Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Management of Gynaecological oncology diseases during COVID-19 global pandemic

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Dear Editor,

Since the first reported cases of COVID-19 in China at the end of 2019, the world is experiencing a devastating crisis with negative expectations in all scenarios [1–3]. Due to the immediate adaptations that the health system needs to make, concerns about cancer diseases, especially gynaecologic cancer diseases, arise [3]. Several medical societies worldwide have mobilized and attempted to create recommendations for the moment of crisis of COVID-19 without jeopardizing the cancer treatments [3]. We have tried to gather the published recommendations related to the treatment of gynaecological cancer in an effort to assist the management of these patients in different health services worldwide [2–4].

Considering that the world population is heterogeneous in terms of the incidence of gynaecological tumours, both access to health services and the contamination rates by COVID-19 are also varied, these recommendations suggest local adaptations [2].

Cervical tumours: it is recommended to postpone the treatment of pre-invasive lesions for 6–12 months. Initial invasive lesions or low risk (<2 cm, favourable histologies) should be considered the standard treatment and, in places with limited access to surgery, consider conisation or simple trachelectomy with sentinel lymph node research and reassess it in 3 months or at the end of the crisis. In the desire to preserve fertility with bulky lesions, neoadjuvant chemotherapy should be considered. Resectable and advanced cases should follow standard treatment with the suggestion of hypofractionation of radiotherapy doses (to decrease visits to the service). And, in cases of asymptomatic patients for COVID-19, brachytherapy should not be delayed [2,4].

Endometrial tumours: Perform outpatient hysteroscopies only for highly suspect patients. Low-risk patients and grade 1 tumours consider non-surgical therapies such as hormone therapy and intrauterine device implants and may postpone treatment for 1–2 months. Intermediate and high risks consider performing hysterectomy with salpingo-oophorectomy and sentinel lymph node research due to low morbidity. And in advanced cases diagnosed by biopsy and systemic therapy, ESMO risk score should be considered [2,4].

Ovarian tumours: initial or suspected cases should be evaluated according to physical examination, the genetic history of cancer (breast/ovary), tumour markers, radiological examinations, and malignancy rates, such as with the use of doppler ultrasound. Isolated adnexectomy should be considered only to shorten the surgical time and postpone the surgical staging by 1–2 months, always with careful inspection of the entire abdominal cavity. In known advanced cases, biopsies guided by imaging exams or small abdominal incisions should be considered to guide systemic treatment. Cases already in use of neoadjuvant chemotherapy can be maintained until they complete 6 cycles and reassessed afterward for rescue and surgical complementation if necessary. Cases that require adjuvant chemotherapy after surgery should be guided by a minimum of two cycles. Hyperthermic chemotherapy at this time of crisis should be avoided [2,4].

Vulva tumours: initial cases should not be postponed, however, it suggests postoperative recovery at home as soon as possible, as most patients, due to age, since the elderly patients are part of the population at risk for COVID-19. Radiotherapy and chemotherapy treatments should be considered in advanced cases that require extensive resections and the need for flap rotation. In the presence of metastatic disease, systemic therapy can be considered in the presence of symptoms [2,4].

Vaginal tumours: most of them are in advanced stages. Therefore, radiotherapy and chemotherapy, when indicated, remains the best option [2,4].

Trophoblastic tumours: due to the excellent potential to achieve cure, and a high chance of metastases at diagnosis, the systemic therapy with usual treatment should be considered [4].

Visits to the doctor should be restricted to new diagnoses, to immediate postoperative follow-up, or in case of urgency and emergency due to symptoms [1]. The use of telemedicine is essential at this time for cancer follow-up, and the decision to manage cancer must take into consideration the patient's location (local epidemiological studies can help these decision), age of the patient, associated comorbidities, disease staging, tumour histology, and rates of potential postoperative complications. Considering that the joint decision about treatment in multidisciplinary tumour boards (online video conferencing) is crucial for the division of responsibilities in decisions [2,4].

Declaration of competing interest

There is no conflict of interest of any of the authors.

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