Covid19 and cancer care

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Clinical Lead West of Scotland
Primary Care Cancer Network
Webinar Outline

• Presentation and Q&A.
  – Regular breaks in presentation for discussion. Please also use “chat” function in zoom
• Covid19 impact on cancer care (GGC data)
• Screening - what next?
• Pathways – response & recovery
Covid19 – impact

- Scottish Referral Guidelines (SRG)
- USoC numbers
- Cancer targets
- Cancer therapies – XRT/SACT/surgery
- Regrading
- CT direct access
Referral Guidance

• Patients who meet USoC criteria should be referred
• Avoid deferring patients in primary care
• Enhanced triage of referrals
• Include performance status where possible
• Direct access USoC imaging continues
USoC by numbers - GGC

<table>
<thead>
<tr>
<th></th>
<th>GP/GDP Suspected Cancer Referrals*</th>
<th>CWT Reportable Cancer Diagnoses**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>4840</td>
<td>508</td>
</tr>
<tr>
<td>Colorectal</td>
<td>4312</td>
<td>215</td>
</tr>
<tr>
<td>Gynaecology</td>
<td>2228</td>
<td>55</td>
</tr>
<tr>
<td>Haematology</td>
<td>420</td>
<td>80</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>3737</td>
<td>181</td>
</tr>
<tr>
<td>Lung</td>
<td>3155</td>
<td>447</td>
</tr>
<tr>
<td>Skin</td>
<td>5781</td>
<td>166</td>
</tr>
<tr>
<td>Upper GI</td>
<td>5083</td>
<td>201</td>
</tr>
<tr>
<td>Urology</td>
<td>3400</td>
<td>638</td>
</tr>
<tr>
<td>Total</td>
<td>32956</td>
<td>2491</td>
</tr>
</tbody>
</table>

* Figures based on GP/GDP USC referrals received July 2017 - June 2018
** Figures based on GP/GDP USC referrals diagnosed with CWT reportable cancer treated in Jan - Dec 2018

Conversion rates vary from just below 20% - 2.5%
USoC referrals 2019 vs 2020
Week 1 = first week of March
Discussion regarding referrals

- Back to referrer issues?
- Mandatory or suggested tests?
- Regrading vs back to referrer
- Target lung?
- Chat?
• Week in Dec
  – 808 USoC
  – 88 cancers
  – 60 < 62ds
Cancer treatments

“Guidelines For Cancer Treatment During COVID-19 Pandemic”

• all decisions are done with the MDT
• clearly communicated with patients
• prioritise treatment for those who will benefit (individual risk/benefit profile)
• patients will be advised on the basis of emerging guidelines what the optimum treatment may be at this particular time
Cancer therapies

The most vulnerable cancer patients:

• active chemotherapy or radiotherapy

• immunotherapy or other continuing antibody treatments

• other targeted cancer treatments which can affect the immune system, such as protein kinase or PARP inhibitors.
Cancer therapies

Systemic anti-cancer treatments

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 haemato-oncology leads.

General approach to prioritising patients on systemic anti-cancer therapy:

- 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.
Figure 1. Age-sex infection fatality rate (IFR)s and contribution by age-sex, cancer and chemotherapy. 

*Estimating the risk of death from COVID Infection in Adult Cancer Patients* Williams et al. doi: https://doi.org/10.1101/2020.03.18.20038067
Figure 2. Projected deaths and survivals in 100 males aged 60-69 with lung cancer who are (a) given and (b) not given adjuvant chemotherapy, who all contract Covid-19.

Williams et al. doi: https://doi.org/10.1101/2020.03.18.20038067
Radiotherapy

- Similar picture to SACT
- Drop ~70% pre-covid19 activity
- Prostate radiotherapy deferred for 3m
- These patients will restart soon
Cancer surgery

Mortality and pulmonary complications in patients undergoing surgery with perioperative SARS-CoV-2 infection: an international cohort study

COVIDSurg Collaborative*

Published Online THE LANCET
May 29, 2020 https://doi.org/10.1016/S0140-6736(20)31182-X

In pts who acquire covid19 51.2% suffered pulmonary complications. These pts account for 82.6% of peri-operative mortality

- Male
- >70
- Cancer surgery
- Emergency/major surgery
- Co-morbidities
Cancer surgery

• Categorisation of patients

• Priority level 1a Emergency - surgery needed within 24 hrs
• Priority level 1b Urgent - surgery needed with 72 hours
• Priority level 2 Surgery can be deferred for up to 4 wks
• Priority level 3 Surgery can be delayed for up to 12 wks
• Priority Level 4 Surgery can be delayed for >12 wks
Cancer surgery

Deferred surgery in West of Scotland

- Urology
- Breast
- Colorectal
- Gynae
- Upper GI
- Sarcoma
- Head & Neck
- Lung

- Deferred Surgery
- Prostate
- Bladder
Discussion regarding cancer treatments

• Figures match experience?
• Patient communications?
• GP involvement in decision making?
Adult Screening Programmes Recovery

Jann Gardner, Chair SSC
Dr Lorna Ramsay, Medical Director, NSS
& SRO National Screening Oversight Function
As a high level summary, the routemap for recovery of the 5 adult screening programmes is broadly as below:

<table>
<thead>
<tr>
<th>LOCKDOWN</th>
<th>STAGE 1</th>
<th>STAGE 2</th>
<th>STAGE 3</th>
<th>STAGE 4</th>
</tr>
</thead>
</table>

* indicative dates – stages may not fully align to SG Routemap phases
<table>
<thead>
<tr>
<th>Screening Programme</th>
<th>STAGE 1</th>
<th>STAGE 2</th>
<th>STAGE 3</th>
<th>STAGE 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bowel</strong></td>
<td>Agree national recovery approach and work plan. Undertake readiness for restart.</td>
<td>All HB’s to recommence screening colonoscopy. Provide HBs numerical FIT values for participants on colonoscopy waiting lists to enable local prioritisation.</td>
<td>Managed recommencement of screening with short term gap for all recall participants. New participants start as normal around 50th birthday.</td>
<td>Commence ‘renewed’ screening approach, including exploration of any potential programme redesign.</td>
</tr>
<tr>
<td><strong>Breast</strong></td>
<td>Agree national recovery approach and work plan. Undertake readiness for restart.</td>
<td>Prioritisation of symptomatic &amp; high risk clinics.</td>
<td>Managed restart of screening from where the pause was implemented. Temp pause on self-referrals for women 71+ &amp; out with the eligible invited age range.</td>
<td>Commence ‘renewed’ screening approach. Breast Screening Review completion and recommendations implementation.</td>
</tr>
<tr>
<td><strong>AAA</strong></td>
<td>Agree national recovery approach and work plan. Undertake readiness for restart.</td>
<td>Prioritisation of high risk with triaging support: Medium AAA – invite if not shielding, agree process if shielding. 2019-20 cohort - invited but cancelled prior to pause.</td>
<td>Managed restart of screening for all eligible 2020-21 participants. Resume screening for small AAA participants, adopting 2 year review interval on a temporary basis.</td>
<td>Commence ‘renewed’ screening approach, including new interval approach. Catch up programme and programme redesign.</td>
</tr>
<tr>
<td><strong>DRS</strong></td>
<td>Agree national recovery approach and work plan. Undertake readiness for restart.</td>
<td>Prioritisation of high risk with triaging support: pregnant women with diabetes; R3/4 participants; R2 six month recall participants; new or recent diagnosis of diabetes</td>
<td>Recommence six month recall maculopathy participants. Managed restart of screening for all with accelerated adoption of revised interval screening.</td>
<td>Commence ‘renewed’ screening approach, including new interval approach. Catch up programme and programme redesign.</td>
</tr>
</tbody>
</table>
Management Pathways

• Enhanced triage of referrals
• Regrading
• Cancer tracking
• Check appropriate pre-referral testing done
• Use SRG guidelines
USoC by numbers

- 45,895 in GGC 2019
- 4-5% “back to referrer”
  - Podiatry, audiometry, physio, anaesthetics, homeopathic….
  - Gen med – chest pain, CVA
- 3300 ENT 2018 (50% SRG non-compliant)
Regrading of referrals

• USOC vetting undertaken by a Consultant.

• Enhanced vetting should involve a telephone call with the patient to identify those with greatest likelihood of a cancer diagnosis.

• For those patients vetted back to referrer, vetting consultant should dictate a letter to GP outlining the discussion, advice and decision.

• For those patients not requiring appointment following telephone consultation, the consultant should dictate a letter to patient and GP outlining the discussion, advice and decision.

• The vetting outcome letter to patients should clearly indicate to patients who to contact.

• A process should be in place for a point of contact to a service for patients whose symptoms worsen.
Cancer tracking

- Where USOC referrals are re-graded to urgent or routine these patients will be removed from cancer tracking.

- Following COVID-19 pandemic potential for full implementation of the USOC re-grading SOP will be reviewed.

- Where USOC referrals are vetted back to referrer these patients will be removed from cancer tracking.

- Where USOC referrals are deferred for USOC appointment following covid-19 pandemic patients will remain on cancer tracking.

- As per national guidance issued on 17th April a waiting times adjustment will only be made where an appointment is deferred as the patient is unable to attend, e.g. shielding and advised not to attend hospital.
Referral Guidance – potential changes

- Endoscopy is a significant challenge as an AGP
- Colonoscopy restarted
- Prioritisation of patients is key
  - Screening
  - Symptomatic
- Qfit valuable tool: >400 high risk
  - Should be considered part of routine assessment
Projected waiting list current 16 scopes/week at current referral rate. Increasing to 32 scopes/week in July with increased referral and re-introduction of screening.
CT access from primary care

A Scottish Imaging Pathway for Primary Care

Direct Access to CT of Chest/Abdomen/Pelvis for Patients with Unidentified Suspected Malignancy

- GP sub & radiology largely supportive
- Awaiting radiology CDS and reporting arrangements
- “cold site”
Discussion regarding pathways

• What about current cancer patients?
• PPE requirements smear taking?
• Changes to analysis
• Chat?
Covid19 and cancer care

Q&A

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