Risk Stratifying Adult Patients with Suspected or Diagnosed Cancer during the COVID-19 Pandemic (exc National Screening) for Myelodysplasia (MDS)

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 MDS 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 MDS and no further diagnostics required.

	<u>Telephone Assessment Criteria:</u> No specific guidance – patients require a bone marrow to exclude if bloods tests suggestive of MDS
Suspend	Patients require a bone marrow to exclude MDS if bloods tests show significant cytopenias. If FBC only shows mild/moderate cytopenias and changes have been stable consider monitoring until the COVID pandemic settles. MDS cases with significant cytopenias require supportive care but it is important to ensure there is no excess of blasts which would warrant treatment with intensive chemotherapy.
Active Management	i) Outpatients/diagnostics identified as appropriate ii) Manage according to current process with clear clinical engagement All patients should be screened for COVID19 prior to starting chemotherapy. Additional capacity constraints or infection considerations may require services to alter the way they provide support and/or treatment. This guidance is based on published advise from the UK MDS Forum and NCRI MDS subgroup. **Hypomethylating agents - azacitidine** New diagnoses of IPSS INT-2/High: Almost all patients will become neutropenic during the first 1-3 cycles of azacitidine • Consider delaying initiating azacitidine. Delay may be acceptable for the following groups but this is not an exhaustive list: - Patients with relatively well preserved blood counts (e.g. neutrophils >1) - Patients with stable blood counts for the preceding 3 months - Patients with lower bone marrow blast count (<10%) - Patients lacking good-risk 'AML' genetic characteristics • If azacitidine therapy is deemed immediately necessary - Consider using G-CSF and antibiotic prophylaxis - Subject to local guidelines for home administration of azacitidine, or consider alternative models of care to minimise hospital attendance for azacitidine injections - Blood count monitoring should not be reduced, but samples taken in the patient's home where possible and attendance to hospital reserved for blood/platelet transfusions • Patients already on azacitidine - Beyond cycle 3, if patients are deemed to be having clinical benefit, consider increasing interval between cycles to 6 weeks, or continuing 4-weekly but reduce to 5 days

	azacitidine per cycle **Lenalidomide** • For newly diagnosed patients with isolated del(5q) MDS who may be candidates, defer therapy and continue transfusional support • For responding patients established on lenalidomide, continue therapy **Intensive chemotherapy** Suggest an individual patient risk:benefit assessment for delaying intensive therapy or considering alternative lower intensity therapy **Allogeneic stem cell transplantation** Suggest an individual patient risk:benefit assessment for delaying **G-CSF** Patients with profound neutropenia and recurrent infection may temporarily be candidates for G-CSF **Transfusion** In an attempt to reduce hospital attendance all transfusion-dependent patients should be reviewed to assess if increased intervals between transfusions is possible

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 if the diagnosis is not confirmed and no further input from secondary care required.
Suspend	As per point 3.
Active Management	Manage according to current process with clear clinical engagement Remote consultations (e.g. 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)	Following telephone review and no suspicions of MDS and no further diagnostics required
Suspend	If cytopenias are only mild or moderate and the patient is well consider delaying review
Active Management	Manage according to current process with clear clinical engagement

MDT/sMDT Guidance:

- Maintain weekly MDT: remotely or virtual will suffice
- Aim to minimise number of staff present at MDT e.g. 2 Haemato-oncologists, 1 Haemato-histopathologist/morphologist 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	Rarely required
SACT	Chemotherapy with curative intent is important and falls within NICE guidance priority level 1-2, pending patient and disease characteristics. Efficacy of therapy is however reduced in patients older than 60 years and co-morbid patients who are not eligible for intensive therapy

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.

9. Research

10. References

1. UK MDS Forum guidance during COVID19 outbreak vs3

2. https://mdspatientsupport.org.uk/coronavirus-mds-blood-cancer-advice/

3. https://www.nice.org.uk/guidance/ng161

4. http://www.bsbmtct.org/wp-content/uploads/2020/03/BSBMTCT-recommendations-for-COVID-Adult-BMT-27th-March-2020.pdf

5. https://www.ebmt.org/ebmt/news/coronavirus-disease-covid-19-ebmt-recommendations-update-march-23-2020