



BASO~The Association for Cancer Surgery

at The Royal College of Surgeons of England, 35-43 Lincoln's Inn Fields, London WC2A 3PE
Telephone 020 7869 6854 Email admin@baso.org.uk
www.baso.org.uk

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BASO Guidance - Strategy for Cancer Surgery sustainability and recovery in the COVID 19 pandemic

The COVID-19 Pandemic has created unprecedented pressure on the healthcare system creating a need to conserve critical resources (e.g. ventilators, ICU beds) and to provide the PPE (Personal Protection Equipment) that is essential for protecting both patients and staff from intra-hospital transmission and unnecessary exposure.

In the COVID-19 Pandemic cancer patients are at an increased risk of contracting the viral infection both because of their underlying disease and the immunosuppression associated with the treatment they are receiving (e.g. surgery or chemotherapy). There is therefore a need to minimise the risk of cancer patients contracting the infection and of avoiding surgical complications whilst making best use of resources. This includes the protection of Health care workers involved in the delivery of their care.

This guidance intends to support front line clinicians, who are witnessing an increasing burden of COVID-19 patients, to continue providing essential cancer surgery. Cancer surgery treats life-threatening diseases, and where practicable, it should go ahead within the SAFE practice framework. This was highlighted in the "Advice on maintaining cancer treatment during the COVID-19 Response" document sent to NHS trusts on 30th March 2020 (Publications approval reference: 001559).

BASO has contributed to the NHS England document "Maintenance of Essential Cancer surgery for adults during the COVID-19 emergency". However as we have members in the devolved nations, as well as internationally, BASO has also provided a more detailed recommendation to all colleagues. The recommended BASO guidance should also be read in combination with the latest government advice regarding the practice of surgery (e.g. Clinical guide for the management of non-coronavirus patients requiring acute treatment: Cancer 23/3/2020).

Cancer Services should continue to investigate, treat and deliver care to patients. There should be plans to identify ways of delivering appropriate care to cancer patients whilst balancing the resources for the coronavirus response. These plans should also include potential situations where cancer treatments may be compromised because of factors such as staff or supply shortages. It is vital that clinicians take the lead at times of cancer services disruption in order to prioritise treatment for those in most need, using best practice. These decisions should be taken with MDT involvement and clearly communicated to patients. It is important to maintain weekly MDT meetings; ideally these should be done remotely. If a face-to-face MDT is felt to be necessary, then aim to minimise the number of staff present at the MDT in person and have other members others joining remotely. Consider a quorate membership of 1 surgeon, 1 oncologist, 1 pathologist, 1 radiologist and one cancer care nurse.



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Many tumour specific societies have provided guidance to their members on prioritising the treatment options in the current climate of the pandemic (see below). These should also be read in line with this document. Whilst most research has stopped, any initiatives that encourage quality improvement in the NHS and require data collection, observational, or potentially randomised interventional trials using innovative pragmatic governance and current technology, should be supported where practicable.

These are unprecedented times and we acknowledge the trauma the work force is facing and will be facing in the future. "Self-care" and "mental wellbeing" support is imperative. Cancer surgeons and the cancer team members have dedicated their careers to improving cancer outcomes and will now be making different types of difficult decisions. Ensuring that we seek help when needed and that we support our colleagues in distress will ensure our sustainability and ability to move into the system recovery phase.



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Phase 1: SAFE Surgery for Urgent Cancer Cases

1. Maintain capacity to under take SAFE surgery for urgent cancers at individual acute hospitals. This should include a system which allows surgeons to pool theatre capacity, lists, and surgical teams to deliver cancer surgery.
2. Decision making for surgery, resource consideration and process – team consisting of senior clinicians to help guide the management regarding clinical cancer; emergency surgery prioritisation and COVID-19 planning (e.g. Medical Director, Cancer Clinical lead (described in National guidance for cancer 23/3/20) and a clinical Director (e.g. surgeon, anaesthetist, intensivist etc). These individuals need to meet daily/more frequently to agree prioritisation of resources. This group will require operational support from management teams.
3. Cancer Clinical Lead – ideally they should have no clinical activity/on call; to coordinate processes around managing patient lists, helping decide priorities for theatre access and answering cancer related queries from management/others.
4. A triage system should be implemented to identify cancer patients who should have surgical intervention (balancing COVID risk and urgency from pathology perspective) and those who might be reasonably deferred during the COVID-19 outbreak.

The “Clinical guide for the management of non-coronavirus patients requiring acute treatment: Cancer” document dated 23/3/2020; has identified clinical priority scores for patients having systemic chemotherapy, as below. However these score can be adapted for cancer surgery:-

Table 1 Prioritising patients for systemic anticancer treatment

Priority level	Categorisation based on treatment intent and Risk: Benefit ratio of treatment
1	<ul style="list-style-type: none"> • Curative treatment with a high (>50%) chance of success • Adjuvant (or neo) therapy which adds at least 50% chance of cure to surgery or radiotherapy alone or treatment given at relapse
2	<ul style="list-style-type: none"> • Curative treatment with an intermediate (20% to 50%) chance of success • Adjuvant (or neo) therapy which adds 20 – 50% chance of cure to surgery or radiotherapy alone or treatment given at relapse
3	<ul style="list-style-type: none"> • Curative therapy of a low chance (10 – 20%) of success • Adjuvant (or neo) therapy which adds 10 – 20% chance of cure to surgery or radiotherapy alone or treatment given at relapse • Non-curative therapy with a high (>50%) chance of >1 year of life extension
4	<ul style="list-style-type: none"> • Curative therapy with a very low (0-10%) chance of success. • Adjuvant (or neo) therapy which adds a less than 10 chance of cure to surgery or radiotherapy alone or treatment given at relapse • Non-curative therapy with an intermediate (15-50%) chance of > 1 year life extension.
5	<ul style="list-style-type: none"> • Non-curative therapy with a high (>50%) chance of palliation / temporary tumour control but < 1 year life extension.
6	<ul style="list-style-type: none"> • Non-curative therapy with an intermediate (15-50%) chance of palliation or temporary tumour control and < 1 year life extension.

Table adapted from NHS England's Clinical guide for the management of non-coronavirus patients requiring acute treatment: Cancer 23 March 2020 Version 2.



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Cancer surgery on the whole falls into categories 1 and 2, but in special circumstances patients may be offered surgery for categories 3 and 4. In the current pandemic we do not recommend surgery for patients with a low chance of success or life prolongation.

Clinical priority can be scored as follows using the Categorisation of patients in the above document:

Table 2: Categorising patients for surgical cancer treatment

Priority level	Categorisation
1a	Emergency - operation needed within 24 hours to save life. This should be undertaken on the acute site, as currently.
1b	Urgent - operation needed with 72 hours. This should be undertaken on the acute site, as currently.
2	Elective surgery with the expectation of cure, prioritised to: Surgery within 4 weeks to save life or prevent progression of disease beyond operability. This should be prioritized for phase 2 (below)
3	Elective surgery can be delayed for 10-12 weeks with no predicted negative outcome. This should be prioritized for recovery phase, depending on length of pandemic.

Table adapted from NHS England's Clinical guide for the management of non-coronavirus patients requiring acute treatment: Cancer 23 March 2020 Version 2.

Patient co-morbidity and frailty should be assessed and factored into the decision-making algorithm. Patients who are at highest risk of COVID related morbidity or mortality should ideally be managed at a "COVID-19 free" clean site (see below). All new data being published should be considered when making decisions, for example information being published is indicating a 20% mortality for patients who develop post-operative COVID-19 pneumonia.

Using this guidance could make triage and resource allocation simpler and objective. This facilitates a way of summarising the variables of clinical treatment priority and post-operative patient risk based on patient frailty, co-morbidity and risk of COVID-19 related adverse outcome. Upfront discussions on escalation of treatment plans and DNAR status in patients embarking on cancer surgery will need to be considered in many of our cancer sites.

5. There needs to be a consultant led and delivered service in order to reduce the number of people in theatres and thereby to decrease risk by aerosoling. This will also free up non-consultant staff to help deal with inpatients being treated for COVID-19 complications (in accordance with PHE letter dated 28 March 2020 on PPE - publication approval reference: 001559).
6. PPE is essential for reducing unnecessary exposure and protecting patients and staff from the intra-hospital transmission. Whilst use of this should follow PHE/national guidance, new evidence is continually emerging and national guidance is undergoing regular updates.



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Phase 2: Clean Sites ("COVID-19 free") for less urgent Cancer Cases (urgent and advanced cancers) where non-surgical options

1. The effects of the COVID-19 pandemic will be long lasting; there is a need to deliver a well-coordinated cancer service for the next 6 months and probably for some time after that. It is likely that there will be a continuing need for COVID-19 patients to occupy beds in wards and in operating theatres in hospitals which have A&E departments. Clean "COVID-19 free" sites therefore need to be identified as a priority.
2. Clean (i.e. COVID-19 free) sites should be identified for delivery of SAFE care for less urgent cancer cases where non-surgical options are not feasible. Cancer Alliances and Health Boards need to identify cold "clean" sites. Each of these should ideally be a hospital without an emergency department e.g. a private hospital or a regional hospital serving 5-6 hospitals in the vicinity with appropriate facilities (e.g. including high dependency, radiology) which can act as "clean" site for the region. There may also be the option of identifying a "clean" isolated site within a large acute hospital if other options are not possible. These "clean" sites can have a dual function as an oncology hub to deliver systemic chemotherapy.
3. Staffing - Ideally there is a need for a clean site to have patients and staff that are less likely to be exposed to the infection risk. COVID-19 screening of staff should be considered. It is important that the fight against COVID works hand in glove with the fight against cancer. We recommend that each service/hospital identify 1-2, an agreed number of surgeons, to provide a "hot block" of operating for these cancer lists over a 4-6 week cycle. They would be expected to deliver and provide clinical continuity of care. Senior trainees will be valuable in the delivery of patient care. This system should limit the resource constraints on the overall staffing requirements for each hospital. Similar workforce planning will need to be undertaken for other teams e.g. anaesthetic staff, Macmillan, AHP and CNS who are imperative in cancer patients' care. It may be possible to call on recently retired colleagues to support this effort.
4. Screening and testing will need to be carried out on all patients being admitted to a designated cold clean site. This should include a careful travel and contact history using a health questionnaire administered at point of entry. This should ideally be undertaken at the pre-operative assessment clinic. In addition, patients should self-isolate 1 week before admission.
5. Assessment for COVID-19 symptoms should be carried out on a daily basis for inpatients. Patients who develop symptoms should be swabbed and moved to cohort wards for suspected or confirmed cases. Contact tracing and isolation of COVID-19 patients or staff should be prioritised.
6. Environment - theatre and ward space needs disinfection as per national guidelines. Each clinical area should have appropriate PPE as per latest national guidelines. No visitors should be allowed into clean hospitals except essential carers.
7. A clinical assessment or triage system (See Phase 1 Para 4) should be instigated. The theatre lists should be managed centrally using the administrative support from the cancer alliances or health boards.



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8. Post-operative major cancer surgery patients should be advised to follow shielding advice as they fall in this high-risk category.
9. Mitigate Risk for cancelled patients- it is essential that a risk assessment be performed on patients who have their surgery cancelled or re-scheduled. Holding treatments such as chemotherapy or loco-regional therapies should be considered wherever possible. The potential risk of progression needs to be clearly discussed with the patients and the option of early reassessment needs to be factored into the treatment plan – including giving high risk patients priority once 'business as usual' is resumed.
10. Patients need to be informed of the extra risk posed by COVID-19 as part of the informed consent process. This requires development of suitable literature.



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Phase 3: Cancer Surgery System Recovery

1. When the system returns to normal we need to identify good practice and innovations which have been introduced during the crisis (e.g. telemedicine for MDTs, follow up clinics, monitoring clinics etc).
2. Extra resources will be needed to cover diagnostic services, theatre and critical care capacity in order to allow delayed cancer treatments to be carried out without further unnecessary delay. Without this further funding there will be a greater secondary death rate because of delayed or cancelled cancer surgery. During this time new cancer cases will be presenting which will require diagnosis, investigation, assessment and treatment.
3. The key for system recovery depends on maintaining a healthy workforce (e.g. adequate PPE), bed and operative capacity.

Conclusions

The COVID-19 Pandemic has put immense strain on our healthcare system but has also led to innovation in a short period of time. It is important that surgery, as one of the few curative options for patients with solid organ tumours, is maintained throughout this crisis. The recommendations above may help commissioners with the system change that is required to respond to the current crisis.

Finally, please refer to the BASO website for updated information regarding COVID-19.

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Document Approved by: *BASO National Council*

Document is Endorsed and Supported by:

(AUGIS) Association of Upper Gastrointestinal Surgeon
(BAETS) British Association of Endocrine and Thyroid Surgeons
(BAHNO) British Association of Head and Neck Oncologists
(BGCS) British Gynaecological Cancer Society
(BOOS) British Orthopaedic Oncology Society
(BSG) British Sarcoma Group
(SCTS) Society for Cardiothoracic Society



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Speciality Association Guidelines/Statements:

UK

ABS

<https://associationofbreastsurgery.org.uk/for-members/covid-19-resources/>

ASGBI

<https://www.asgbi.org.uk/>

ACPGBI

<https://www.acpgbi.org.uk/news/considerations-for-multidisciplinary-management-of-patients-with-colorectal-cancer-during-the-covid-19-pandemic/>

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AUGIS

<https://www.augis.org/wp-content/uploads/2020/03/Advice-for-Endoscopy-Teams-during-COVID-ver-2-3-published-17032020FINAL.pdf>

<https://www.augis.org/wp-content/uploads/2020/03/Surgical-Priority-in-Oesophageal-and-Gastric-Cancer.pdf>

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BAHNO

https://www.bahno.org.uk/clinicians_area/default.aspx

BASO *

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BGCS

<https://www.bgcs.org.uk/covid-19/>

BOA

<https://www.boa.ac.uk/resources/statement-for-boa-members-on-trauma-and-orthopaedic-care-in-the-uk-during-coronavirus-pandemic.html>

BAUS

https://www.baus.org.uk/about/coronavirus_covid-19.aspx

SBNS

<https://www.sbns.org.uk/index.php/about-us/news/>

SCTS

<https://scts.org/guidance-for-surgical-support-during-covid-19/>

International

Society of Surgical Oncology

<https://www.surgonc.org/resources/covid-19-resources/>



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NHS England Guidance:

<https://www.england.nhs.uk/coronavirus/>

Other Guidance:

Macmillan

<https://www.macmillan.org.uk/coronavirus>

**BASO's recommendations (in consultation with Professor Jeffrey Tobias, Professor of Clinical Oncology, and Professor Bob Leonard, Professor of Medical Oncology) to be used in conjunction with the guidance already issued by Association of Breast Surgery (ABS) for the management of breast cancer patients during Covid-19.*

References:

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3. <https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/specialty-guide-acute-treatment-cancer-23-march-2020.pdf>
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