Breast 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 Breast 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 within Breast MDTs. These should not be viewed as being prescriptive, rather as a support for local decision making and should be used alongside Department of Health guidance.

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

Letter to go out with breast clinic appointment stating new model of appointment and guidance regarding actions should they have symptoms of COVID-19 or live with someone who is self-isolating.

3.1 Triage of Referrals

- See only referrals where there is a higher index of suspicion of cancer, providing that there are staff to run clinics.
- Write to or phone referrals with a lower index of suspicion of cancer e.g. breast pain
- Very frail elderly patients, especially if in nursing homes, referred with suspicious lumps should not be seen in clinic until the situation has changed. If the Government introduces self-isolation for people 70 and over then consideration should be given as to whether these patients should be seen in the clinic. Older patients especially with co-morbidities are at highest risk of

death from coronavirus and they should be seen once the pandemic is over. Start on endocrine therapy empirically.

Note: potential to roll out 'Nottingham model' for breast demand management. This is currently being rolled out in Brighton University Hospital. Contact the relevant Cancer Alliance for more details.

4 New Cancer Patients

4.1 Surgical

4.1.1 Categorisation of Patients

Priority level 1a

- Emergency: operation needed within 24 hours to save life

Priority level 1b

- Urgent: operation needed with 72 hours

Based on: urgent/emergency surgery for life threatening conditions such as obstruction, bleeding and regional and/or localised infection permanent injury/clinical harm from progression of conditions such as spinal cord compression

Priority level 2

Elective surgery with the expectation of cure, prioritised according to:

- within 4 weeks to save life/progression of disease beyond operability based on:
  – urgency of symptoms
  – complications such as local compressive symptoms
  – biological priority (expected growth rate) of individual cancers

Local complications may be temporarily controlled, for example with stents if surgery is deferred and /or interventional radiology.

Priority level 3

Elective surgery can be delayed for 10 -12weeks if they have no negative predicted outcome.

Availability of anaesthetists and theatre staff must be considered.

4.1.2 Surgical Recommendations

- Clip put in all cancers when biopsy performed
- Aim for day case surgery in majority of patients
- If theatre space is limited, surgical priority given to ER negative patients first.
- No immediate breast reconstruction. Mastectomy and delayed reconstruction being offered at a later date

- If insufficient theatre capacity, post-menopausal ER+ patients to be commenced on primary endocrine. If not enough theatre capacity pre-menopausal ER+ patients may also have to be commenced on primary endocrine therapy
- Discuss with oncology whether all grade 3 or node positive ER+ positive patients should have genomic testing performed on the core bopsy. If a high score to have surgery as would normally need adjuvant chemotherapy.

Currently genomic testing is not reimbursed in this situation, but this will need to be re-considered.

All decisions should be clearly documented.

4.1.3 Benign Disease

- No surgery for benign disease or risk -reduction to be performed

4.2 Systemic Anti-Cancer Treatments

Treatment decisions will need to be made on a case-by-case basis with input from both patients and the MDT. The prioritisation details should be overseen by the nominated trust haemato-oncology leads at provider level.

General approach to prioritising patients on systemic anti-cancer therapy:

- Categorise patients by treatment intent and risk-benefit ratio associated with treatment.
- Consider alternative and less resource-intensive treatment regimes.
- Seek alternative methods to monitor and review patients receiving systemic therapies.

Clinicians will also need to consider the level of immunosuppression associated with an individual therapy and the condition itself, and patients' other risk factors.

4.2.1 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 to 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 to 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 to 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 to 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

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

4.2.2 Non chemotherapy SACT

- Consider risk of immune compromise vs extended duration anti-hormone response in metastatic patients on CD4/6 inhibitors
- Consider 6 months trastuzumab rather than 12 months (persephone trial)
- No good data to show longer course better than shorter course adjuvant chemotherapy. Consider 4 courses adjuvant chemo rather than 6 to reduce time spent in immune-compromise .

4.2.3 Patient management

- Patients to have blood tests locally or via district nurse
- Use of telephone/virtual clinics
- Ensure patients have information leaflets/hotline numbers

4.3 Radiotherapy

For adjuvant breast radiotherapy 26Gy in 5 fractions is isotoxic compared with 40.05Gy in 15 fractions and may mitigate a deferred start date in patients with node negative breast cancer.
Offer omission of adjuvant breast radiotherapy to those patients with low risk breast cancer who fulfil the NICE Early Breast Cancer Guideline (2018) criteria.

4.3.1 Patient management

- Telephone clinics for new patient interviews (Planning and Pre-Treatment)
- Skin assessments conducted whilst patient attending for treatment and managed according to local protocol. All other reviews should be managed via telephone clinic.
- Patients should be provided with agreed emollient prior to treatment commencing with clear instructions for use.

5 Follow-Up of Cancer Patients

- Try to minimise the number of patients attending breast clinics for routine review. Postpone appointments where appropriate and consider introducing telephone reviews for those where review is required
- This is especially important for frail elderly patients on primary endocrine treatment.
- Consider roll out of Personalised Stratified Follow-up pathways for early stage or low risk patients. Alliance to support rapid, clinically safe roll out.

6 MDT Meetings

- Maintain weekly MDT; can be done remotely if needed. Aim to minimise the number of staff present at the MDT e.g. 1 surgeon, 1 oncologist, 1 pathologist, 1 radiologist and one breast care nurse.
- Maintain a list of patients with surgical delay on primary endocrine therapy.

7 Research Activity

It is recommended that all recruitment and screening to all clinical trials be suspended with immediate effect. No new trials should be opened.
The exceptions to this are:

- Research into COVID-19, or
- 'The experimental treatment is essential for serious, or life-threatening conditions, and in the opinion of the treating clinician, receiving treatment in the context of the clinical trial may be very significantly advantageous to the patient concerned compared with receiving standard of care treatment. These individual cases need to be discussed with and approved by the divisional research lead'.

8 Workforce reduction plan

Now and assuming up to - 25% Staffing loss	A - 50% Staffing loss	B - 75% Staffing loss

Weekly Covid-19 Status Meeting <Insert date/time> Team leaders Update Huddles for all staff <Insert date/time> **Daily** Clinic HCA to ring imaging (Ext) to ascertain cancelled imaging slots available today. These slots will be utilised for 2WW new pts with high Covid-19 risk due to age, pregnancy, co-morbidity to avoid second visit for imaging where possible. **To Increase 2WW urgent capacity:** •Cancel all Family History tele-clinics. •Keep clear records of all cancelled pts •Postpone all 6 & 12 month F/U **To increase surgical cover:** •Cancel and defer routine endocrine clinic patients. •Cancel and defer all routine plastic clinic patients. All pts to be contacted by Admin team •Cancel and defer routine endocrine clinic patients. •Cancel and defer all routine plastic clinic patients. All pts to be contacted by A&C team **Triage referrals:** Pts to be seen in clinic: Discrete lump or asymmetrical thickening Pts to be offered Tele consultation in first instance: Under 25, pain, no lump, nipple discharge, nipple eczema, gynaecomastia Admin staff to book all pts in clinic with appropriate letter sent – outcomes to be recorded as face to face or Tele consultation on local systems.	**As per 'Now' and to also to include:** Review, reflect and amend as indicated **Surgery** Cancel all benign and plastic surgery. **To increase surgeon capacity**: Post-op clinics to be covered by CNS/ANP **To increase clinic capacity:** Tele clinics for all follow up where patient is not on a current cancer treatment pathway.	**As per 'Now'and 'A' and to also to include:** Review, reflect and amend as indicated To implement latest Association of Breast Surgery Guidelines for Covid-19 as detailed in this document.

9 Other considerations

To request the national team to suspend Breast screening which could divert radiologists and radiographer