Stage migration of colorectal cancer during COVID-19 pandemic

Editor

All cancer pathways across the UK have been adversely affected by the implications of COVID-19 pandemic. Colorectal cancer (CRC) pathway by no means an exclusion to this adversity. Treatments of large number of CRC, have been either deferred or revised to minimise the detrimental outcomes of concurrent SARS-CoV-2 infection[1-2]. Colorectal cancer being largely a disease of advanced age, SARS-CoV-2 infections could have deleterious effects in them. Cancer research UK has extrapolated that approximately 5000-6000 patients would require surgery for CRC in the next three months averaging the need of 110 resections per day.

CRC pathway is one of the most robust cancer pathways in the UK designed to streamline screening, investigation, treatment and surveillance of CRC patients. De-escalation of referral routs in primary care settings and diversion of clinical resources towards capacity expansion have contributed to the stern disruption of the CRC pathway during the locked-down time. There was no universally agreed protocol to adopt on the optimum management of CRC patients during the pandemic. However, the recommendations by the NHS, ACPGBI, BSG and BSGAR on[3] risk stratification and treatment prioritisation of colorectal cancer patients were available to local CRC multi-disciplinary teams across the UK to assist in best interest decision making during this difficult time.

National Bowel Cancer Screening Programme (NBCSP) that account for about 10% of new CRC diagnosis (most of which are early cancers) has been temporarily suspended during the lockdown time. Endoscopy services and virtual colonoscopies (i.e. CT colonogram) have been strictly limited to selective cases due to the presumed fear of generation of viral particles laden aerosol generation[3-4] during these procedures. Only rapid access two weeks wait referral (2WW) pathway was effectively in operation during the locked-down time. Nonetheless, CT scan with ante-grade colonic enhancement (CT ACE) coupled with Faecal Immunochemical Test (FIT) was the alternative to routine colonoscopy in this rout. Patients were also assessed in semi-virtual clinics by the primary care physicians and clinicians in the absence of physical evaluation. As the yield of new colorectal cancer diagnosis from the current rapid access pathway falls around 3-4%[3], a significant proportion of high-risk patients might have been slipped from the safety net of the cancer services during this time.

Cancer treatments are time sensitive. Early detection and timely intervention largely dictate the prognosis and life expectancy of these patients. Delay in diagnosis and treatment of patients with early stage cancer will increase the likelihood of metastatic disease. Stage migration, therefore, is a feared complication of delayed cancer treatment and tumours can progress from being curable by surgery (or radiotherapy) with near normal life expectancy to being incurable, with very limited life expectancy[5]. Anecdotal evidence during the lockdown time has revealed the need for emergency surgical intervention of a significant proportion of patients with colorectal cancer presented with bowel obstructions or tumour perforations that could have been otherwise treated with one stage surgery and perhaps with improved quality of life and overall survival.

Cancer services in the UK, particularly the CRC pathways are currently overwhelmed with the unprecedented scale of back logged patients of whom the treatments have been differed during the lockdown time. A surge of newly diagnosed cancer cases is also expected to be added on to the burden as the routine referral pathways and screening programmes resume their normal activities soon. In the wake of wide enthusiasm on re-starting routine cancer services, an efficient strategy to recognise and prioritise the high-risk colorectal patients that need timely interventions need to be formulated in order to mitigate the potential catastrophe from unobtrusive stage migrations in these patients.

A. S. D. Liyanage, K. Gokul, B. H. Babu and P. Ainsworth

Department of General Surgery, Southport and Formby District General Hospital, Southport, United Kingdom, PR8 6UX @liyanagealoka

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