Risk Stratifying Adult Patients with Suspected or Diagnosed Cancer during the COVID-19 Pandemic (exc National Screening) for Myeloproliferative Conditions (MPN) such as Essential Thrombocythaemia (ET), Polycythaemia Rubra Vera (PRV) and Myelofibrosis (MF)

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 MPN 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.

	<u>Telephone Assessment Criteria:</u> No specific guidance for suspected MPNs. Diagnosis can sometimes prove challenging.
Suspend	New patients with MPN (PV, ET, MF) and thrombosis or other life threatening complications can represent potential life-threatening haematological emergencies and must in all circumstances be seen by a haematologist as soon as practicable. 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 and patient pathways. All patients should be screened for COVID19 prior to commencement of intensive chemotherapy. New patients with MPN (PV, ET, MF) and thrombosis or other life threatening complications require urgent investigations and treatment cannot be delayed. See regional guidelines for management. Patients commenced on antiplatelet drugs do not require regular follow ups. Those commencing on JAK2 inhibitors will require regular blood tests during the initial weeks to assess for cytopenias and need of transfusions. Frequency of visits should be assessed on a case-by-case basis, weighing up risks and benefits. MPN patients who are stable on treatment with for example ruxolitinib, hydroxycarbamide, aspirin, venesection etc can reasonably skip an appointment and have medication sent out by post followed up by a telephone consultation. Where possible they should still have their regular full blood count either through their GP or at a drop in blood clinic at their local hospital. Recently diagnosed patients, those with unstable disease status, other intercurrent difficulties and those with transfusion needs should be considered on a case-by-case basis regarding their need for review in outpatients, weighing up the risk-to-benefit ratio.

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

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	MPN patients who are stable on treatment with for example ruxolitinib, hydroxycarbamide, aspirin, venesection etc can reasonably skip an appointment and have medication sent out by post followed up by a telephone consultation. Where possible they should still have their regular full blood count either through their GP or at a drop in blood clinic at their local hospital.
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)	Molecular test results may be delayed during the peak of the pandemic. Many other investigations excluding secondary causes of thrombocythaemia or polycythaemia may pose a risk to the patient due to frequent hospital visits and should be delayed if not absolutely necessary. Do not discharge until all diagnostic investigations are completed.
Suspend	As per PTL
Active Management	Manage according to current process with clear clinical engagement Patients starting antiplatelet drugs do not require regular follow ups. Those commencing on JAK2 inhibitors will require regular blood tests during the initial weeks to assess for cytopenias and need of transfusions. Frequency of visits should be assessed on a case-by-case basis, weighing up risks and benefits.

MDT/sMDT Guidance:

- Maintain weekly MDT: remotely if needed
- 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	Not applicable

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