Coronavirus and cancer services

Exploring the impact on cancer services of covid-19

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What will happen to cancer patients that still need managing?

NHS England has released guidance on managing cancer patients during the coronavirus pandemic.

Specialty guides: Clinical guide for the management of cancer patients during the coronavirus pandemic attempts to shape the primary priorities for cancer services amid the unprecedented crisis.

"Cancer services may not seem to be in the frontline with coronavirus but we do have a key role to play and this must be planned. In response to pressures on the NHS, the elective component of our work may be curtailed", the document says.

"However, cancer services will need to continue to deliver care. We should seek the best local solutions to continue the proper management of these cancer services while protecting resources for the response to coronavirus."

Cancer services have been asked to consider the following elements:

- **Leadership**
- **Surgical patients:** Continue to require admission and surgical management
- **Systemic anti-cancer treatments**
- **Radiation therapy**
- **Proton beam therapy**

For 'leadership', each cancer unit is to be headed by a 'lead consultant' to provide rapid decision-making and co-ordination, particularly with other departments.

How will cancer services prioritise cancer surgery patients?

In surgery, surgical patients have been divided into three categories of priority:

1A emergencies, where intervention must be made in order to save a life within the next **24 hours**,

1B within the next **72 hours**,

2 within the next **four weeks** in order to provide a meaningful curative element, and then

3 whose interventions can be delayed for **up to 12 weeks** without causing harm

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What are the new guidelines on chemotherapy and other drug treatment?

Under the category of SACT (systemic anti-cancer treatment) which includes drug and chemotherapy treatment, the document says treatment decisions will need to be made on a case-by-case basis with input from both patients and the multi-disciplinary teams (MDT).

Prioritisation will be overseen by the nominated trust haemato-oncology leads at provider level.

This will involve categorising patients by treatment intent and the risk-benefit ratio associated with treatment.

Clinicians have also been advised to consider alternative and less resource-intensive treatment regimes, and alternative methods to monitor and review patients receiving systemic therapies. This could involve remote blood testing or telephone and virtual appointments.

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

It is assumed that services will be disrupted and many patients will be not be able to undergo normal treatment. So a form of prioritisation for treatment will be introduced, based on a system going from 1 to 6 on how critical a treatment is and how effective it would be. This runs as follows:

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

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What other changes to drug treatment should be considered?

1. Change intravenous treatments to subcutaneous or oral if there are alternatives.
2. Select regimens that are shorter in duration.
3. Consider using 4-weekly or 6-weekly immunotherapy regimens rather than 2-weekly and 3-weekly.
4. Dispense longer periods of oral medications.
5. Consider deferring supportive therapies such as densoumab and zoledronic acid treatments (except for hypercalcaemia).
6. Consider home delivery of oral medication where possible (but need to confirm the resilience of home care providers).
7. Use of GCSF as primary prophylaxis to protect patients and reduce admission rates.
8. Consider treatment breaks for long-term treatments when risk of coronavirus is high.
9. Consider what supportive services are required to deliver regimens safely.

What's the outlook for cancer patients now?

The guidance is issued as clinicians are commenting in the media on the complexities of cancer care during the outbreak, and how for some patients, there are no easy solutions with care and treatment options.

Chemotherapy could make them more susceptible to coronavirus, and some surgery patients are now deemed not "time critical" enough to warrant their operations, according to consultant prostate surgeon Prasaana Sooriakumaran. Writing in the Guardian, she suggests that services will have to be reorganised nationwide over the next few months to manage the demand and place clinicians in the right locations.

"We should consider redistributing current resources to create hubs where oncologists and cancer surgeons could treat their urgent patients".

HSJ has reported that changes to cancer treatment are already coming through, with Barking, Havering and Redbridge Trust announcing it was cancelling chemotherapy and routine cancer operations for a fortnight due to coronavirus pressure.

Cancer waiting times guidance has been changed to provide for some urgent referrals for suspected cancer to be sent back to GPs without diagnosis.

Why are chemotherapy regimes being affected?

Oncologist Ranjana Srivastava considers both clinicians and patients to face some tough choices on chemo.

"Whether chemo should continue depends on the individual, the diagnosis, the type, duration and intent of treatment.

The usual high risks of chemotherapy are magnified during a pandemic. Immunosuppressed patients are more prone to infections and many chemotherapy agents cause mucositis, thus breaching a natural protective barrier.

In many patients, chemotherapy may be safely de-escalated, paused or even stopped without causing harm. Experts suggest a review of new and ongoing therapies to determine options including oral substitutes."

What about immunotherapy agents?

Immunotherapy agents have of late made headlines as a promising innovation, but come with their own disadvantages at this stage, distinct from chemo. They can cause a variety of immune-related complications such as pneumonitis. Normally this could be treated with steroids but this is more hazardous in a treatment context of covid-19, and could impede recovery from acute respiratory distress syndrome, associated with the coronavirus disease.

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