

Guidance for treatment of uro-oncology patients during COVID-19 pandemic

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Chemotherapy

- 1) Patients due to commence upfront Docetaxel chemotherapy for hormone sensitive prostate cancer should NOT start chemotherapy. This group can continue with androgen deprivation until the current COVID-19 has abated and the chemotherapy service has returned to normal
- 2) Wherever possible, patients with castrate resistant prostate cancer should be considered for alternative therapies such as Abiraterone / Enzalutamide / Ra223 etc. Chemotherapy should therefore be deferred to a later date
- 3) Stable patients on oral agents (eg Abi/Enza) should be offered 3 months' supply
- 4) Stable patients on docetaxel do not need to be reviewed in clinic every cycle, 2 cycles can be confirmed on chemocare at a time
- 5) Where docetaxel chemotherapy has already commenced or is unavoidable, then we accept that adherence to a 3-weekly schedule may not be feasible. Treatment gaps or less frequent administration (eg 4 or 5 weekly) may be required
- 6) Some patients that would normally be offered neo-adjuvant bladder chemotherapy (eg T2N0) could go straight for radiotherapy (if still available) and then be considered for adjuvant chemo at a later date instead
- 7) Consider adding GCSF to all chemotherapy that must go ahead
- 8) Prioritisation for chemotherapy cancellation should be as follows:

High Priority	Testicular Germ Cell Chemotherapy NeoAdjuvant bladder chemotherapy Bladder immunotherapy in responding patients / new PDL1+
Medium Priority	Clinical trial patients Adjuvant chemotherapy for upper tract TCC Palliative bladder chemotherapy Prostate chemotherapy already started – castrate resistant
Low priority	Prostate chemotherapy already started – hormone sensitive Prostate chemotherapy due to start – castrate resistant Prostate chemotherapy due to start – hormone sensitive

Brachytherapy

- 1) There will be limited or possibly no capacity for general anaesthetic so most or all cases may need to be performed under spinal anaesthetic
- 2) Prioritisation for cancellation should be:

Highest priority	Radical gynaecology Salvage gynaecology Prostate HDR boost in patients who have already completed
EBRT	Prostate Salvage (especially if SpaceOAR already in place) Prostate LDR Prostate HDR monotherapy
Lowest priority	Template Biopsy

External beam radiotherapy

- 1) There is minimal evidence for overall treatment time effects in prostate cancer so we should accept that treatment gaps may be inevitable and that category 1 patients should be prioritised over all prostate cases
- 2) Any prostate cancer patient receiving neo-adjuvant hormonal therapy that has not yet started RT can be deferred if necessary, until the disruption from the current COVID-19 has eased. In general there is no rush to start any prostate radiotherapy and other tumour groups should be prioritised
- 3) We should be mindful of starting any new 46Gy / 23# unless certain of brachytherapy capacity at the end of the external beam treatment
- 4) Priority for radiotherapy cancellation should be as follows:

Highest priority	Radical bladder cancer Symptomatic palliative (prostate / bladder) Radical high-risk prostate Prostate bed
Lowest priority	Radical low / intermediate risk prostate