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Specialty guides for patient management during the coronavirus pandemic

Clinical guide for the management of essential cancer surgery for adults during the coronavirus pandemic

7 April 2020 Version 1

Background

Government and the NHS nationally have made it clear that cancer treatment should continue to be prioritised wherever possible during the response to the COVID-19 emergency.

On 23 March 2020, the NHS issued national guidance to support clinicians on treatment decision-making and prioritisation, and to inform conversations with patients on treatment plans: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/specialty-guide-acute-treatment-cancer-23-march-2020.pdf

On 30 March 2020, national guidance recommended that urgent consideration should be given to consolidating cancer surgery in a COVID-free hub, with centralised triage to prioritise patients based on clinical need: https://www.england.nhs.uk/coronavirus/publication/advice-to-trusts-on-maintaining-cancer-treatment-during-the-covid-19-response/

This supplementary guidance, which builds on the experience in China, Italy and London, supports cancer services on the prioritisation and management of essential cancer surgery

for adults during the COVID-19 emergency. It has been developed in collaboration with the Royal College of Surgeons of England and the British Association for Surgical Oncology.

Organisational planning

NHS England and NHS Improvement regions should take steps to ensure that sufficient capacity and pathway arrangements have been put in place to maintain access to surgical treatment for cancer patients who require this during the COVID-19 outbreak, in line with the guidance published on 30 March (see above).

It is recommended that the cancer senior responsible officer (SRO) for each region should:

- Confirm with trusts what capacity and pathway arrangements are in place to support the continuation of cancer surgery during the COVID-19 period. This assurance may also involve Cancer Alliances, ICSs and/or lead providers where 'hub' arrangements are already in development.
- Where it is considered that further resilience is, or is likely to be, required, the cancer SRO should task the relevant organising unit (Cancer Alliance, ICS or lead provider) to undertake a rapid assessment of need, in line with the guidance previously issued, and to develop a proposed solution. This step should involve trusts, specialised commissioners and local systems/CCGs.
- Where the solution uses independent sector capacity, the cancer SRO should ensure that cancer activity is part of local system planning to make optimum use of the available capacity.

Management of priority cancer patients for surgery

National guidance (23 March 2020) proposed a system of prioritisation for cancer patients requiring surgery:

- priority level 1a: emergency operation needed within 24 hours to save life
- priority level 1b: urgent operation needed with 72 hours
- priority level 2: elective surgery/treatment with the expectation of cure needed within four weeks to save life/stop progression, taking into account symptoms and potential complications from lack of treatment
- priority level 3: elective surgery can be delayed for 10 to 12 weeks and will have no predicted negative outcome.

To support local hubs to plan activity:

- Appendix 1 lists the conditions likely to covered by priorities 1a, 1b and 2. This is not intended to be an exhaustive list but may help with the estimation of treatment volumes.

- Appendix 2 gives an estimate of the breakdown of expected surgical activity once the prioritisation criteria are applied. Nationally, specialised commissioning is seeking to ensure appropriate coverage of rarer conditions across the emerging cancer hubs.

Emergency operations (priority level 1a/b) will normally be performed by emergency surgical services at whichever site the patient presents, although in some cases it may be possible to stabilise patients for transfer to specialist teams, ideally after rapid testing for COVID-19.

For emergency surgery where COVID-19 testing is impractical, patients should be assessed on the basis of their history, and chest imaging performed in all cases. A plain chest X-ray is the minimum requirement, but many patients will undergo CT scanning preoperatively, in which case the chest should be included.

Patients prioritised as level 2 require management that balances the risk from the cancer with the need for strict infection control to maximise safety. These patients should be prioritised for ‘clean sites’.

Wherever possible, operations will be deferred for patients prioritised as level 3, with arrangements in place with cancer care providers for review if their condition worsens and for tracking to ensure their treatment is prioritised as soon as capacity allows.

Maintaining essential cancer surgery will follow these principles:

- equitable treatment of patients with life-threatening cancer who need access to surgical and critical care capacity, in relation to COVID-19 patients
- in line with national guidelines, balancing the urgency of cancer surgery against the risks of the procedure, particularly the risk of complications and a requirement for intensive care support
- equity across local healthcare systems, with capacity maximised in dedicated NHS or independent sector hospitals to allocate patient activity based on the greatest prospects for cure
- safety of patients, especially with regard to infection control and access to critical care as required
- safety of staff undertaking surgery and other care.

Local cancer hubs – operational and management guidance

In establishing systems within local cancer hubs, it is recommended that local systems have regard to the following guidance:

(i) A central triage point within a local cancer system

1. All cancer patients should be discussed at their usual specialist MDT. Both surgical and non-surgical treatment should be considered. Surgical decisions should be based on the priorities described above.

2. Time-critical cancer surgery, for which there is no capacity within a trust, should be referred to a central, clinically led triage point. This may be placed at a regional, local cancer system (Cancer Alliance) or lead provider level, depending on local circumstances. Clinical prioritisation will be done by a group of senior clinicians from across the relevant cancer disciplines, with reference to the information from the specialist MDT.

3. The role of the triage system will be to prioritise patients for surgery on the basis of clinical need, and the level of risk, both patient and service-related, and to match patients with appropriate surgical specialisms and capacity across the cancer system.

4. A risk assessment must be performed by referring trusts, for patients who do not proceed to operation or whose surgery is rescheduled. Holding treatments such as systemic anti-cancer treatment or loco-regional therapies may be explored. The potential risk of progression needs to be clearly discussed with the patient and the option of early reassessment clarified in their treatment plan.

5. Where local capacity is insufficient to provide timely care, mechanisms should be in place to seek assistance from neighbouring or other systems, if patients are well enough to travel for treatment.

(ii) Consolidation of cancer surgery in ringfenced ‘clean’ facilities

1. Wherever local circumstances permit, cancer surgery should be consolidated on a ‘clean’, COVID-19 free site (or several sites) within the local system. This could include independent sector provision where this has been secured.

2. If fully COVID-19 free sites are not available, separate COVID-19 free facilities should be designated on a site, with dedicated access and admission processes as well as inpatient areas separate from those where COVID-19 patients are being treated.

3. Staffing for clean facilities will require a designated pool of anaesthetic and surgical consultants, who may need to work outside their employing trust. Appropriate governance arrangements will be required to support this, such as honorary contracts.

4. Staff who have recovered from proven or suspected COVID-19 infection must follow Public Health England guidance on return to work, ideally supported by PCR testing to confirm they are negative before returning. If possible, staff in clean facilities will be tested for immunity to COVID-19 by serology, when this becomes available.

5. Surgeons and anaesthetists will need to maximise use of theatre time, with consultant-delivered procedures and, where possible, dual-consultant operating to reduce theatre times and the number of people in theatres who may be exposed to aerosols.

6. Adequate supplies of personal protective equipment (PPE) will be required for staff working in the designated facilities, in accordance with current national guidelines. PPE is essential to avoid unnecessary exposure and to protect patients and staff from intra-hospital transmission. This will be required even where patients have tested COVID-19 negative.

7. Arrangements will need to be in place to test all potential admissions for COVID-19 at most 48 hours before surgery, with patients self-isolating for seven days before admission. Patients will need to consent to testing and self-isolation at the time of listing for surgery. Only patients who have no symptoms suggestive of COVID-19 infection, have been isolated for seven days and have a negative COVID-19 PCR test should be admitted to the designated facilities.

8. For any cancer patient with symptoms or who is found to be COVID-19 positive, clinicians will need to decide locally when that patient will be considered fit for surgery; they will be considered alongside other urgent surgery within a hospital treating COVID-19 patients.

9. Postoperative major cancer surgery patients should be advised to follow shielding advice, as they will then fall into the high risk category.

The national cancer team and national specialised commissioning team will work with regional offices and Cancer Alliances to monitor preparations across the country. They will offer more intensive support in areas where plans are not as advanced, where requested. As noted above, the national specialised commissioning team will work with hubs to ensure continuity of services in respect of rarer cancers for which there are a relatively small number of providers.

If you have any questions or you feel the national cancer team can provide any particular support, please do not hesitate to contact us at: england.cancerpolicy@nhs.net.

Appendix 1: Indicative list of conditions expected to fall within the remit of this guidance

Note: This list is neither exhaustive nor mandatory. Refer to the Surgical Specialty Association guidelines for more detailed recommendations to support MDT decision-making.

Tumour site	Within 1 month	Within 3 months
Breast	Breast cancer resection: ER negative/Her2+; pre-menopausal ER+ve with adverse biology	Breast cancer resection: pre-menopausal ER+ without adverse biology
Lower GI		Resection of colon cancer (if predicted aggressive biology) Resection of rectal cancer
Gynaecology	Suspected germ cell tumours Early stage cervical cancer Pelvic confined masses suspicious of ovarian cancer High grade/high risk uterine cancer Primary vulval tumours	
Thoracic	Resectable non-small cell lung cancers	
Bladder	Bladder cancer invading muscle Upper tract transitional cell cancer surgery Bladder cancer surgery – high risk carcinoma in situ	Bladder cancer surgery not invading muscle
Penile	Penile cancer surgery including inguinal node surgery	Penile cancer surgery: low grade and premalignant
Prostate		Prostate cancer surgery: high/ intermediate risk
Kidney	Renal carcinoma Partial nephrectomy on a single kidney	
Testicular	Testicular cancer non-metastatic	
Head and neck	EUA/biopsy for malignancy – hypopharynx; larynx Nasopharyngeal surgery for malignancy Oropharyngeal; tonsil; tongue cancer resection +/- reconstruction surgery for malignancy Treatment of small, high grade salivary cancers	Salivary gland tumours: Low grade Otological cancer surgery.

	Treatment of sinus cancers – threatening sight	
Oesophago-gastric	Oesophagogastric cancer causing obstruction	Oesophagogastric cancer surgery GI stromal tumour resection
Hepatobiliary/ pancreatic	Hepatobiliary/pancreatic cancer causing obstruction (biliary/bowel)	Hepato-pancreatico-biliary cancer surgery
Endocrine	Thyroid/parathyroid cancer surgery Adrenal cancer surgery	Thyroid cancer surgery: including diagnostic lobectomy Adrenal resections – intermediate masses: a) >4cm <6cm) with hypersecretion (cortisol/androgen) b) metastases – progressing on scan at 3/12
Brain/CNS	Brain tumour surgery (including gamma knife for metastases) Spinal tumour surgery	
Orthopaedics	Sarcoma surgery – any site Solitary metastasis – any site Destructive bone lesion surgery with risk of fracture (eg giant cell tumour)	
Paediatrics	Surgery for nephroblastoma, neuroblastoma, rhabdomyosarcoma	
Plastic surgery	Major soft tissue tumour resection (all sites) Skin cancer resection – all sites: melanoma; poorly differentiated cancers; nodal disease; compromise of vital structures, including the eye, nose and ear	Resection of head and neck skin cancer – moderately/well differentiated with no metastases

Appendix 2: Estimated breakdown of anticipated workload for level 2 procedures

These figures are indicative and derived from modelling in the Royal Marsden Partners Cancer Alliance.

Tumour site	%
Breast	25–30
Lower GI	15–20
Gynaecology	10–15
Thoracic	5–10
Bladder	5–10
Skin (mainly day case, local anaesthesia)	5–10
Kidney	3–5
Head and neck	3–5
Endocrine	2–3
Metastatic disease (spinal cord)	2–3
Brain	2–3
Sarcoma	2–3
Prostate	≤1
Testicular	≤1
Penile	≤1
Oesophago-gastric	≤1
Hepatobiliary/pancreatic	≤1