

Interim Guidance on re-starting therapy in patients with cancer after infection with COVID-19

Version 2

This guidance is for adult patients who have had their cancer therapy interrupted during the COVID pandemic and who have experienced COVID symptoms in that time

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Developed by: Cancer Treatment Response Group

1 General Principles

1.1 Re-starting immunosuppressive therapy is fundamentally a clinical decision, and the results of a viral PCR SARS CoV-2 test cannot be the sole indicator of infectivity of a patient.

1.2 To restart treatment with SACT, the patient should be at least 14 days from the onset of symptoms, and at least 48 hours without fever.

1.3 They would then be managed for their next SACT appointment as if they were still infected:

- Isolated or cohorted in a separate area on arrival to cancer centre
- Staff would wear PPE of gloves, aprons and facemask and the patient would also wear a facemask
- If an outpatient visit, they would then be sent home and if their next appointment was at least 14 days later, they would be considered non-infected, unless they had redeveloped symptoms in the intervening period.

1.4 The patient could be re-tested at this first post-COVID-19 visit, if it would help in the management and/or staff re-assurance, but was not essential.

1.5 If they have more than one visit for treatment, or are inpatients, in the week following their first SACT treatment post suspected or confirmed COVID-19 infection, they should be re-tested. While awaiting test results, the patient should be managed as if infectious until the swab result is confirmed negative.

1.6 If the clinician felt further SACT was necessary in less than 14 days from the onset of COVID-19 (this situation would be rare), the patient is managed as infectious until day 14, and then follow guidance points 1.1 to 1.5.

2 Patients at highest risk

2.1 Patients particularly at risk of serious COVID-19 morbidity are those with lung issues:

- they have undergone therapy that is toxic to the lungs (thoracic radiotherapy, surgery, chemotherapy) and/or
- those with pre-existing lung morbidity (previous lung damage from treatment or respiratory conditions such as COPD , pulmonary fibrosis)

3 Surgery and Pre-testing

3.1 The risks are likely to outweigh the benefits of high risk (cat III) surgery at the current time. Lower risk surgery (e.g. breast cancer surgery) does not have the same risk/ benefit profile and there is a strategic need to balance the risk of undertreating now versus increased risk of treating now. These issues are being considered in more detail.

4 Staff returning to work

4.1 Teams should work to the current model of safety to return to work, but the severity of symptoms of the staff member who had been sick should be taken into account.

- if not seriously unwell (i.e. did not require hospital admission) then staff member can return to normal duties on day 8 (defined from day of onset of first symptoms),
- if staff member has been more significantly unwell – hospital ward admission or worse, then they could be kept away from high risk patients for the first week in discussion with the service/line manager