Clinical Standard Operating Procedure (SOP)

CLINICAL PRIORITISATION OF CANCER TREATMENT DURING THE COVID-19 PANDEMIC

SETTING	South West Cancer Alliance
FOR STAFF	All clinical staff
FOR PATIENTS	Adult patients receiving non-surgical oncology and haematology treatment

Standard Operating Procedure

The scope of this SOP is to ensure consistent decision making in the clinical prioritisation of non-surgical oncology and haematology treatment for patients during the COVID-19 pandemic.

Background:

- To determine criteria for equitable access to non-surgical cancer treatments (defined as systemic anti-cancer treatment (SACT), radiotherapy and clinical trials) when capacity is limited due to service disruption during the COVID-19 pandemic

- Priority is determined by the predicted absolute benefit provided to the patient receiving the therapy and the capacity available at that time

- The Trust and service responsibility is to ensure that, where possible, essential cancer care continues. In response to pressures on the NHS, diversion of staff to other clinical areas, staff sickness and possible supply chain shortages, cancer services will be compromised. During disruption, cancer services will need to curtail some work and prioritise treatment based on this agreed local strategy, the best available evidence and national guidance [(1)]

- Patients with cancer are at additional risk of becoming seriously ill if they contract COVID-19 and, in addition to immunosuppression, other factors and co-morbidities will be linked to poorer prognosis.[(2)]

Systemic Anti-Cancer Treatment Prioritisation

General principles:

Consider whether patients requiring systemic therapies may be given an alternative regimen or schedule, may receive treatment in a different location or via other modes of administration, to minimise patient exposure and maximise resources, for example:

- Change intravenous treatments to subcutaneous or oral if there are alternatives
- Use regimens that are shorter in duration or have longer intervals between administrations
- Use 4-weekly or 6-weekly immunotherapy regimens rather than 2-weekly and 3-weekly
- Defer supportive therapies such as Densoumab and Zoledronic acid treatments (except for hypercalcaemia)
- Use lower than standard steroid doses, and avoid in haematology patients responding to treatment, both in frontline and relapse setting
- Consider G-CSF support to maintain a normal neutrophil count
- Allow prescribing of some treatment outside the usual blood test window if results previously stable.

Treatment of patients:

Patients not known to have COVID-19

- Ask patients to attend appointments without family members or carers, if they can, to reduce the risk of contracting or spreading the infection
- On arrival at the cancer unit, patients should be asked if they have any symptoms suggestive of COVID-19 and have their temperature checked.
- The nursing staff should escalate any concerns to the on call COVID-19 assessment unit registrar.

Patient with known or suspected COVID-19

- Patients should be advised not to attend for treatment if they have symptoms suggestive of or have been diagnosed with COVID-19
- If a patient or a member of their household becomes unwell with symptoms of COVID-19, systemic therapy will be deferred or cancelled based on the clinical situation, and the patient will be advised to self-isolate in accordance with current UK government guidance
- The patient's consultant team will be informed.

Categorisation of treatment priority:

- Categorisation of patients for treatment will follow NICE guidance in accordance with **Table 1 below**
- Tumour site specific teams will agree and prioritise individual cancer care plans so that as services become disrupted, treatment can be determined accordingly
- **With immediate effect**, an additional mandatory field will be added to the SACT pre-assessment form requesting categorisation of treatment intent as per **Table 1**.

Table 1

Priority Level	Prioritising patients for SACT
1	Curative therapy with a high (>50%) chance of success Adjuvant or neoadjuvant treatment which adds at least 50% chance of cure to surgery or radiotherapy alone or treatment given at relapse
2	Curative therapy with an intermediate (15-50%) chance of success Adjuvant or neoadjuvant treatment which adds 20% to 50% chance of cure to surgery or radiotherapy alone or treatment given at relapse
3	Curative therapy with a low (10% to 20%) chance of success Adjuvant or neoadjuvant treatment which adds 10% to 20% chance of cure to surgery or radiotherapy alone or treatment given at relapse Non-curative treatment with a high (more than 50%) chance of more than 1 year extension to life
4	Curative therapy with a very low (0% to 10%) chance of success Adjuvant or neoadjuvant treatment which adds less than 10% chance of cure to surgery or radiotherapy alone or treatment given at relapse Non-curative treatment with an intermediate (15% to 50%) chance of more than 1 year extension to life
5	Non-curative therapy with a high (>50%) chance of palliation / temporary tumour control but < 1 year expected life extension.
6	Non-curative therapy with an intermediate (15-50%) chance of palliation or temporary tumour control and < 1 year life extension

Oncology categorisation:

- **Table 2** outlines the categorisation of common oncology treatments. This table may not cover all tumour sites or treatment indications but should be used as a guide
- Categorisation will be used when delivery of SACT is compromised to determine treatment priority.

Table 2

Disease	Neo-adjuvant	Adjuvant	Locally advanced Chemo-RT	First line advanced	Second line advanced	Third and subsequent
Breast ER+/Her2+	3	2		3	3	6
Breast TNBC	3	3		3	4	6
Breast ER+ Her2-*		2		3	3	6
Lung NSCLC			2	Pembro: 3 Doublet: 4 Gem: 6	Anti-PD1: 4 Docetax: 6	6
Lung SCLC			3	3	5 / 6	6
GI – OG			2	FLOT 3 Other 3	6	6
GI Pancreatic		4		5	6	6
GI Biliary		3		4	6	6
GI HCC				4	6	6
GI NET				4	6	6
GI Colon		2		3	6	6
GI Rectum		2	2	4	6	6
GI Anus			1	4	6	6
Ovarian endometroid	3	3		4	5	6
Ovarian BRCAm+	1	2		3	3	P sensitive 4 P resistant 6
Ovarian HG serous	2	3		4	4	P sensitive 5 P resistant 6
Ovarian Clear cell	4	4		4	5	6
Uterine		4		6	6	6
Uterine Clear cell	4	4		4	6	6
Cervix		4	1	3	6	6
Kidney				4	6	6
Bladder	4		2	4	5	6
Ureter	4	2 (if indicated)		4	5	6
Prostate				4	5	6
Testis / NSCGT		1 (if indicated)		1	2	5
Testis / Seminoma		Omit		1	2	5
Penile				6	6	6
Head and Neck	1		4	6	6	6
Sarcoma STS	4			6	6	6
Sarcoma Bone + EFT	1	1		4	6	6
Sarcoma GIST	3	2		3	6	6
Melanoma	2			2	BRAF+ 2 BRAF -6	6
Non-melanoma skin				6	6	6
CNS		1		6	6	6

*Refers to chemotherapy not endocrine therapy

Haematology categorisation:

- **Table 3** outlines the categorisation of common haematology treatments. This table may not cover all tumour sites or treatment indications but should be used as a guide
- Categorisation will be used when delivery of SACT is compromised to determine treatment priority
- Treatments that have category 1 or 2 but are likely to require ITU admission will be determined according to ITU capacity and **are not** expected to proceed. Where possible alternative schedules should be considered.

Table 3

Disease	Neo-adjuvant	Adjuvant	Locally advanced Chemo-RT	First line advanced	Second line advanced	Third and subsequent
Lymphoma Hodgkin's				1	1	1
Lymphoma HG NHL				1	2	3
Lymphoma LG NHL				1	3	3
Haem – ALL, AML				1	2	4
Haem – CLL				3	3	3
Myeloma				1	3	3
MDS				3		
Allo BMT Acute leukaemia				1/2	2	
Allo BMT high risk MDS				1/2		
Allo BMT Lymphoma				N/A	2(1)	2(1)
Allo BMT Myelofibrosis				1/2		
Auto BMT Lymphoma				1/2	1/2	
Auto BMT Myeloma				Deferred	deferred	
CAR T cells Lymphoma				N/A	2	2
CAR T cells ALL				N/A	1	1

Additional information:

- Consider full antimicrobial and anti-viral prophylaxis. Prescribe standard 12 weeks of Levofloxacin for newly diagnosed myeloma patients as well as co-trimoxazole
- Consider increasing the interval/interrupting of systemic maintenance treatment but if at all possible, do not stop maintenance. Relapse of myeloma is a greater risk than Lenalidomide
- Delay frontline ASCT if possible especially in standard risk myeloma (EBMT guidelines) Principles of treatment of Acute Myeloid Leukaemia: NCRI document published 23rd March 2020 with detail on individual scenarios including use of reduced doses of Mylotarg and Cytarabine, use of Venetoclax as an alternative to intensive induction therapy and omission of final consolidation cycles where patients are MRD negative. www.cureleukaemia.co.uk/AML-Working-Party-COVID-19-Recommendations.

Radiotherapy and radio-isotopes

General Principles:

- Alternative dose fractionation schedules will be offered as a safe alternative and concurrent chemotherapy omitted in favour of a different dose fractionation schedule, based on available clinical data
- In all cases, the most clinically appropriate hypo-fractionated schedule should be used, for example single 8Gy fraction for metastatic spinal cord compression (MSCC)
- Anaesthetic availability will determine the capacity for some radiotherapy including gynaecological brachytherapy, Total Body Irradiation and paediatrics
- Radioactive Iodine treatment will cease.

Treatment prioritisation based on categorisation of patients:

This will differ according to tumour type, and will be based on priority levels outlined in **Table 4**

Table 4

Priority Level	Prioritising patients for Radiotherapy
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.
2	• Urgent palliative radiotherapy in patients with malignant spinal cord compression who have useful salvageable neurological function.
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.
4	• Palliative radiotherapy where alleviation of symptoms would reduce the burden on other healthcare services, such as haemoptysis.
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.

Treatment by site

Continuously updated guidance is available on the Royal College of Radiologists website: https://www.rcr.ac.uk/college/coronavirus-covid-19-what-rcr-doing/coronavirus-covid-19-resources/coronavirus-covid-19-1

REFERENCES	1. NHS Action Plan: Clinical Guide for the Management of Cancer Patients during the coronavirus pandemic 3rd March 2020 2. Estimating the Risks from COVID-19 Infection in Adult Chemotherapy Patients. M. Williams et al, Imperial College London https://doi.org/10.33697/ajur.2019.003.