Head and Neck 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 Head and Neck 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 Current Pathways

Continue to use current referral methods as much as possible. If this changes, you will be notified

4 Referrals

4.1 Triage of referrals

- 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
- Ensure senior clinicians have access to Trust laptops in order to be able to provide triage service / primary care advice
- Need to ensure safety netting in place for all referrals to ensure follow-up occurs appropriately post-pandemic

4.2 TWR referrals

- All 2-week referrals should be logged and then followed up following the cessation of the pandemic.
- Ensure appropriateness of 2ww waits. Consider two level triage – on receipt of initial referral and then again on the telephone to check symptoms with patients and the need to be reviewed within the urgent timeline and also that the patients want to proceed with the referral. Will also potentially allow ordering the first test prior to patient being seen to reduce visits to the hospital.
- A telephone conversation will count as first visit on the revised CWT

5 First hospital attendance

Consider one stop services e.g.

a) An OMFS clinic with ability for review, local anaesthetic biopsy and pre-op assessment as required.
b) Neck lump clinic with ability for review, ultrasound scan and fine needle aspiration or core biopsy.

6 Diagnostics

- Consider initial telephone triage to highlight the imaging required so that on the day of the face to face consultation the diagnostic imaging may be potentially completed.
- Try to maintain normal diagnostics for as long as possible. Consider deferring CT thorax in early stage tumours until after the pandemic, or alternatively use a PET-CT as a single imaging modality.
- Think about how GA EUA, panendoscopy and biopsy could be delivered
- Unlikely that FNE services can be offered as routine for diagnosis as requirement for full PPE. May be limited to cases with very high diagnostic suspicion of cancer and plan to obtain biopsy at the same examination.
- De-prioritise dental assessments during this period. Restorative dentistry which involves high speed drilling or scaling with an ultrasonic scaler are aerosol generating procedures and should be stopped during this period.

7 MDT Meetings

- Revise MDTs as per BAHNO to minimum quorum of single specialist from each discipline. Coordinate presence 24 hours before each meeting (forward plan rotas risk being unhelpful due to unplanned absence)
- How many people actually need to attend the meeting and can it be kept as virtual as possible?
- MDTs should record the treatment recommended as well as the ideal treatment if that is altered because of COVID-19
- Referring Consultant to send a clear plan of what they feel is their treatment plan

8 Arbitration/Ethics group

- Consider forming this within your team – ENT/OMFS/Anaesthetics/Oncology to allow of rapid decision making around urgent cases outside of the MDT o discuss any contentious treatment decisions or difficulties with resources. There are guidelines due to come out with regards these decisions and several Trusts already have overarching Ethical committees to help with difficult decisions.

9 Treatment

- Surgical treatment plans should be minimal. Could procedures be done in a staged fashion or reconstructed at a later date? Can free flaps be avoided? Consider age and co-morbidities of the patient . Is adjuvant treatment required? Could it be de-escalated or postponed? Is chemotherapy required?
- General anaesthetic procedure should be done with the patient having an endotracheal tube (not with an LMA)
- Can tracheostomy be avoided? High aerosol production and risk
- If elective surgical capacity is constrained discuss with MDT if radiotherapy can be used as alternative.
- Consider surgical neck dissection in preference to sentinel node (as may avoid second procedure)
- Ask MDT if PET evidence of primary would suffice for treatment plan if node biopsy already confirmed cancer
- Avoid neoadjuvant chemotherapy
- Where possible consider hypofractionated radiotherapy regimens to reduce fraction burden on department and hospital visits for patient (55/20#).
- 70/35# shouldn't be in common use but should be substituted for 65/30#
- Consider minimizing RT volumes in an attempt to reduce the need for peg/ngt, and consider treating the ipsilateral neck where previously treated bilateral. Reducing chemorad, only radiotherapy for post op. Chemorad for only the most robust of patients.
- Consider stopping all weekly Cisplatin at 200mg/m2 (5 weeks from 6) Moving to reactive NGT and away from prophylactic RIG.
- Avoid prophylactic RIG/PEG placement (high exposure risk procedure) and plan for reactive NGT placement if dysphagia develops.
- Talk to dietitian staff about support for NGT over RIG/PEG
- Palliative fractionation- consider 8/1 or Quad Shot over 20/5
- Plans for COVID radiotherapy as per department
- Cat 1 patients for treatment wherever possible.
- Radical H&N radiotherapy is Priority 1 as per NHSE priority table
- See the attached NHS document: Clinical guide for the management of cancer patients during the coronavirus pandemic with regards how to prioritise both surgical and radiotherapy patients.

10 Follow-ups

- To do virtually as able

11 Recurrence

- Have a pathway in place for patients who contact during this period who are concerned about recurrence. Consider telephone triage and then review the patients as required to decide on next steps.
- Discuss with staff in isolation about their capability to triage telephone enquiry

12 Palliation

- Involve local teams as much as possible and keep at home as able.

13 Current Guidelines

- Current guidelines available (This is changing on a regular basis and the most up to date guidance from NHSE, BAHNO, ENT-UK and BAOMS should be used):
    - *British Association of Head and Neck Oncologists:* https://www.bahno.org.uk/bahno_statement_on_covid-19.aspx https://www.bahno.org.uk/bahno_laryngectomy_guideance_during_covid-19_pandemic.aspx
    - *ENT-UK:* https://www.entuk.org/covid-19
    - *British Association of Oral & Maxillofacial Surgery: https://www.baoms.org.uk/professionals/omfs_and_covid-19.aspx*
    - NHSE: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/specialty-guide-acute-treatment-cancer-23-march-2020.pdf
    - NHSE: https://www.england.nhs.uk/coronavirus/secondary-care/other-resources/specialty-guides/