BAHNO statement on COVID-19

Initial guidance for head and neck cancer management during Covid-19 Pandemic
In consultation with BAHNO, ENT-UK & BAOMS
Issued 17 March 2020
Plan to be reviewed in the next 4 weeks

To: UK H&N 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, H&N surgery (depending on case mix likely represents 1x ENT and 1x OMFS), 1x clinical oncologist, 1x radiologist (with H&N specialist interest) and 1x pathologist
   - Specific AHP guidance/input should 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 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 postponed appointing (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 recruitment to studies if there are issues with capacity or safety
   - Additional guidance should be available from local R&D guidance (supported by MHRA and clinical trials unit/centres).