer experts issued an international expert consensus statement in the Radiotherapy & Oncology journal regarding treatment options for patients with rectal cancer during the coronavirus disease 2019 (COVID-19) pandemic [4].

For early stage, total mesorectal excision (TME) alone without pre-operative radiotherapy is recommended.

For locally advanced (T2N+ or T3-4/Nany) operable rectal patients, we should strongly consider using short-course pelvic radiotherapy (5Gy x 5 fractions) during this pandemic with comparable outcomes for local recurrence,

disease free survival, overall survival and late toxicity compared to the usual 5 weeks of radiotherapy coupled with chemotherapy [5,6].

More recently, timing for rectal cancer surgery after neoadjuvant chemoradiotherapy has been studied as an independent variable that may influence perioperative complications, risk for local recurrence, and overall survival.

Recent evidence indicates that surgery, which usually takes place one week after radiotherapy, can be safely postponed for 6 to 8 weeks or more [7,8].

This approach avoids the need for chemotherapy, which can compromise the immune system leaving patients vulnerable to infection.

The Stockholm III trial randomly assigned patients to 5 × 5 Gy radiotherapy and surgery within 1 week (short-course radiotherapy), 5 × 5 Gy radiotherapy and surgery after 4–8 weeks (short-course radiotherapy with delay), or 25 × 2 Gy radiotherapy and surgery after 4–8 weeks (longcourse radiotherapy with delay).

the trial showed no difference in local recurrence rates, distant metastases, recurrence-free or overall survival between the three arms with any postoperative morbidity (53% vs. 41%,  $p = .001$ ) and surgical morbidity (36% vs. 28%,  $p = .03$ ) were higher in the short-course RT with immediate surgery group compared to the delayed surgery groups. Reoperations did not differ between groups (15% vs. 14%).

The National Comprehensive Cancer Network (NCCN) has published guidelines for the Cancer Care Community to keep patients with cancer, care providers and staff safe during the COVID-19 Pandemic.

They recommend consider several months delay of routine endoscopic, radiologic and biologic surveillance monitoring until the pandemic has resolved and the using of telehealth to evaluate patient and assure clinical stability especially in older patients or those with other comorbidities.

For colon cancer, Timing of surgery has been shown to affect outcomes in many forms of cancer, including colon cancer.

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The ideal time of resection has been estimated to be between 3 and 6 weeks from diagnosis, which is unlikely to be achieved during COVID-19 outbreak [9].

The experts strongly recommend a course of neoadjuvant capecitabine or CapeOx chemotherapy for patients with newly diagnosed stage 2–3 cancer who are unable to have surgery due to COVID-19 constraints.

For adjuvant therapy, the American Society of Clinical Oncology (ASCO) Guideline recommends recently, based on the results from trials of 3- and 6-month oxaliplatin-containing chemotherapy leucovorin, fluorouracil, and oxaliplatin (FOLFOX) or capecitabine and oxaliplatin (CAPOX), Shorter-Course Adjuvant Chemotherapy for low risk patients with Stage III Colon Cancer.

The guideline defines low-risk patients as having either T1, T2, or T3, and N1 stage tumors and high-risk patients as having T4 and/or N2 stage tumors

As stated, treatment for colorectal cancer is not elective and therefore we must help our patients to receive optimized treatment for their colorectal cancer, while at the same time minimizing their individual risk of infection and maintain optimal clinical outcomes, especially in the curative setting.

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## AUTHORS' CONTRIBUTIONS

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## COMPETING INTERESTS

The authors declare no competing interests with this case.

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