

# **BAHNO statement on COVID-19**

Initial guidance for head and neck cancer management during Covid-19 pandemic in consultation with ENT UK. BAOMS endorsement awaited.

Issued 17 March 2020

**To:** UK head and neck multidisciplinary teams

## **BAHNO position:**

Healthcare services internationally are seeking to meet and manage the unprecedented impact of the Covid-19 pandemic.

The following is guidance for the provisioning of head and neck (H&N) cancer services during this period. It is intended to guide and support decisions made locally/regionally within H&N 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. They will be updated as priorities and understanding of the situation evolves.

### **1. Referrals**

- Immediate referral triage strengthening (both two-week wait and urgent cancer referrals) with prioritisation of cases highly likely to represent malignancy
- Referrals less likely to represent H&N cancer should be delayed/deferred but a record retained for future recall. Consider telephone consultations to ascertain severity where referral urgency is unclear
- Non-cancer or benign cases should be deferred/rejected
- Patients over 70 years of age (and/or with high risk co-morbidities, frailty) who fulfil urgent cancer criteria should be prioritised in such a way as to minimise time in hospital environment.

### **2. Diagnostic/ staging workup**

- Limit diagnostic workup for low risk cases or those where there is a low clinical suspicion of malignancy
- Ensure personal protective equipment is available when needed
- Follow ENT-UK advice for nasendoscopy
- Consider best utilisation of available diagnostic capacity. Where necessary, limit investigations to those modalities that are necessary for safe treatment decision making
- Expedite one-stop investigations if possible
- AHP input remains essential but should be targeted to those in most need
- Additional procedures (e.g., dental assessment/extractions, PEG provision) should be restricted to absolute need.

### **3. MDT working**

- Maintain normal MDT frequency (where service allows) but minimise its duration
- Quorate MDT constitutes (minimum)

MDT co-ordinator, 1x surgeon (depending on case mix ENT/OMFS/Plastics), 1x clinical oncologist, 1x radiologist (with H&N specialist interest) and 1x pathologist

- Specific AHP guidance/input should be sought where treatment decisions are likely to be influenced
- All MDTs should expedite/encourage steps to facilitate dial-in options for core MDT membership.
- Immediate steps should be taken locally to plan prioritisation of treatment plans for H&N cancer (as below) with appropriate discussion in the MDT setting (with clearly documented decisions)
- Consider limited discussion/protocolisation of common clinical scenarios with well-recognised treatments (e.g. early cancers of oral cavity and glottic larynx).

#### **4. Treatment**

- Local contingency plans should be made immediately for prioritisation of surgical and non-surgical treatment

Surgical examples - cessation of all but the most urgent thyroid cancer surgery, prioritise day case surgery where feasible (e.g. wide local excision without reconstruction), restriction/cessation of surgical procedures requiring post-operative HDU/ITU care. Given consideration to reducing the length of surgery when possible e.g. use of local/pedicled flaps rather than free flaps. Restrict non-essential personnel in theatre environment i.e. medical students, additional trainees, medical reps. Ensure personal protective equipment are worn by all staff.

Non-surgical examples - restriction/cessation of chemoradiotherapy in favour of radiotherapy alone, consideration of hypo-fractionated radiotherapy courses in appropriate patients. Delay commencement of palliative chemotherapy in asymptomatic individuals.

#### **5. Follow up**

- Minimise all follow up appointments.
- Immediate attempt to minimise patient contact by postponing (6-9 months) for patients beyond the period of highest risk for recurrence (e.g. 18-24 months post treatment). Prioritise patients in immediate (4/52) post-treatment phase and consider longer intervals between follow ups as soon as suitable. Instigate telephone follow up where possible/appropriate immediately

#### **6. Research/Clinical trials**

- Prioritise support of patients who are on clinical trials
- Consider immediate cessation of trial recruitment if issues exist with capacity or safety
- Additional guidance should be available from local R&D guidance (supported by MHRA and clinical trials unit/centres).

<https://mhrainspectorate.blog.gov.uk/2020/03/12/advice-for-management-of-clinical-trials-in-relation-to-coronavirus/>

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