Risk Stratifying Adult Patients with Suspected or Diagnosed Cancer during the COVID-19 Pandemic (exc National Screening) for Chronic Myeloid Leukaemia (CML)

Purpose of this document:	To provide clear processes for all Provider Trusts to implement with regard to the clinical management of Adult Patients with suspected or diagnosed CML through the COVID-19 pandemic, in order that patients are treated consistently and equitably across the Region. Please refer to this document in conjunction with GM Cancer COVID-19 Cancer Management SOP V1 (for instruction on processes relating to management of patients in Somerset).
Exclusions:	This paper relates to Adult Patients only. Children, Teenage and Young Adult Cancers should be managed in accordance with normal protocol. Excludes National Screening Programme
Version Control:	
V DRAFT (07.04.20)	Authors: Eleni Tholouli (ET) with thanks to colleagues across GM for their contribution In line with national guidance issued 17.03.20, 19.03.20)

1. Introduction

This document sets out the process to be implemented in relation to the cessation and risk stratification of Adult Patients with suspected or diagnosed cancer in the event that diagnostic and treatment resources are limited as a result of the COVID-19 pandemic, or where clinical risk exceeds normal treatment or diagnostic pathways.

There is a limited (or no clear) evidence base for many of these recommendations which are practical and reflect expert consensus in this unprecedented time of crisis.

Given the rapid changes, this document is expected to be updated, in line with any changes to National Guidance.

2. Key Message

ANY PATIENTS WHO MAY REQUIRE CANCER DIAGNOSTICS, EVEN IF THIS IS POST PANDEMIC, **MUST** BE RETAINED BY THE TRUST **AND** REMAIN ON A PTL, **AND** ON A DEDICATED COVID WAITING LIST.

ONLY PATIENTS WHO DO NOT NEED ANY SECONDARY CARE APPOINTMENTS OR DIAGNOSTICS ON A SUSPECTED CANCER PATHWAY CAN BE DISCHARGED.

3. PTL Management

Clinical Leads should risk stratify PTLs in accordance with the following criteria and categorise into the appropriate group:

Action	**Criteria**
Step Down	As per normal PTL management on receipt of all necessary diagnostic results and a non-cancer decision. No change to current practice.
Safe Discharge	Following review and no suspicions of cancer/no further diagnostics required. Telephone Assessment Criteria: No specific guidance for suspected CML, assuming the diagnosis of cancer has been excluded. This diagnosis is

	unlikely if normal blood counts.
Suspend	All patients with suspected CML are considered a haematological emergency and must in all circumstances be seen by a haematologist as soon as practicable. Patients with symptoms consistent of leukostasis incl visual disturbances require immediate treatment. If one regional Trust lacks capacity, there is a duty on the haematologist to have that patient seen by a Greater Manchester colleague at an alternative Trust.
Active Management	i) Outpatients/diagnostics identified as appropriate ii) Manage according to current process with clear clinical engagement Diagnosis and indications for treatment to be made according to existing regional guidelines. All patients should be screened for COVID19 prior to commencement of intensive chemotherapy. Newly diagnosed patients with CML should be treated with Imatinib only and hydroxycarbamide reserved for those patients presenting with a very high WCC +/- leukostasis. See regional guidelines for management of chronic and accelerated phase / blast crisis. Treatment with TKIs should be continued for all patients throughout the COVID19 pandemic and not discontinued if they responded well. CML patients on treatment with a stable remission (CCR, MMR, CMR etc) can reasonably skip one three monthly appointment and molecular monitoring and have their medication sent out by post with the option of a telephone consultation. Recently diagnosed patients, those with unstable remission status, TKI side effects or emerging TKI resistance need to be considered on a case-by-case basis regarding their need for review in outpatients by the local consultant haematologist, weighing up the risk-to-benefit ratio. CML in blast crisis requires urgent intensive chemotherapy plus TKIs and this cam usually not be delayed.

4. Management of Long Term Follow Up/CNS lists/Recently treated patients (patients NOT on a live PTL)

Clinical Leads to review FU clinic waiting lists/recent treatment lists and categorise into groups to safely discharge/suspend with review date/actively manage.

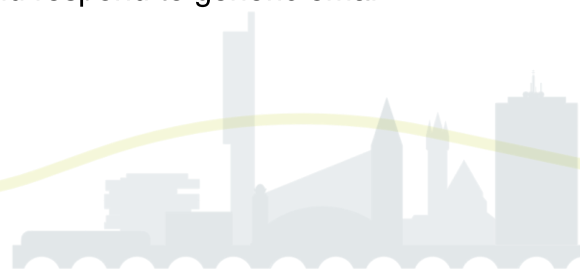
Action	Criteria
Safe Discharge	Following review and no further input from secondary care required. Not applicable for this group of patients
Suspend	Appointments can be deferred for patients in a stable remission (CCR, MMR, CMR etc) by 3 months requiring active follow up in secondary/tertiary care. Remote consultations (eg by telephone) should be offered to patients.
Active Management	Manage according to current process with clear clinical engagement Remote consultations (eg by telephone) should be offered to patients. Blood test monitoring may be required although the risk of attendance should be minimised where possible (eg symptomatic patients should not attend, appointments should be made to avoid congestion in waiting rooms, blood tests in GP surgeries or other less busy phlebotomy services at a different hospital). Arrangements for this will vary according to local policies.

5. Management of New GP/Dental Referrals (excludes National Screening Programmes)

Each tumour group should ensure processes are in place for the daily triage of referrals and follow the following tumour specific guidance:

PLEASE NOTE:
Referrals cannot be rejected without discussion with primary care. Patients may be discharged after telephone appointments **if cancer is no longer suspected and there is no longer need for any cancer diagnostics**. Telephone appointments can now be counted as 'first seen appointment' as per national guidance.

1. Cancer Services / Booking Centre: distribute referrals as per tumour group decision.
2. Cancer Services / Booking Centre: Register patients on PAS as per normal process
3. Clinical leads: review emails daily in accordance with criteria of safely discharge after review if cancer no longer suspected and no further cancer investigations needed/suspend with review date/actively manage and respond to generic email.



Action	Criteria
Safe Discharge (following review and no further input from secondary care required)	If blood tests do not confirm diagnosis of CLL or other haematological cancer and there are no other concerns (e.g. enlarged spleen or constitutional symptoms) then the patient can be discharged after telephone assessment
Suspend	As per PTL
Active Management	Manage according to current process with clear clinical engagement Recently diagnosed patients, those with unstable remission status, TKI side effects or emerging TKI resistance need to be considered on a case-by-case basis regarding their need for review in outpatients by the local consultant haematologist, weighing up the risk-to-benefit ratio. Suggested new patient reviews if otherwise well are 1 week after treatment initiation and thereafter bi-weekly for 1 month and then every 2 months. Patients in blast crisis require urgent intensive chemotherapy as per ALL or AML protocol. Consider starting TKIs and delaying intensive chemotherapy in COVID19 positive patients but in most cases treatment cannot be delayed.

MDT/sMDT Guidance:

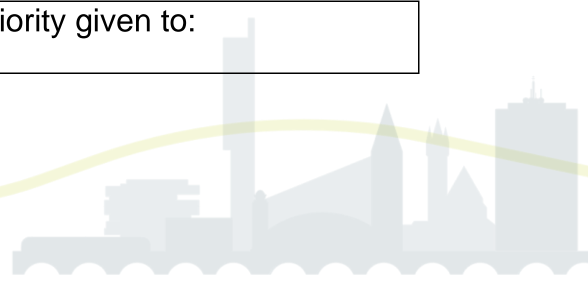
- Maintain weekly MDT: remotely if needed, virtual MDT sufficient
- Aim to minimise number of staff present at MDT e.g. 1 Haemato-oncologist, 1 Haemato-histopathologist and 1 CNS

6. Annotation - delays/treatment plan changes on Cancer Tracking system

If general delays (identified through referral management and tracking) are observed, the recording of formal clinical prioritisation (following PTL clinical review and prioritising), and the recording of treatment types offered that would not normally be considered outside of the COVID-19 pandemic (From MDT / treatment planning) must be formally documented for each patient (see SOP).

7. Clinical Prioritisation

Surgery	If theatre space is limited, surgical priority given to:



	Not applicable
Radiotherapy	Not applicable
SACT	TKIs are molecular targeted drugs offering patients good quality of life with mostly normal life expectancy

8. Alternative treatment given / recommended

Clinical Leads should use the following criteria when making decisions that result in changes to a patient's treatment from that which would have been offered prior to the COVID-19 pandemic.

Not applicable

9. Research