

Guidelines for cancer treatment during COVID 19 pandemic

20 March 2020, Version 1

Introduction

These clinical guidelines have been agreed by the Scottish Government's National Cancer Treatment Response Group

They align with the majority of similar guidance produced by NHS England: Clinical guide for the management of cancer patients during the coronavirus pandemic (Publications Ref 001559). Variations to these have been agreed in relation to some aspects of SACT, to reflect existing differing service environments in Scotland.

These guidelines will be reviewed and revised frequently over the coming weeks and months.

The risk of COVID19 is a new factor in harm and benefit considerations for cancer treatment. Increasing prevalence of the virus will compound this. Already, individual cancer treatment decisions are changing to reflect this, in consultation with risk assessments and the expressed preferences of patients. Treatment pathways will continue to alter significantly, and necessarily, to continue to do no harm.

In that context, vital cancer treatments are expected to continue, and patients can be assured that their clinical teams will continue to offer the best treatment options for them.

COVID19 advice

For the latest definitive public advice on COVID19, please see NHS inform

Advice for cancer patients, reiterating national advice and where to seek guidance, will be shared with cancer services

For general information about Coronavirus patients and the public can call 0800 028 2816

The most vulnerable cancer patients

Some people with cancer are more at risk of becoming seriously ill if they contract the coronavirus infection, including people:

- With cancer who are undergoing active chemotherapy or radiotherapy
- With cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
- Having immunotherapy or other continuing antibody treatments for cancer
- Having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors.
- Who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs.

In addition to immunosuppression, several factors/co-morbidities are likely to be linked with a poorer prognosis with coronavirus: age over 60; pre-existing cardiovascular disease; and pre-existing respiratory disease.

The more of these individual factors a cancer patient has, the more likely they are to develop a serious illness with coronavirus especially if treated with systemic anti-cancer therapies.

Clinicians may also need to prioritise treatment for those most in need. It is important that all decisions taken are done so with multidisciplinary team (MDT) input and clearly communicated with patients

Leadership

- **A consultant must be designated as 'lead consultant'**. This duty can be for one day, a few days or even five days in small units. This is an essential role during crisis management. It cannot be performed by the consultant 'on-call'. They must be free of clinical duties and the role involves co-ordination of the whole service from emergency department (ED) through to liaison with other specialties and managers.
- It can be very stressful during a crisis. Support each other and share the workload. Do not expect the clinical director to do all the co-ordination.
- Make contingency plans for supply chain issues.

Surgical patients

If appropriate, MDTs may consider non-surgical options, including prolongation of neoadjuvant treatment and non-surgical treatment if the outcomes are similar.

Categorisation of patients

- *Priority level 1a*
Emergency: operation needed within 24 hours to save life
- *Priority level 1b*
Urgent: operation needed with 72 hours

Based on: urgent/emergency surgery for life threatening conditions such as obstruction, bleeding and regional and/or localised infection permanent injury/clinical harm from progression of conditions such as spinal cord compression

- *Priority level 2*
Elective surgery with the expectation of cure, prioritised according to:

within 4 weeks to save life/progression of disease beyond operability based on:

- urgency of symptoms
- complications such as local compressive symptoms
- biological priority (expected growth rate) of individual cancers

Local complications may be temporarily controlled, for example with stents if surgery is deferred and /or interventional radiology.

- *Priority level 3*
Elective surgery can be delayed for 10-12 weeks with no predicted negative outcome.

General measures to consider

All complex cancer surgery will require level 1 support routinely. There is a small risk of postoperative complications requiring return / admission to ITU in (usually) the first week.

Separation of the location of emergency from elective operations within the same Board may allow elective work to continue at one site.

If appropriate, MDTs may consider non-surgical options, including prolongation of neoadjuvant treatment and non-surgical treatment if the outcomes are similar.

Systemic anti-cancer treatments

Treatment decisions will need to be made on a case-by-case basis with input from both patients and the MDT. The prioritisation details should be overseen by the nominated haemato-oncology leads.

General approach to prioritising patients on systemic anti-cancer therapy:

- Categorise patients by treatment intent and risk-benefit ratio associated with treatment.
- Consider alternative and less resource-intensive treatment regimes.
- Seek alternative methods to monitor and review patients receiving systemic therapies.

Clinicians will also need to consider the level of immunosuppression associated with an individual therapy and the condition itself, and patients' other risk factors.

Categorisation of patients

This will differ according to tumour type, but it is suggested that clinicians begin to categorise patients into priority groups 1-6. If services are disrupted, patients can be prioritised for treatment accordingly.

- *Priority level 1*
Curative therapy with a high (>50%) chance of success.
- *Priority level 2*
Curative therapy with an intermediate (15- 50%) chance of success.
- *Priority level 3*
Non-curative therapy with a high (>50%) chance of >1 year of life extension.
- *Priority level 4*
Curative therapy with a low (0-15%) chance of success.
Non-curative therapy with an intermediate (15-50%) chance of > 1 year life extension.
- *Priority level 5*
Non-curative therapy with a high (>50%) chance of palliation / temporary tumour control but < 1 year life extension.
- *Priority level 6*
Non-curative therapy with an intermediate (15-50%) chance of palliation.
Temporary tumour control and < 1 year life extension.

General measures to consider

Consider whether systemic therapies can be given in alternative regimens, different locations or via other modes of administration to minimise patient exposure and maximise resources. The impact on and resilience of the supply chain must be confirmed before implementing a change.

1. Changing intravenous treatments to subcutaneous or oral if there are alternatives.
2. Selecting regimens that are shorter in duration.
3. Consider using 4-weekly or 6-weekly immunotherapy regimens rather than 2-weekly and 3-weekly.
4. Consider alternative models for supply of oral systemic anticancer treatments to minimise hospital attendance.
5. Consider deferring supportive therapies such as denosumab and zoledronic acid treatments (except for hypercalcaemia).
6. Consider use of G-CSF in patient groups currently not receiving this routinely, where there is evidence of clinical benefit in order to protect patients and reduce admission rates. (Noting that G-CSF does not provide protection from viral infections including Covid-19.)
7. Considering treatment breaks for long-term treatments when risk of coronavirus is high.
8. Consider what supportive services are required to deliver regimens safely.

Seek alternative methods to educate, monitor and review patients on systemic therapies. Identify alternative arrangements to minimise patient exposure. This could involve patients having blood tests locally or telephone/virtual appointments.

Radiation therapy

Categorisation of patients

- *Priority level 1*

Patients with category 1 (rapidly proliferating) tumours currently being treated with radical (chemo)radiotherapy with curative intent where there is little or no scope for compensation of gaps.

Patients with category 1 tumours in whom combined External Beam Radiotherapy (EBRT) and subsequent brachytherapy is the management plan and the EBRT is already underway.

Patients with category 1 tumours who have not yet started and in whom clinical need determines that treatment should start in line with current cancer waiting times.

- *Priority level 2*

Urgent palliative radiotherapy in patients with malignant spinal cord compression who have useful salvageable neurological function.

- *Priority level 3*

Radical radiotherapy for Category 2 (less aggressive) tumours where radiotherapy is the first definitive treatment.

Post-operative radiotherapy where there is known residual disease following surgery in tumours with aggressive biology.

- *Priority level 4*

Palliative radiotherapy where alleviation of symptoms would reduce the burden on other healthcare services, such as haemoptysis.

- *Priority level 5*

Adjuvant radiotherapy where there has been complete resection of disease and there is a <20% risk of recurrence at 10 years, for example most ER positive breast cancer in patients receiving endocrine therapy.

Radical radiotherapy for prostate cancer in patients receiving neo-adjuvant hormone therapy.

General measures to consider

In all cases, the most clinically appropriate hypofractionated schedule should be used, for example single 8Gy fraction for metastatic squamous cell cancer (MSCC).

For adjuvant breast radiotherapy 26Gy in 5 fractions is isotoxic compared with 40.05Gy in 15 fractions and may mitigate a deferred start date in patients with node negative breast cancer.

Offer omission of adjuvant breast radiotherapy to those patients with low risk breast cancer who fulfil the [NICE Early Breast Cancer Guideline \(2018\)](#) criteria.

Anaesthetic availability may be the determining factor for capacity for some radiotherapy including gynae brachytherapy, TBI and paediatrics.

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General measures across all services to minimise risk and maximise workforce capacity

- Minimise face-to-face appointments – Offer consultations via telephone or video consultation wherever possible.
 - Cut non-essential follow-up visits.
 - Accelerate adoption of stratified follow-up models.
 - Home delivery of oral systemic agents where suitable/available.
- Reduce dwell time in services – for those who do still need to attend, particularly for treatment, schedule appointments to reduce waiting times.
- Encourage patients not to arrive early – consider measures such as texting them when ready to see them so they can wait in their car.

- Follow broader Board actions and protocols including testing and isolation of patients with coronavirus symptoms.
- If staff are required to self-isolate due to contact with a confirmed case of coronavirus, consider ways they can continue to provide care and/or support MDTs. For example:
 - virtual attendance at MDT meetings
 - telephone or video consultations, especially follow-ups
 - identifying vulnerable patients and making contact to discuss changes to care and treatment
 - identifying patients suitable for remote monitoring/follow-up
 - data entry (where remote access enabled).

Overall considerations

- We should avoid unproductive attendances at hospital.
- Senior decision-making at the first point of contact should reduce or even prevent the need for further attendances.
- A decrease in elective work will allow for a greater senior presence at the front door.
- Clinicians may need to work in unfamiliar environments or outside of their sub-specialist areas. They will need to be supported.
- No patient should be scheduled for surgery without discussion with a consultant.
- The longer hours will allow ED access and help reduce crowding in waiting rooms.
- The possibility of a seven-day service may need to be considered.
- Consider postponing long-term follow-up patients until the crisis has passed.
- Can a follow-up virtual clinic be developed with your facility?
- CT scanning may be limited as it is the investigation of choice for coronavirus pneumonitis.