Commission on Excellence and Innovation in Health.

Systemic cancer therapies during COVID-19

Guidance for South Australian cancer service providers

Background

COVID-19 presents an unprecedented challenge to the South Australian health system with an anticipated significant increase in demand on both public and private health services. Current information suggests that people undergoing cancer treatment or recovering from cancer treatment have higher risk of infection and serious complications from COVID-19 than the general population. Whilst there is limited evidence on the optimal management of cancer patients during a pandemic, there is a need to proactively initiate measures to minimise risk for people being treated for cancer.

Purpose

This document outlines a range of measures that health services treating people with cancer should consider implementing as part of their business continuity planning. These suggestions are a general guide based on expert advice and limited publicly available evidence and should be considered alongside the existing policies and guidelines used within the health service and private practices within the state.

It is recognised that information regarding COVID-19 is rapidly evolving and new information may be made available after the release of this document. Staff should continue to monitor information made available by their health service, professional colleges and other state and federal recommendations. Additional information may also be available on the SA Health and Australian Government websites:

- www.sahealth.sa.gov.au/COVID2019
- https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert

General principles

"Protect yourself, protect your patients, and protect their oncological path"

Protect yourself

- General hygiene, personal protective equipment (PPE) and contact precautions for prevention of spread of COVID-19 – follow your local health services guide/recommendations.
- Reduce face-to-face contact with other people including people with cancer and colleagues to reduce risk of COVID-19.
- Continue to provide optimal care for those in need.
- Regular exercise, food intake, hydration and sleep.
- Watch for fatigue, emotional distress and burnout; seek help from Employees Assistance Programs, when needed.

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Protect your patients

The risks vs benefits of treatment should be balanced with COVID-19 related complications. For patients without known COVID-19 infection, in most circumstances, it is more important to initiate or continue systemic cancer treatment than to delay or interrupt treatment. However, individualised and shared treatment decisions should be made after considering the overall goals of treatment, the patient's current oncologic status, general medical condition and treatment tolerance.

Treatment decisions should be proportionate, equitable and transparent. It is important to consider that people with cancer or on cancer treatment have differing ability to self-manage and differing psychosocial support. Given the uncertainty associated with cancer outcomes and COVID-19, it is expected that patients and their carers will have many concerns and questions. Hence, clear and empathetic communication, monitoring psychosocial issues and appropriate interventions are required. Interventions could include, but are not limited to, referral to support services (e.g. Cancer Council SA) and provision of information and resources.

Up-to-date resources for people with cancer and their family can also be sourced from:

- Department of Health (Australia) – https://www.health.gov.au/news/health-alerts/novel-coronavirus-%202019-ncov-health-alert).com
- Cancer Council - https://www.cancer.org.au/cancer-and-covid-19
- Coronavirus Health Information Line: 1800 020 080

Protect their oncological path

Standard therapies should be continued for the following situations where the benefits from cancer treatment (symptom control, improved quality of life or cure) may exceed the potential risks from COVID-19 infection:

- Rapidly growing cancers – e.g. acute leukaemia, lymphomas, small cell lung cancer
- Advanced cancer with symptoms – e.g. pain from metastatic disease, dyspnoea from lymphangitis
- Oncological emergencies e.g. febrile neutropenia, spinal cord compression, superior vena cava compression, raised intra cranial pressure from secondaries
- Those who are already on treatment – if clinically deemed essential to continue.

Assuming healthcare service provision is adequate

Health services should consider the following changes for non-urgent cases where the patient's clinical status is stable or less likely to deteriorate and modifications in care are less likely to significantly alter outcomes.
Non-urgent cases may be defined as those on

- Post treatment surveillance or on active surveillance
- Survivorship care
- On maintenance/adjuvant hormonal therapies, cytotoxics, immunotherapies, oral kinase inhibitors, bisphosphonates and denosumab
- Indolent cancers

New patient triage:

- Defer consultation and add to a wait list if the referral is deemed as low priority as per local triage criteria. High priority triaged cases should be seen as per usual practice.
- Defer consultations for a second opinion if they are already on treatment at another site.
- Consider communication strategies for impacted patients e.g. consider appropriate staff calling the patient to ascertain their clinical requirements and indicate to patient likely timelines for clinic review and commencement of treatment.

Clinic reviews for follow-up visits:

- Review clinic lists and defer reviews where appropriate.
- Use remote consultations with telephone calls or videoconferencing where available especially for post-treatment surveillance, those on active surveillance and survivorship care.
- Consider staff training for telephone consultations.

Treatment

The following practice points may be considered:

- Involvement of patients and their carer in informed decision making is paramount.
- Proactively discuss revisions to treatment and management plans and be transparent about plans that compete with usual cultural rituals and social norms.
- Some cancer types such as lung cancer patients, those with comorbidities and elderly are particularly vulnerable to COVID-19 related severe complications.
- Decisions on modifying or withholding chemotherapy should include consideration of the indication for chemotherapy, the goals of care, where the patient is in the treatment course and their tolerance of treatment - for e.g.:
    - the risk: benefit assessment for proceeding with chemotherapy in patients with untreated extensive small cell lung cancer is different from that for patients on maintenance pemetrexed for metastatic NSCLC.
    - In cases where the absolute benefit of adjuvant chemotherapy may be quite small, and where non-immunosuppressive options are available (e.g. hormonal therapy in ER+ early-stage breast cancer, anti-androgen therapies for castrate resistant prostate cancer), potential exposure to COVID-19 may be considered as an additional factor in weighing the different options available to the patient.
- Refer to national and international organisations that have provided tumour specific practical guidelines (See references especially Segelov et al. and Ueda et al).
- For patients in prolonged and deep remission who are receiving maintenance therapy, stopping chemotherapy may be an option.
- Consider avoiding immunosuppressive treatments in high risk patients (elderly with significant comorbidities).
- Consider delaying planned intensely immunosuppressive treatments such as stem cell transplantation if appropriate.
- Consider patients for whom it is suitable to switch chemotherapy from parenteral to oral administrations, which would decrease the frequency of hospital appointments.
- Consider increasing cycle lengths (e.g. change to 6 weekly pembrolizumab, 4 weekly nivolumab); prophylactic G-CSF, antibiotics use.
- Consider deferring supportive therapies e.g. maintenance denosumab.
- Consider port flushes/locks infrequently (8 weekly instead of 6 weekly).
- Appropriate education for patients, families and carers regarding the symptoms of COVID-19, proper handwashing, hygiene, and minimizing exposure to COVID-9 positive contacts and large crowds.
- If a local transmission affects a cancer centre, giving a chemotherapy break for two weeks, arranging infusion at an unaffected satellite site or arranging treatment with another facility non-COVID-19 hospital that is not affected, may be reasonable options or consider chemotherapy at home options.
- Consider oral medications being dispensed by a community pharmacy (these can be delivered to a patient's home) or if a hospital pharmacy dispenses them, the pharmacy contacts the patient to arrange collection/delivery – reducing time in hospital building.
- Consider dispensing longer periods of oral medications e.g. two cycles at a time of oral medications with patient having a consultation by telephone or video consultation before starting second cycle (i.e. reducing need to re-present to hospital to obtain medications)
- For those who present with fever and who are on systemic cancer therapies, use local febrile neutropenia protocol. Routine recommendations for screening for

- COVID-19 for such patients do not exist as yet, however, may need to be considered as screening guidelines change.
- All suitable people with cancer and survivors should have influenza vaccines when they become available.
- Early discussion on advanced care planning using (where appropriate):
    - SA Health Resuscitation Planning 7 Step Pathway Policy Directive
    - Advanced Care Planning Australia – Fact Sheet for Healthcare Professionals

Routine investigations:

- Consider trained staff calling all scheduled patients 1-day in advance of clinic visit to screen for COVID-19 exposure/symptoms.
- Pre-chemotherapy nursing assessments performed over the phone if possible
- Consider home collection of routine lab samples by phlebotomists instead of patients coming into the clinic, if suitable for treatment after phone calls.
- Defer routine surveillance investigations and/or consider performing tests outside of an acute care facility.

Multi-disciplinary (MDT) meetings

Limit the number of attendees with one representative per speciality, using teleconferencing facilities, use online peer groups for advice on management.

Workforce

Consider working from home on non-clinic or ward service days, no more than two consultants of the same specialty at the same time within the same room, seated one person per 4m^2 with contact precautions; consider smaller teams.

Teaching

Online only.

Research:

For ongoing trials: Consider telephone or videoconference consults on non-treatment visit days.

New trial related activities: can be considered based on clinical needs and local resources permit.

Consider new research activities that can evaluate the impact of COVID-19 on cancer care and their outcomes as well evaluation of the service delivered.

Staff and clinic preparedness:

- All staff may need additional training to screen patients and accompanying carers for possible COVID-19 infection/other infections.
- Procedures to isolate potentially infected patients may need review and updating.
- Staff may need additional training on the use of PPE.
- Additional PPE may need to be obtained/sourced, as staff that do not usually use it may be required to perform tasks where it is appropriate. LHNs need to consider supply needs and escalate procurement issues.
- Clinic staff may need additional training on how to undertake COVID-19 testing for patients according to current testing guidelines.
- All staff should have influenza vaccine when it is available.
- Where possible, create a separate waiting area for patients undergoing chemotherapy to reduce exposure to other patients e.g. separate space within the chemotherapy unit, use a separate room.
- Waiting room chairs to be separated so that there is only one person per 4m^2.
- All toys and magazines etc. are to be removed from waiting rooms and chemotherapy units.
- Staff to look at efficient scheduling of patients' appointments to reduce the patient waiting times.
- Consider workforce rostering strategies to maintain service continuity in the event of a staff member becoming infected with COVID-19 e.g. create smaller

teams who work on a rotation basis to minimise number of staff potentially coming into contact with infected staff member
- Develop a strategy and communication plan in place for vulnerable populations including Indigenous people who may be adversely affected or push-back on strategies such as social distancing.
- Refer to Cancer Council (phone 13 11 20) information and support services to provide emotional support to patients and their families and practical information to minimise the risk of infection, particularly for those that are not receiving active treatment.

If accelerated community spread of COVID-19 and healthcare service capacity is exceeded

Additional measures may be required in the event of the capacity of the health service being exceeded, or in the event of cancer service workforce unavailability. Some services (e.g. The Peter MacCallum Cancer Centre's medical oncology clinical response plan) have already planned for staff level availability-based health care delivery for treating people with cancer, survivors and their family.

Cancer service staff may also need to be re-deployed to see non-cancer patients with or without COVID-19. In such events, measures could include:

- Further scaling down of treatment for non-urgent cases
- Cancelling MDTs
- Only patients undergoing treatment to be reviewed in clinics
- Any clinic reviews to be undertaken by telephone or video consultation
- Cancel all teaching
- Non-treatment trial related activities may need to be omitted (with anticipated protocol violation).
- If a local transmission affects a cancer centre, giving a chemotherapy break for two weeks, arranging infusion at an unaffected satellite unit or arranging treatment with another facility that is not affected, may be reasonable options or consider chemotherapy at home options.
- Staff rostering should be considered if patients require transfer at alternate sites

Care of a cancer patient with suspected/proven COVID-19

- For patients with fever or other symptoms of infection, a comprehensive evaluation should be performed as per usual protocol.
- At this stage, management of COVID-19 should be similar for patients with and without cancer.
- For patients with diagnosed COVID-19 on active anti-cancer treatment, follow the standard clinical management plans for delay or modification of cancer treatment in a patient with active infection. Seek opinion from infectious disease experts for any further advice.
- There is no proven effective treatment for COVID-19 infection. Consider using local and international treatment protocols (e.g. https://www.covidprotocols.org).
- There is limited evidence for the safety of anti-cancer drugs in a COVID-19 infected patients. Oral kinase inhibitor was administered safely in a single patient with active COVID-19 infection.
- There is little data on reactivation of COVID-19 when subsequent cancer therapies are initiated after recovery from the infection. Consider whether home infusion of chemotherapy drugs is medically appropriate and logistically feasible for the patient, medical team and caregivers once the COVID-19 infection is cleared.

To provide feedback or for further enquiries, please email the Statewide Cancer Clinical Network - CEIH:Cancer@sa.gov.au

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Approval Date	Version	Approver	Reason for change
19/3/20	V1.0	Ganessan Kichenadasse, Clinical Lead, Statewide Cancer Clinical Network	First draft
23/3/20	V1.1	Prof Paddy Phillips, Commissioner, Commission on Excellence and Innovation in Health	Amendments following feedback from Statewide Cancer Clinical Network Steering Committee