Guidance for the Management of Acute Oncology Patients During the Coronavirus Pandemic.

(Coronavirus may also be referred to as COVID-19 or SARS-CoV-2).

Acute Oncology Advisory Group

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Acute Oncology

Acute Oncology Services play a key role in the assessment and management of those cancer patients who have been identified as most vulnerable and are more at risk of becoming seriously ill if they contract the coronavirus (COVID-19) infection:

- People with cancer who are undergoing active chemotherapy or radiotherapy
- People with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
- People having immunotherapy or other continuing antibody treatments for cancer
- People having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
- People who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs
- People on non-steroid immunosuppression for immunotherapy related toxicity including mycophenolate mofitil (MMF) and tacrolimus

They also have a continuing responsibility for patients who are admitted with an acute complication of their cancer and those patients who have a new diagnosis of cancer made in the emergency setting.

Leadership: Key point of contact

Acute Oncology Service Lead Clinicians must engage with those planning the local response for the continuation of cancer services and ensure that acute oncology services are included in the response to this emergency.

The role of acute oncology services;

- Working with the 24-hour advice line triage service to support face to face assessment of patients away from ED where safe and appropriate
- Providing expert advice and guidance to urgent care and inpatient services that can support the patients early discharge and ambulatory management
- Providing expert advice, guidance and support to emergency and acute medical teams, to ensure that patients attending hospital are managed appropriately. This includes providing guidance on escalation of care in the deteriorating patient

AO Staffing:

Access to AO advice and support will play a significant role in prioritisation and safe cancer care and will support hospital capacity planning, admission avoidance, early discharge and patient safety netting. These benefits need to be balanced against the need to re deploy AO staff when absolutely necessary

Staff working:

AOS skills are well placed to deliver virtual working and coordination of care alongside expert advice –reduce face to face service unless absolutely necessary.

Consider how the AOS can provide the most responsive service

- professional advice without requiring multiple ward visits
- inpatient telephone consultations and support
- 7 day rotas
- Joint working with specialist palliative care

AOS PATIENTS

AOS can play an important role in reducing non- essential face to face outpatient appointments and can act as a bridging gap following hospital discharge

- Support honest conversations, before discharge, between specialist Oncology teams and patients/ general medical ward staff in relation to appropriate onward care and the need to reduce non-essential OPD Oncology clinic visits
- The ACP trainees committee have produced a useful video to help allay some of the concerns of cancer patients - https://youtu.be/ZqetOXCTPb4
- Ensure all patients are aware of the changing risk benefit of cancer treatment Ongoing treatment plans will need to be reviewed by the treating team to ensure their continued safety
- Raise awareness that subsequent appointments by oncology will increasingly be via telephone, at least initially.
- Work closely with site specific Clinical Nurse Specialists (CNS's) and Specialist Palliative Care Teams (SPCT) to streamline follow up and offer remote support to patients who may have limited access to community services
- **Advice for the management of COVID-19 (SARS-CoV-2) positive patients is changing rapidly, and some trusts are introducing pharmacological interventions such as antimicrobials and antivirals. This should be led locally and AOS teams should check the local guidance regularly**

Acute Oncology Subtypes (I-III)

Type I (emergency presentation of new cancer):

- Acute oncology teams have a role in the management of patients who receive a cancer diagnosis in an emergency setting –typically, Malignancy of Unknown Primary (MUO).
    - Pathways to support early discharge of patients with good performance status who are suitable for ambulatory symptom control and further investigation management should be developed.

    - Patients with poor performance status are unlikely to be candidates to receive palliative SACT. Both patients and clinicians will benefit from honest conversations and expert advice on the appropriate diagnostic pathway
    - Local SPCT services may be under considerable pressure and, AOS should support patients as much as possible within their own skill set. AOS teams should use local symptom control guidelines where possible and liaise closely with both hospital and community SPCT to optimise follow up and support.
- A significant number of patients with site specific cancers (in addition to MUO) may present as an emergency with resultant poor outcomes. AO expertise should also support site specific teams with difficult conversations at an earlier point in the diagnostic pathway for all poor performance status emergency presentation cases

Type II:

- Acute oncology teams will have a significant responsibility for the continued monitoring of patients both in the acute and ambulatory setting.
- They will have a significant role as patient navigators ensuring that SACT/Radiotherapy treating teams are aware of the patient's situation and that clinical review prior to next treatment and/or treatment delay is managed appropriately, minimising OPD attendances
- All patients undergoing SACT should continue to be routinely advised to monitor symptoms and temperature
- All patients should continue to contact the local Cancer Chemotherapy helpline according to local advice (not NHS 111) – all patients should have this already as part of national chemotherapy standards
- The AOS team should actively support good symptom control and psychological support using local guidelines, and in liaison with both community and hospital SPCT.

Suspected Neutropenic Sepsis

- Any patient deemed at risk of sepsis should continue to be advised to attend the nearest and most appropriate facility (day unit/hospital) to assess clinically and carry out an urgent blood count. Sepsis in cancer can be rapid and life threatening
- Where practical and safe, consideration should be given to allow suspected neutropenic sepsis patients to be reviewed in a separate assessment area, away from ED.
- Standard neutropenic sepsis management should remain the same i.e. immediate dose of intravenous antibiotics and reassess with blood results
- Access to Point of care testing (neutrophils) should be considered to speed up decision making
- A cohort of low risk febrile neutropenic patients can be discharged on oral antibiotics but require careful telephone follow up.

Patients with suspected COVID-19 (SARS-CoV-2)

- Patients with symptoms most suggestive of COVID-19 (respiratory symptoms and fever) should proceed through the standard hospital pathway and managed with acute oncology in reach
- Access to rapid COVID-19 testing of patients should be considered for atypical symptom presentation. COVID-19 testing at assessment would greatly inform next steps with future advice concerning self-isolation and treatment planning or subsequent treatment cycles
- Acute oncology teams should develop pathways to manage low risk NS COVID-19 positive patients in an ambulatory setting. This will require daily monitoring (14 days) and rapid access back into the acute setting if required
- If COVID-19 is later diagnosed in someone who is not isolated on admission or presentation, follow Public Health England initial investigation and management guidance - https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection

Immunotherapy Guidance

This is an evolving field and advice is likely to change. The main concern in this group is the concurrent use of steroids in patients with COVID-19 (SARS-CoV-2)

- All patients/clinicians should contact the usual cancer helpline for advice on locally existing Immunotherapy related pneumonitis management guidelines
- Toxicity management for all except pneumonitis remains the same and as per protocol management with the following additions

If patients are started on IV methylprednisolone, prednisolone ≥60mg OD and those who have been on >25mg prednisolone for >6 weeks (as per steroid tapering guideline) consider PCP prophylaxis with Co-trimoxazole (Septrin) 480mg (Mon/Wed/Fri) to prevent superadded infections.

It is reasonable to consider a high dose oral prednisolone as alternative to IV methylprednisolone in borderline cases. Where this is considered advice can be gained from the patients' consultant and the IO team.

For patients with suspected/confirmed IO induced pneumonitis

It can be difficult to differentiate between the IO induced pneumonitis and the ARDS picture seen with COVID -19 (SARS-CoV-2).

For those with a new presentation of pneumonitis requiring admission they should be managed as per protocol but swabbed for COVID-19 following discussion with infection control. Patients should remain in hospital if clinically indicated. There should be a remote monitoring procedure in place to ensure that patients who are discharged receive regular follow up and their swab results are reviewed.

If patients are presenting with any symptoms of pneumonitis and they meet the case definition of COVID-19 they should be admitted and swabbed for COVID-19.

- The local clinical team should assess the risk vs benefit of commencing steroid therapy prior to obtaining the swab test results
- In the majority of cases if Grade 2 then teams can consider waiting for the results of the swabs prior to starting steroids. If Grade 3/ 4 commencement of steroids could be considered but reviewed rapidly following COVID-19 test result

If patients are already on treatment for pneumonitis, but symptoms are worsening, consider urgent assessment in the acute setting and testing for COVID-19.

Type III:

AOS remain a critical link with site specialist teams and the general medical service:

- advanced communication skills supporting honest conversations
- Supporting and liaising with SPCT that may be under significant pressure

MSCC

Follow MSCC NICE guidance

AOS will play an increasingly important role in communicating and supporting decision making for appropriate treatment and/or transfer:

- Surgery for MSCC = priority level 1b
- Radiotherapy for MSCC = priority level 2 if useful salvageable neurological function.
- Radiotherapy for MSCC = priority level 4 if for alleviation of symptoms

In all cases, the most clinically appropriate hypofractionated schedule should be used, for example single fraction in the majority of cases.

The Role of 24-Hour Advice Line Services:

24 Hour Advice Line Services have a vital role in ensuring that patients have prompt access to specialist advice, triage and assessment. This should be the first point of contact for patients and is key in identifying patients who need further face to face assessment and those that can be managed remotely.

Action: This service should be prioritised and supported in order to reduce the risk of unnecessary attendance of immunocompromised patients and to ensure that unwell patients are directed safely to the appropriate point of care.

It should be noted that the 24-hour advice line services have always been in demand and well used by patients receiving systemic anti-cancer treatment

Helpful guidance for telephone and video consultations has been produced by primary care: Covid-19: a remote assessment in primary care.- https://www.bmj.com/content/368/bmj.m1182

Trusts should consider **setting up a COVID-19 general advice line, distinct from standard clinical hot line to reduce burden on clinical triage service**

In the current situation clinical triage services could be expanded and play a much larger role in the management of patients remotely.

The triage and telephone support /monitoring role may be suitable for staff who:

- Return from retirement or
- Lack the up to date clinical skills to work at the patient bed side or deliver systemic anti - cancer treatment.
- Are working remotely and are self-isolating

Cancer helpline staff should be supported by senior decision makers as appropriate to ensure a fully informed decision and appropriate signposting that minimises Hospital and ED referral.

UKONS triage Tool
(https://www.ukons.org/site/assets/files/1134/oncology_haematology_24_hour_triage.pdf)

UKONS triage tool can be used to risk assess and categorise patients using a cumulative RAG scoring system and a symptom check list.

Categories are:
Green – low risk
Amber – moderate risk. (2 or more ambers = red)
RED – high risk.

Interpretation and outcomes for the UKONS tool should be taken in the context of reducing face to face and ED presentation and with the support of senior decision makers.

Green – low risk - Patients in this group would be reassured and contact with 111 and/or A&E avoided.

Amber – moderate risk – commence active monitoring, remain at home and telephone assess the patient within 24 hours. Instruct the patient to call back if the problem worsens. In the current situation the period of monitoring would be increased supporting patients in their own homes. The service could also provide remote monitoring of patients on the low risk neutropenic sepsis pathway.

Community Patient management should be facilitated wherever possible via helpline Access to local GP and local pharmacy services for prescribing and delivery

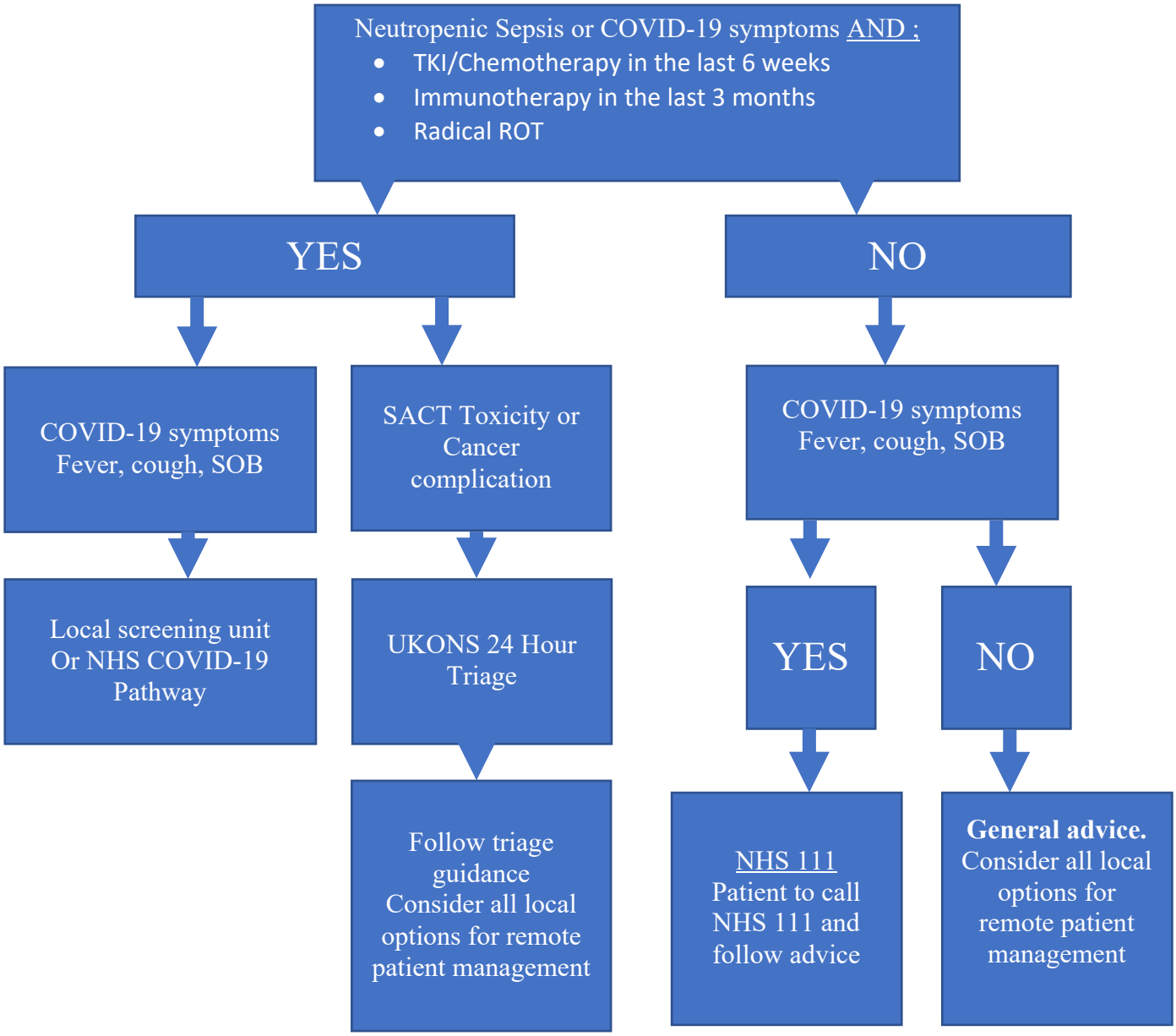
RED – high risk (2 or more ambers = red) - the triage service would identify high risk patients and either direct patients to urgent face to face assessment or facilitate

timely senior clinical review by telephone/video. It is vital that the pathway to assessment is agreed and easily accessed by triage teams.

Options might include:

- Direct to 999 and ED
- Suspected COVID-19 symptoms – standard pathway (recognising I-O and NS)
- Consider triage to safe and or suitable place away from ED
- Define cases for timely, escalation to senior decision makers by telephone/video

Appendix 1: Suggested COVID Triage



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