

Head and neck cancer and COVID-19

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General advice

- Individual treatment centres will need to adapt their strategy based upon capacity and structure
- Discuss proposed changes to current treatment pathways with your head and neck MDT. This will mean that other unforeseen consequences of COVID-19 (e.g. lack of surgical capacity) are considered and that the MDT can communicate effectively with patients.
- Use the RCR H&N Forum as a way to discuss/seek advice from colleagues
- Discuss any change to an individual treatment plan with the patient and document that discussion.
- Ensure treatment intent is clear in the patient record. In particular, ensure that patients having treatment with a high chance of cure and who become unwell have access to ITU support.
- Reduce the risk of emergency admissions – e.g. avoiding palliative chemotherapy in patients with worse PS

Curative treatment

Risks will be higher than usual, particularly for older patients and those with comorbidities who are at higher risk of serious COVID-19 infection. For example, patients with cardiovascular and metabolic illnesses have higher risks from COVID-19 infection.

- Curative treatment remains a high priority with many patients treated with the expectation of cure.
- Consider hypofractionated radiotherapy regimens to reduce the number of patient visits to hospital, to reduce the duration of treatment in order to make successful completion of treatment more likely and to reduce overall burden to radiotherapy departments. 65Gy in 30 fractions is preferable to 70Gy in 35 fractions. Prior reported series from the UK demonstrate the efficacy and safety of hypofractionated radiotherapy with 55Gy in 20 fractions over 4 weeks¹; this can be considered as an evidence-based option which would reduce treatment duration further.
- It is still reasonable to offer concurrent chemotherapy were indicated. However, this will increase overall risks of treatment. The absolute benefit of concurrent chemotherapy reduces with age² and older patients are at higher risk from developing a serious COVID-19 infection. In this group the increased risks of infection complications may outweigh the benefit of chemotherapy. Aim to limit the use of concurrent chemotherapy to those under 60 years old with good performance status and without significant comorbidity.
- Accelerated fractionation without chemotherapy (e.g. six fractions per week³) may be an option but places an increased burden of twice-daily treatments on radiotherapy departments with limited capacity and may not be feasible. A simultaneous integrated boost represents an alternative approach.

- Consider cisplatin or carboplatin concurrently. Carboplatin is associated with lower rates of emesis or acute kidney injury⁴, although randomised comparative efficacy data is lacking. Different centres are likely to have differing experiences of inpatient or outpatient cisplatin delivery and rates of subsequent admissions related to cisplatin; the ability to resource this may influence the appropriate choice of concurrent chemotherapy agent.

Adjuvant treatment

It is important to consider appropriateness/type of treatment particularly for older patients and those with comorbidities who are at higher risk of serious COVID-19 infection.

- Strongly consider omitting concomitant chemotherapy.
- Consider omitting adjuvant radiotherapy if the benefit is likely limited and may be outweighed by the risks e.g. patients with an RO resection and with minor risk factors who would normally have been considered at lower/intermediate risk of recurrence.

Palliative treatment

- Do not deliver palliative radiotherapy unless benefits clearly outweigh current risks.
- If delivering palliative radiotherapy, consider using short fractionation schedules (e.g. 25Gy in 5 fractions over 1 week, 20Gy in 5 fractions over 1 week, 30Gy in 6 fractions with IMRT over 2 weeks, or single 8Gy fraction depending upon clinical scenario)
- Consider not starting or delaying palliative chemotherapy/immunotherapy where the benefit is small and may be outweighed by the risks. Only consider starting palliative systemic therapy if progressive symptoms and if palliative radiotherapy is not more likely to achieve similar benefit.
- For patients already having palliative chemotherapy/immunotherapy, consider stopping treatment or increasing the gap between cycles. It may be appropriate to stop palliative chemotherapy after 2-4 cycles when response is limited or stable disease. Single agent chemotherapy e.g. cisplatin may be considered rather than multi-agent therapy.

Infection prevention considerations

- Patients who have had a laryngectomy/have a tracheostomy have high levels of aerosol generation and radiographers have to get close to the patient for each fraction. Patients with who have had a laryngectomy/have a tracheostomy should only be treated when staff have appropriate PPE.

Other resources of advice

[ENT UK](#) and [BAHNO](#) have both published useful advice for management of head and neck cancer during the COVID-19 pandemic.

References

1. Chan AK, Sanghera P, Choo BA et al. Hypofractionated accelerated radiotherapy with concurrent carboplatin for locally advanced squamous cell carcinoma of the head and neck. [Clin Oncology 2011 Feb;23\(1\):34-9.](#)
2. Pignon JP, le Maître A, Maillard E, Bourhis J; MACH-NC Collaborative Group. Meta-analysis of chemotherapy in head and neck cancer (MACH-NC): an update on 93 randomised trials and 17,346 patients. [Radiother Oncol. 2009 Jul;92\(1\):4-14.](#)
3. Overgaard J, Hansen HS, Specht L et al. Five compared with six fractions per week of conventional radiotherapy of squamous-cell carcinoma of head and neck: DAHANCA 6 and 7 randomised controlled trial. [Lancet. 2003 Sep 20;362\(9388\):933-40.](#)
4. Wilkins AC, Rosenfelder N, Schick U et al. Equivalence of cisplatin and carboplatin-based chemoradiation for locally advanced squamous cell carcinoma of the head and neck: a matched-pair analysis. [Oral Oncology 2013;49\(6\):615-9.](#)