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Guidance for Stereotactic Radiosurgery (SRS) During COVID-19 Pandemic

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SRS delivery is likely to become more complex as the COVID-19 pandemic evolves, particularly in light of changes in accessibility to neurosurgery, and with the need to carefully balance the risks and benefits of treatment for patients at risk of contracting coronavirus.

NHS England published [guidance for non-coronavirus patients with cancer](#) on 23rd March, with a framework for priority setting in oncology. Subsequently, the [NICE guideline for radiotherapy delivery](#) was published on 28th March which also provided guidance for patient prioritisation.

In line with other sub-specialist clinical oncologists who have developed advisory documents for cancer treatment during the COVID-19 pandemic, it is important for stereotactic radiosurgery providers to have an agreed approach to delivery of SRS at this time, taking the above documents into account.

Non-Malignant Lesions

In response to increasing workload, and in light of the importance of minimising risk to patients attending hospital appointments, many radiotherapy centres will now have suspended treatment for non-malignant lesions.

As per the [NICE radiotherapy guideline](#), and in line with the [Neuro-oncology guidance document](#), the recommendation is not to treat non-malignant conditions with radiotherapy unless there is an *immediate threat to life or function*.

Brain Metastases

- Local MDT judgement should be used to prioritise patients suitable for SRS using the [NICE radiotherapy framework](#).
 - If delay to treatment would lead to neurological deterioration or possible need for surgery (which may be increasingly difficult to access), treatment could be considered as priority 2, however,
 - Treatment of brain metastases, as a palliative intervention, would usually be considered as priority 4.
- Patient visits should be minimised, and duration of time at hospital should be kept as short as possible.
- For metastases <10cc, use single fraction treatment.
- Use SRS in cases where surgical resection may normally be considered, if there are limitations to neurosurgical access.
- Consider whether alternative treatments (e.g. conventional radiotherapy) may be suitable on an individual patient basis.

General Points

According to NICE guidance [Section 8 'Modifications to Usual Care'](#):

- Centres should discuss changes to standard cancer treatment pathways within their operational delivery networks. This may include discussing alternative dose fractionation schedules or radiotherapy techniques with appropriately experienced centres, if a radiotherapy technique is not available locally; and
- Centres should work with their operational delivery networks and/or cancer alliance to manage capacity issues across their area.

SRS centres may therefore be called upon by other NHS Trusts to provide advice on treating lesions with SRS – for example if surgical resection cannot be undertaken due to capacity/resource issues; referral to an SRS centre outside of the usual place of care may be sought for some patients. In this situation, careful consideration must be given to the significant risk a patient may be exposed to by travelling to another centre in the context of the COVID-19 pandemic. SRS providers should work within their specialist MDTs to agree on the most appropriate management plan for each patient taking into account their specific needs.