

RCR Guidance on the Management of Cancer Patients during an Influenza Pandemic

Board of the Faculty of Clinical Oncology
The Royal College of Radiologists

Given the uncertainties of the impact on the general population and staff within the health sector, it is difficult to have detailed and rigid planning in place. The Department of Health (DH) has issued detailed general guidance on the approach to pandemic flu:

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_080734

The Royal College of Physicians has published a very good overall document on the general approach to, and management of, a pandemic flu outbreak for hospital medical specialties.

<http://www.rcplondon.ac.uk/pubs/contents/2dafbbf5-7b36-463f-908f-33b33a740cb1.pdf>

There are two major factors to be considered in planning services for cancer services at a time of pandemic flu:

- The availability of clinical staff to maintain services
- The potential impact on patients of:
 - Attendance at hospitals increasing risk of contracting flu and possible complications
 - The impact of treatment directly increasing the risks for patients, particularly of infection.

Individual healthcare organisations have been advised to plan for pandemic flu. It seems likely that these plans will need to be flexible to respond to geographical variations and uncertain duration of the flu 'surge'. The general principles of reducing all non-essential services and elective procedures and attendances within wider healthcare organisations should allow the relative priority of cancer services to be supported. Oncologists should clearly work within DH and their individual trust policies relating to infection control and other processes and procedures.

It would be hoped that the prioritisation of the vaccination of healthcare staff would reduce the impact on staff availability as a factor but inevitably some impact is likely.

Part of the preparation for a pandemic flu surge allows for organisations to plan for a degree of prioritisation of clinical services and treatments.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098769

Cancer services and treatments are part of a complex pathway of processes and services provided by many professionals. Any particular step along that pathway may be particularly hit by staff shortages or workload pressure and individual multidisciplinary teams (MDTs) or services may need to make plans for regular and active assessments of priorities and capacity to ensure prioritised patients' treatments are not compromised.

The oncology guidance on the Royal College of Physicians website is strongly recommended and will not be duplicated in full here:

<http://www.rcplondon.ac.uk/pubs/contents/757eb1f4-dec0-4176-9ed5-2287826c214f.pdf>

A decision to cancel all routine follow-up appointments during the four-month 'surge' period and avoidance of unnecessary face-to-face contacts and use of alternatives, such as telephone consultations, are important principles.

For systemic anti-cancer treatment (SACT), the vaccination of patients and close family, primary prophylaxis against neutropenia using granulocyte colony stimulating factors (GCSF) and the consideration of alternative oral or simpler chemotherapy regimens and altered scheduling to avoid unnecessary contacts and visits should all be considered.

In making decisions on treatment, the balance of risk and benefit for individual patients needs to be assessed on a case-by-case basis, taking into account performance status and other medical conditions. The timing of adjuvant treatment, possible alternatives and consideration of delays in treatment all need to be considered as would the availability of vaccination for patients or if a patient has already had flu and is well.

Good communication and documentation of any discussions with patients and relatives relating to changes from normal practice or procedures is advisable.

For some patients, the indications for treatment and timing are not absolute, for example, low grade lymphoma and for others symptomatic metastatic disease may be a higher priority for intervention than asymptomatic treatment during the surge period. For other patients with either curative conditions or rapidly progressing conditions such as small cell lung cancer, treatment should still be a priority.

Radiotherapy

Radiotherapy may be particularly vulnerable to treatment delays and interruptions due to the multiple attendances required particularly for radical treatment courses, and the reliance of patients and relatives and hospital transport. Radiotherapy management teams will need to regularly meet to assess the impact of staffing on planning and treatment capacity and patient priorities to maintain a service. A use of extended and more flexible working hours with staff that are well may allow capacity to be maintained.

Patients already undergoing treatment courses should complete their treatment using the RCR standards and guidelines for the management of unscheduled treatment interruptions if there are any delays.

[https://www.rcr.ac.uk/docs/oncology/pdf/BFCO\(08\)6_Interruptions.pdf](https://www.rcr.ac.uk/docs/oncology/pdf/BFCO(08)6_Interruptions.pdf)

The treatment of category 1 patients and radical treatment should be prioritised. In some treatment indications, the use of hormone therapy may safely allow some treatment courses to be deferred. Neoadjuvant treatment for curable patients such as rectal cancer should be maintained.

Maintaining an emergency radiotherapy service should be prioritised.

Postoperative adjuvant radiotherapy may be deferred under conditions of major shortage of treatment capacity, based on individual patient risk. Under certain conditions, discussions with patients may even allow alternative treatment pathways to avoid a high chance of radiotherapy being necessary such as mastectomy vs. local excision + radiotherapy.

For palliative radiotherapy simpler treatment techniques and shorter fractionation should be considered.

Adrian Crellin

Registrar of Faculty of Clinical Oncology

August 2009

Citation details:

The Royal College of Radiologists. *RCR Guidance on the Management of Cancer Patients during an Influenza Pandemic*. London: The Royal College of Radiologists, 2009.

Ref No. BFCO(09)2 © The Royal College of Radiologists, August 2009.

For permission to reproduce any of the content contained herein, please email: permissions@rcr.ac.uk

This material has been produced by The Royal College of Radiologists (RCR) for use internally within the National Health Service in the United Kingdom. It is provided for use by appropriately qualified professionals, and the making of any decision regarding the applicability and suitability of the material in any particular circumstance is subject to the user's professional judgement.

While every reasonable care has been taken to ensure the accuracy of the material, RCR cannot accept any responsibility for any action taken, or not taken, on the basis of it. As publisher, RCR shall not be liable to any person for any loss or damage, which may arise from the use of any of the material. The RCR does not exclude or limit liability for death or personal injury to the extent only that the same arises as a result of the negligence of RCR, its employees, Officers, members and Fellows, or any other person contributing to the formulation of the material.