

## **Lower GI response to Covid-19 outbreak**

This document was written by Oxford Colorectal Oncologists, with review by Dr Rachel Cooper, Leeds Cancer Centre. The document was based on discussions that took place on the RCR online forum '[colorectal chemotherapy in light of covid-19](#)' (RCR member login required) and summarises the similar strategies being drawn up in different centres around the UK.

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### **General principles**

- All patients currently on chemotherapy treatment, should be contacted and a decision taken regarding continuing, in view of guidelines below.
- Consider GCSF for all subsequent cycles, if patients become neutropenic while on treatment.
- All patients in whom chemotherapy / radiotherapy is continued or started, should be counselled regarding risks and advised self-isolation.
- Consultations should be performed by phone if possible.

### **Rectal cancer treatment:**

- LCRT for margin threatening disease – to be changed to Short course RT and delay, (unless there is significant pelvic wall disease and the patient is young and fit).
- Due to decreasing access to surgery, and subsequent ITU; consider SCRT as primary treatment in all patients >70 and those younger with comorbidities as ITU may not be available post op if there is a complication.
- Surgical procedures may be revised to minimise chance of post op complications (ie. Hartmans instead of anterior resection).
- Should we reach a time where surgery is not available, all rectal cancer patients could be treated with SCRT (or LCRT in the group mentioned above).
- No neoadjuvant chemotherapy prior to RT or after CRT unless patient young, fit and biology of tumour necessitates it.
- No adjuvant chemotherapy.

### **Neoadjuvant colon cancer treatment:**

- No FOXTROT style therapy
- Consider neoadjuvant chemo in young, fit patient if tumour unresectable but surgery could be considered at a future date if a response is achieved.

### **Adjuvant chemotherapy:**

Stratify patients according to age and risk/benefit of chemotherapy:

- If benefit of chemo is less than 5% absolute improvement in survival, then do not treat
- If benefit is between 5 to 10 %, **likely recommend not treating** however merits discussion eg. In young (<60yrs) fit patients who could have capecitabine alone (less bone marrow suppressing and minimal time in hospital).
- If benefit greater than 10% consider treating in young fit patients.
- No patient should receive more than 3 months CAPOX.

For example:

- Do not treat any one over the age of 70 with adjuvant therapy
- Consider anyone over 60, particularly with comorbidities, as high risk
- For T4 N0 <70y consider Capecitabine only for 6 months
- For Node +ve < 70y consider 3 months CapeOX
- No “adjuvant “ chemotherapy post metastectomy

### **Metastatic patients:**

- Treat only people in whom their disease cannot be delayed for 3 months, eg. rapidly growing, systemic symptoms of malignancy, large burden of disease. Delay wherever possible.
- Aim for break after 3 months.
- NHS England have allowed breaks off biological agents at this time to facilitate this.

### **Anal patients:**

- New patients - To continue to treat with standard radical chemoradiotherapy in view of high cure rates and severe morbidity /mortality of uncontrolled disease, provided patient fit.
- Lower threshold to consider 30Gy in 10# with chemo for poor PS patients, elderly or early stage cancer. (although the data is for 30Gy in 15fractions Hatfield et al. and Charnley et al. agreement among clinicians this is acceptable).
- Reduce follow up frequency except in patients in first 2 years post CRT who would be fit for an APR if recurred.
- If not surgeries are being performed, consider delaying follow up until pandemic over.

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