Colorectal 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

- This guidance has been drawn up incorporating guidance from the Association of Surgeons, RCR, BSG, the SSCA Colorectal clinical leads and with regional colorectal cancer leads.
- 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

To provide guidance for the investigation and management of patients with suspected and confirmed colorectal cancer during the COVID-19 outbreak, where the capacity is already restricted to 25% of normal capacity. This is not designed to replace the normal pathway where capacity is available, or where there is an opportunity to use an alternative (eg Independent sector) operational site. It is recognised that in this period there will be extreme pressure on provider trusts and that normal standards of care will not be possible. It is likely that as the numbers of COVID-19 patients requiring ventilator support increases then only patients who are at immediate risk of death related to their cancer will be offered surgery. The current Government strategy is to tighten and relax the lockdown to protect the NHS and prevent complete collapse. This is an inexact science. It is possible that in the periods of lockdown as COVID-19 cases fall there will be opportunity to operate on patients who will be disadvantaged by further delay to treatment. This document is intended to limit the numbers of patients at very low and low risk from entering the system but allow them to be tracked. Moderate and high risk patients will be investigated as resources allow. Emergency patients will be treated to save life and preserve function.

Advice and guidance has been developed to address the following:

- Minimise risk to other patients and staff. It is essential to reduce the sickness absence rate and the need for staff to adopt forced self-isolation
- Staff availability will decline as infection, self-isolating, childcare and redeployment are enforced.
- The risk of faecal transmission is not clear at present but it is plausible and possible.

- Asymptomatic COVID-19 infected patients are a known source of infection.
- Stocks of standard and enhanced Personal Protection Equipment need to be prioritised, both for our own patients and for other areas of the hospitals.
- Endoscopy is severely restricted in some organisations already to emergencies only. Even patients, who have completed their staging, may be unable to be listed for major surgery in the foreseeable future, because of the pressure on ICU and HDU beds for post-operative care. There is also likely to be a shortage of theatre staff. For this reason, we suggest that where the routine diagnostic pathways are not available due to COVID, that this guidance offers support for investigation to radiology only and stratify patients with an obvious cancer for consideration of need for urgent surgery

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 Colorectal 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 TWR Referrals

With the current Covid-19 health risk to certain patient groups, as well as the pressure on hospital services the following should be taken in to account when referrals are made especially via the TWR pathway, with reference to BSG guidance:

- **We recommend that 2WW referrals be vetted on a case by case basis before tests such a CT are organised, to prioritise those felt clinically to be at greatest need and to account for limited availability of facilities, staff and appropriate PPE.**
- We recommend that only those with a significant risk of delay to treatment are investigated as urgent e.g. those with symptoms of obstruction. All others should be paused until we can safely investigate and treat where required. (see below)
- **2 Week Wait cancer referrals –to be assessed on an individual basis**. We recommend a group of consultant's and appropriate staffs review and triage these referrals, reserving investigations for those judged to be highest priority.
- We recommend all referrals suitable for investigation have a FIT test (see thresholds for action below) to help stratify risk of significant cancer, unless overt rectal bleeding. Ideally this test should be done in primary care prior to

referral to avoid unnecessary travel to hospital for all patients. However, providers may take the view that symptomatic assessment is more useful in determining further investigation, and we cannot mandate FIT testing.

- Where FIT testing identifies a level of < 120 micrograms, we recommend the patient is referred to be held on a safety net in secondary care for contact when business as usual returns, but they will not be investigated immediately.
- In the case of patients >70 years or <70 years with comorbidity (any heart or lung disease/ diabetes/ immunosuppressed) significant to preclude active treatment, the primary care clinician should ensure that the patient is aware that active investigation or treatment may not be possible or appropriate with the current risk of Covid-19 before referral

- TWR pathway patients fitting the above criteria should be telephone triaged by an experienced clinician (medical or nurse) to stratify immediate risk and significant symptoms, to avoid any inappropriate diagnostic tests. See Appendix 1 high risk clinical symptoms to use.
- FIT test: levels between **10 and 120** micrograms **will be considered low risk** (unless they have symptoms of suggestive of obstruction). These patients will be recorded on CWT system (Somerset or Infoflex) and recorded as agreed See Appendix 2 for Codes. Free text - currently low priority for investigation.
- Those with a FIT of >120 micrograms will be triaged by consultants as to best next test, but we recommend a CT in the first instance +/- MRI if significant rectal symptoms. Clinicians may still consider pausing pathway if symptoms not of immediate concern, but these must be recorded on Somerset or Infoflex and recommend they are highlighted for investigation in the future when normal service is planned to resume. CNS contact key for this group, to report any change in symptoms.
- Only patients with proven Iron deficiency anaemia (ferritin <20ng/dl and HB less than 10) and no other obvious cause of blood loss should be accepted on the colorectal pathway. (FIT testing is not appropriate for patients with established iron deficiency anaemia). Where iron deficiency anaemia is the only symptom, then iron replacement treatment and a CT from secondary care can be requested.
- An MDT discussion on a case by case basis will be made on either confirmed or suspected CRC to either delay further investigation or consider whether urgent surgery is required.
- Standard recommendation and adjusted recommendation due to COVID -19 documented

If Primary Care colleagues identify a patient not covered by the above criteria, advice and guidance calls can be requested.

4 Diagnostics

We would advise the following action in view of COVID-19 that patients, who would in normal times be listed for endoscopy, should be investigated using CT Chest abdomen and pelvis. If the CT is inconclusive or if the patient has rectal bleeding, a PR should be considered. Limit PR examination however those who require, clinician should use PPE. Avoid Rigid Sigmoidoscopy or Proctoscopy.

"STANDARD LETTER

Public Health England (PHE), which has a responsibility in England for safeguarding public health, have advised that, based on the available evidence, the current COVID 19 risk to the UK is 'high'. In view of this, we have a responsibility to safeguard patients and health care staff from the COVID 19 virus.

You have been referred and would under routine service have had an endoscopic procedure next. We have to vary our practice in these difficult circumstances. We will be using our professional judgement to assess the risk and make sure you receive safe care. On this basis we will be working with you to decide which procedures must go ahead and which procedures can be cancelled or deferred. As you will not be examined, part of our assessment will be limited; this is due to exceptional circumstances related to COVID 19.

We have reviewed your symptoms and the indication for the endoscopy procedure (by reviewing the referral form/Telephone consultation), and we feel that your procedure can be cancelled/cancelled but we advise you to contact GP if symptomatic in 6 weeks or more/procedure deferred by 6 weeks or more."

4.1 Diagnostic Biopsies and Histology:

Routine biopsy may not be possible, and subject to local availability and capacity.

If urgent for obstruction, then preoperative biopsies and completion colonoscopy is not likely to be possible, and the individual MDT and surgical team would agree straight to surgery if appropriate.

For significant cancers seen on imaging that may require chemotherapy or radiotherapy, particularly if mestastic or inoperable then risk/ benefit of biopsy needs individual case discussion.

5 New Cancer Patients

5.1 Surgical

5.1.1 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.

Ideally, surgery will be potentially curative, and have low complication rate with as short a length of stay as possible**. In deciding the procedure and technique, surgeons should be aware of the potential risk of viral spread with laparoscopic surgery and that the more complicated the surgery, the greater the risk of complications.**

Please refer to ASGBI guidance (26/3/20)

Please refer to Updated Intercollegiate General Surgery Guidance on COVID-19 25th March 2020 (attached)

Priority level 3

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

Availability of anaesthetists and theatre staff must be considered.

5.1.2 Surgical Recommendations: Colon cancer

In the context of COVID-19, clinicians and patients will have to balance the risk of COVID-19 infection post operatively with the consequences of delays to surgery on a case by case basis.

- Moratorium on surgery for most cancers with regular telephone follow up to prevent emergency presentation and to provide reassurance and support. Colon cancer without evidence of obstruction is considered priority level 3.

All decisions should be clearly documented.

5.1.3 Surgical Recommendations: Rectal cancer

Clinicians and patients will have to balance the risk of COVID-19 infection post operatively with the consequences of delays to surgery for rectal cancer on a case by case basis.

- Moratorium on surgery for early rectal cancer, again with regular telephone follow up to prevent emergency presentation and to provide reassurance and

support. The same considerations need to be taken when considering neoadjuvant chemotherapy or radiotherapy (see section on oncology).

- For more advanced cancers who might require down-staging, then de-functioning may be an appropriate first treatment to control symptoms. Again patients will need careful individualised treatment and risk benefits explained.

All decisions should be clearly documented.

5.1.4 Surgical Recommendations: Resection of Liver Metastases from Colorectal Cancer

- Clinicians and patients will have to balance the risk of COVID-19 infection post operatively with the consequences of delays to surgery for liver secondaries on a case by case basis. Similarly so, for neoadjuvant chemotherapy. The risk of progression without surgery or chemotherapy sufficient to upstage the disease must be balanced against the increased risk of COVID-19 infection.

All decisions should be clearly documented.

5.1.5 Surgical Recommendations: Anal cancer

- For patients with anal cancer, clinicians will have to liaise with clinical oncology colleagues regarding availability of chemo-radiotherapy or radiotherapy alone (see oncology section 4.3.3) as for most patients this is the first definitive treatment. In patients where this may not be possible immediately or palliation of symptoms is considered urgent, discuss option of palliative de-functioning stoma.

All decisions should be clearly documented.

5.1.6 Benign Disease

- No surgery for benign disease or risk -reduction to be performed
- Polyp surveillance should be suspended.

5.1.7 Decision making

All decisions regarding patient care must be recorded in the patient notes and in the cancer tracking system in the normal way. Clinicians must record the discussion with the patient and also the clinical colleague who has been involved. Decisions, especially those which would not be considered part of the normal pathway were it not for COVID-19, must not be taken by a single clinician but must be discussed with a colleague and this discussion recorded. All cases should be discussed at CR MDM as usual.

5.2 Chemotherapy

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 for Chemotherapy:

- 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.

5.2.1 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

5.2.2 Adjuvant Chemotherapy

- Stratify patients according to age and risk benefit of chemotherapy
- If benefit of chemo is less than 5% absolute improvement in survival then do not treat
- If the benefit is between 5 to 10 % consider but ensure patient is aware of risks and the need for social isolation etc. (likely recommend not treating
- If the benefit is greater than 10% consider treating ensure patient is aware of risks and the need for social isolation etc.
- Do not treat any one over the age of 70 with adjuvant therapy
- Consider anyone over 60 as high risk
- For T4 N0 <70y consider Capecitabine only for 6 months
- For Node +ve < 70y consider 3 months CapeOX
- No "adjuvant " chemo post metastectomy
- No adjuvant chemo in rectal cancer patients.

5.2.3 Neo-adjuvant colon cancer:

- No FOXTROT style therapy
- Consider neo-adjuvant chemo in fit patients if cancer un-resectable

5.2.4 Metastatic Patients:

- Consider delaying start if low burden or slow growing disease.
- Consider treatment breaks after 3 months of treatment.

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
GI Colon / Rectum	2	3		4	6	6
GI Anus			1	4	6	6

5.2.5 Patient Management:

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

- Ensure management is communicated to Primary care

5.3 Chemo-Radiation

5.3.1 Categorisation of patients

Radiation therapy

Priority level 1

- Patients with category 1 (rapidly proliferating) tumours currently being treated with radical (chemo) radiotherapy with curative intent where there is little or no scope for compensation of gaps.
- Patients with category 1 tumours in whom combined External Beam Radiotherapy (EBRT) and subsequent brachytherapy is the management plan and the EBRT is already underway.
- Patients with category 1 tumours who have not yet started and in whom clinical need determines that treatment should start in line with current cancer waiting times.

Priority level 2

- Urgent palliative radiotherapy in patients with malignant spinal cord compression who have useful salvageable neurological function.

Priority level 3

- Radical radiotherapy for Category 2 (less aggressive) tumours where radiotherapy is the first definitive treatment.
- Post-operative radiotherapy where there is known residual disease following surgery in tumours with aggressive biology.

Priority level 4

- Palliative radiotherapy where alleviation of symptoms would reduce the burden on other healthcare services, such as haemoptysis.

Priority level 5

- Adjuvant radiotherapy where there has been compete resection of disease and there is a <20% risk of recurrence at 10 years, for example most ER positive breast cancer in patients receiving endocrine therapy.
- Radical radiotherapy for prostate cancer in patients receiving neo-adjuvant hormone therapy.

5.3.2 Neo-adjuvant Rectal cancer treatment

- Use short course Radiotherapy and delay rather than the usual long course Chemo-Radiotherapy unless young fit, pelvic side wall disease and aware of the risks
- No neo-adjuvant chemotherapy prior to Radiotherapy

- All post Chemo-Radiotherapy patients on chemotherapy pre surgery to be re-discussed at MDT with a view to stopping chemo and doing surgery if at all possible.

5.3.3 Anal cancer patients

- New patients - to continue to attempt to treat with radical Chemo-Radiotherapy in view of high cure rates and severe morbidity of uncontrolled disease, provided patient fit.
- Lower threshold to consider Hatfield and Charnley 30Gy in 15# regimens.

5.3.4 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.
- Dietetic advice should be followed as per local guidance.
- Stoma care should be followed as per local guidance.

6 Follow-Up of Cancer Patients

- Try to minimise the number of patients attending colorectal clinics for routine review. Postpone appointments where appropriate and consider introducing telephone reviews for those where review is required.
- Follow up will be carried our remotely including the first post-operative appointment (clinician or nurse led)
- Consider roll out of Personalised Stratified Follow-up pathways for early stage or low risk patients. Alliance to support rapid, clinically safe roll out.
- Investigations such as CT TAP and colonoscopy should be deferred unless clinically indicated.
- Anal patients - reduce follow up frequency except in patients in first 2 years post CRT who would be fit for an APR if recurred.

7 MDT Meetings

- Maintain weekly MDT; recommend be done remotely to avoid contact between personnel. Aim to minimise the number of staff present at the MDT e.g. 1 surgeon, 1 oncologist, 1 pathologist, 1 radiologist and one colorectal nurse.
- Maintain Social Distance at MDT as per Gov guidance. MDT room should be adequate to address this.

- In the context of COVID-19, the usual membership of the MDT may not be quorate in which case the most senior clinician may direct treatment.
- Standard recommendation and Covid-19 recommendation to be documented with clear reason.

8 Research Activity

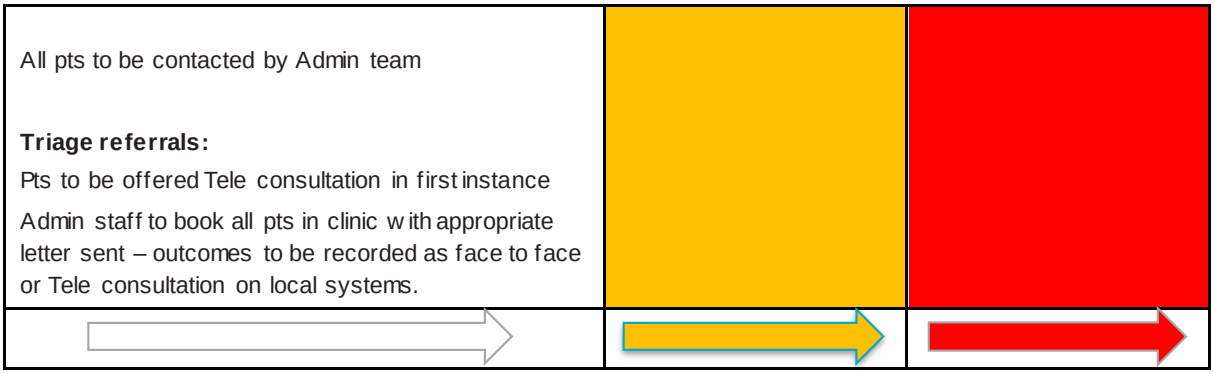
It is recommended that all recruitment and screening to all clinical trials be suspended with immediate effect. No new trials should be opened.

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'.

9 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:** •Postpone all 6 & 12 month F/U clinics •Keep clear records of all cancelled pts **To increase surgical cover:** •Cancel and defer routine 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.	**As per 'Now' and to also to include:** Review, reflect and amend as indicated **Surgery** Cancel all surgery except for Anal cancer **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 **Surgery** Cancel all surgery



10 Other considerations

To request the national team to suspend FIT screening which can divert radiologists/radiographers to symptomatic or other essential services and release lab testing capacity.

Appendix 1: High Risk Symptoms:

- over 50 with new and persistent loose stools (likely to be colitis in younger group)
- rectal bleeding without anal symptoms over 50 years of age over a period of 6 weeks
- over 50 with rectal bleeding - blood in stool
- rectal bleeding - if blood on toliet paper only, needs also to have a rectal or anal mass palpable (to avoid piles being referred)
- tenesmus - incomplete evacuation WITH presence of a rectal mass
- over 50 with abdominal pain with increasing abdominal distension
- palpable abdominal mass
- palpable rectal mass
- over 50 with any two symptoms

Appendix 2: CWT Codes (**please note – may change pending final sign off**)

Codes
2ww 97 – Other Reason not listed FDS 97 – Other reason 62 Day 97 – Other reason not listed OP Cancellation Codes in System CV – Patient has concerns about attending due to COVID-19 CVS – Patient is sick with symptoms of COVID-19 (could be confirmed or unconfirmed COVID-19)

CVH – Hospital has cancelled appointment due to COVID-19 pressures (eg clinic cancelled as clinician unwell) CVP – Appointment postponed after clinical review due to COVID-19 For IP – cancel using national cancellation codes and enter COVID-19

Comment: Due to uncertainty and dynamic situation, recommendation may need change if any updates are published