Blood Cancer Management Guidance in Response to COVID-19

The following guidance has been produced by the COVID-19 South East Cancer Cell, 30th March 2020

1 Key Points

- For use to determine access to services when capacity is limited
- Higher priority chemotherapy will have protected access to available capacity
- Priority is determined by the absolute benefit a therapy provides to patients receiving that therapy

2 Purpose of document

The following is guidance for the provisioning of Blood cancer services during the period of the COVID-19 pandemic and its emergency management. It is intended to guide and support decisions made locally/regionally and should be used in conjunction with any guidance from expert bodies. These should not be viewed as being prescriptive, and cannot cover every possible scenario and therefore will require individual MDTs and clinicians to make decisions based upon their best clinical judgement.

3 GP referral to clinic

The emphasis is on the triage of the referral once received rather than putting off the referral. This is so that patients are logged in the system even if the decision is to defer treatment for now. Cancer cell are working on deferral codes and there will be central guidance on this to follow:
https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/cancer-alliance-information-on-managing-cancer-referrals-19-march-2020.pdf

4 Categorisation of Patients

Priority level 1

- Curative therapy with a high (>50%) chance of success
- Adjuvant (or neo) therapy which adds at least 50% chance of cure versus surgery or radiotherapy alone or treatment given at relapse

Priority level 2

- Curative therapy with an intermediate (20- 50%) chance of success
- Adjuvant (or neo) therapy which adds 20 – 50% chance of cure versus surgery or radiotherapy alone or treatment given at relapse

Priority level 3

- Curative therapy of a low chance (10 – 20%) of success
- Adjuvant (or neo) therapy which adds 10 – 20% chance of cure versus surgery or radiotherapy alone or treatment given at relapse
- Non-curative therapy with a high (>50%) chance of >1 year of life extension

Priority level 4

- Curative therapy with a very low (< 10%) chance of success
- Adjuvant (or neo) therapy which adds less than 10% chance of cure versus surgery or radiotherapy alone or treatment given at relapse
- Non-curative therapy with an intermediate (15-50%) chance of > 1 year life extension

Priority level 5

- Non-curative therapy with a high (>50%) chance of palliation / temporary tumour control but < 1 yr life extension

Priority level 6

- Non-curative therapy with an intermediate (15-50%) chance of palliation / temporary tumour control and < 1 yr life extension

Tumour Groups and Chemotherapy Regimen Priorities

Where chemotherapy is given as part of multi-modal therapy the score below reflects the contribution of chemotherapy to the whole treatment

Disease	Neo-adjuvant	Adjuvant	Locally advanced Chemo-RT	First line advanced	Second line advanced	Third and subsequent
Breast Her2+ / TNBC	2	2		3	3	6
Breast ER+ Her2-	3	3		3	4	6
Lung NS CLC	4	4	2	Pembro: 3 Doublet: 4 IO + chemo: ?3 Vinorelbine: 6	Anti-PD1: 4 Docetax: 6	6
Lung SCLC			2	3	5 / 6	6
GI – Oesophagus & Gastric			2	FLOT: 1 Other: 3	6	6
GI Pancreatic	4	3		4	6	6
GI Biliary		3		4	6	6
GI HCC				4	6	6
GI NET				4	6	6

GI Colon / Rectum	2	3	Need to score	4	6	6
GI Anus			1	4	6	6
Ovarian	4	4		4	6	6
Ovarian BRCA m	3	2		3	4	P sensitive 4 P reseistant 6
Ovarian HG serous / endometrioid	3	4		4	5	P sensitive 5 P resistant 6
Ovarian other	4	4		4	5	6
Uterine		4	Need to score	6	6	6
Uterine	4	4		4	6	6
Cervix		4	1	3	6	6
Kidney				6	6	6
Bladder / Ureter	4	4	Need to score	4	5	6
Prostate				4	6	6
Testis	2	2		1	4	6
Penile				6	6	6
Head and Neck	4		4	6	6	6
cSCC				5	6	6
Sarcoma GIST	3	3		3	6	6
Melanoma	2	Individualised scoring according to exact stage		2	BRAF+ 2 BRAF- 6	6
Non-melanoma skin				6	6	6
CNS				6	6	6
Lymphoma Hodgkin's				1	1	1
Lymphoma HG NHL				1	2	3
Lymphoma LG NHL				1	3	3
Haem – ALL				1	4	5
Haem – AML				1	3	4
Haem – CLL				3	3	3
Myeloma				3	3	4
CUP / MUO				6	6	6

5 Appendix - Haematology

5.1 Lymphoma / CLL protocols

Prioritisation of treatment (non-oral regimens)

The following are considered high priority for delivery of chemotherapy:

1st line Chemo for high grade B-cell and T-cell non-Hodgkin lymphoma, as well as 1st line salvage lymphoma (NHL and HL) and subsequent salvage (HL) given with curative intent

- CHOP +/- rituximab
- MATRix (in patient) for CNS lymphoma
- ESHAP +/- rituximab

- GDP +/- rituximab – PREFERRED SALVAGE REGIMEN AS OP treatment
- GEM-P - PREFERRED SALVAGE REGIMEN AS OP treatment
- NORDIC regimen for MCL
- IVE/ICE +/- rituximab
- miniBEAM

Chemo for Hodgkin lymphoma given with curative intent (or as a bridge to curative treatment)

- ABVD / AVD
- Escalated BEACOPP
- Brentuximab vedotin
- Nivolumab or pembrolizumab

Chemotherapy for low grade lymphoma / CLL (frontline or relapse) given for highly symptomatic patients or patients with impending organ dysfunction due to lymphoma (NB this is NOT regarded as palliative treatment as although not considered curative, responses are often excellent and highly durable, prolonging duration and quality of life by many years)

1st 3 cycles of:
- Bendamustine +/- rituximab
- CVP +/- rituximab
- CHOP +/- rituximab
- Chlorambucil +/- rituximab
- FCR
- Venetoclax +/- rituximab

Modification of protocols considerations

1. Reduction in number of cycles
2. Defer treatment of LG NHL and CLL patient if clinically possible
3. CANCEL/DEFER maintenance Rituximab
4. Use of Rituximab instead of Obinotuzumab due to reduction in Day unit time and aseptics time.
5. Curative treatments will be prioritised over palliative/disease control treatments.
6. For regimens given with a non-curative intent, cycle length could be prolonged by a week: Low grade NHL / CLL regimens (R-CVP, R-bendamustine, R-FC)
7. Using subcutaneous rituximab with chemotherapy in all settings/combinations (after cycle 1 which always has to be IV) would reduce day unit time and avoids the need for aseptic input considerably. This requires approval by NHSE for use during the COVID19 epidemic.
8. The list above needs be used case by case. There will be exceptions.

5.2 Myeloma protocols

Specification of categorisation for non-oral regimens.

	1st line	2nd line	3rd line
CVD	3	3	4
VTD	3	3	4
DVD	3	3	4
DD	3	3	4

5.3 AML protocols

Guidance from the AML Working party to be adopted where possible.

www.cureleukaemia.co.uk/AML-Working-Party-COVID-19-Recommendations

5.4 Radiotherapy Recommendations

Early stage HL and DLBCL receiving CMT:

No delay in treatment; usual dose and fractionation

Consider hypo-fractionated regime for those at risk, especially > 60

Consider 28Gy/10, rather 30Gy/15 as close radiobiological equivalence for tumour and normal tissues dose.

Advanced stage – as consolidation in those achieving CMR or those with residual disease:

Consider a delay of consolidation RT for patients achieving a complete metabolic response at the end of chemotherapy

Low grade lymphomas:

Aim to delay RT if possible as indolent disease.

If symptomatic/organ compromise then would consider 4Gy/2# or even 4Gy/1# and think about definitive treatment at later date if still appropriate

Myeloma:

Optimise analgesia as much as possible

Otherwise 8Gy/1 for most patients, including cord compromise.

Solitary plasmacytoma:

Consider hypofractionated regime. ?40Gy/15, 43Gy/15, 39Gy/13, but need to watch cord dose.

COVID-19 + patients before treatment:

Don't start RT. Re-consider once recovered, depending on situation.

COVID-19 + patients during treatment:

If symptomatic – consider stop treatment.

If asymptomatic – continue RT as long as COVID pathways in place: treating all COVID positive patients on one linac, as well as sterilization of equipment and use of PPE as per department protocol.