Non-melanoma skin cancer management and COVID-19 pandemic: update

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Introduction

The safety and management of cancer patients in the current severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2, COVID) pandemic is paramount. Most cancer centres have planned for contingencies. At the height of the pandemic, several scientific associations developed guidelines or recommendations to aid oncologists in their clinical practice [1]. The NICE guidelines include a series of measures to minimize face-to-face contact, e.g., offering telephone or telemedicine consultations (in particular for follow-up visits), using home delivery services for medicines and using local services for blood tests [2].

The risk of severe complications and death from COVID-19 is highest in patients who are older or who have comorbidities including immunosuppression, diabetes, cancer, or cardiopulmonary disease [3]. The prevalence of these risk factors is high in older patients who typically present with non-melanoma skin cancer. Hence, the various international committees have proposed triaging and or delaying definitive local treatments [4, 5].

At this moment, it is difficult to predict when the current outbreak will end and there is the potential for a second wave of cases over the winter period. Moreover, learning from past outbreaks and pandemics, suggests that complete eradication of a pathogen after its emergence is rarely achieved. We could see COVID coming back as an endemic cause of seasonal pneumonia with the potential to overwhelm current health- system capacity. Therefore, postponing cancer treatments might be associated with some risks, the impact on waiting times and patient outcomes [6] and competing patient- level and system- level priorities.

Hence, it is desirable that oncologists, if possible, should avoid delaying any curative interventions (systemic treatments, radiation, and surgery). There is increasing emphasis on avoiding the “distraction effect” of the pandemic i.e. risk of shifting focus away from standard clinical care to COVID-19 only care [7]. The risk to develop COVID-19 disease in the setting of oncological patients can be stratified into three scenarios: a) to prevent a patient with advanced skin cancer who is COVID-19 negative to be exposed to viral infection; b) to prevent a patient with advanced skin cancer who is COVID-19 positive to infect the health professionals; c) to prevent a patient with advanced skin cancer COVID-19 positive to infect other patients.

Adoption of proactive management and containment measures, including adherence to the international guidelines (a tiered approach to categorize patients into different priority levels to receive active cancer therapy), can help to protect healthcare workers and patients from possible contamination and enable us to choose the best therapeutic strategy for the patients [1, 8, 9].
Therefore, we sought to update the guidance for management of non-melanoma skin cancer (NMSC) patients in radiotherapy departments taking into consideration the risk patients face from both cancer and from infection.

General advice

- **Alterations in MDT functioning:** 1) One specialist for each discipline can be physically present at the MDT; 2) The room identified to hold the meeting allows to have at least 1.5 meters of distance among the participants; 3) All other participants take part through a dedicated platform that guarantees the audio-video participation of members and sharing of radiological images, photographic documentation and medical records.

- Switch from face to face outpatient clinic appointments to telephone/ video-based outpatient consultations where possible.

- Consider delivery of systemic therapies in COVID free hubs or at home and home delivery of oral treatments to avoid breaking shielding.

- These service changes underpin how the recommendations 1 and 7 of NICE NG161 on communicating with patients and modifications to usual service that can be introduced in practice for staff and patients.

- Use the RCR Skin Cancer Forum to seek advice from colleagues.

- Clearly record all changes in standard management in the patient record and document discussion with the patient / family.

Radical radiotherapy

In routine practice, there is evidence for benefit of hypo fractionated radiotherapy in NMSC. Systematic reviews have shown excellent local control rates ranging between 90 and 100% when using hypo fractionated RT in NMSC [10, 11]. A recent ASTRO practice guidelines and dose fractionation evaluation also recommended hypo-fractionation in the definitive and adjuvant settings for NMSC [12, 13].

In the current months, post-COVID-19 peak, we are likely to see an unprecedented surge in referral of NMSC patients, for consideration of RT. In order to meet the demand hypo fractionated regimes should be considered [14]. Ultra-hypo fractionation with single fraction doses of 15-18 Gy is also a reasonable option in NMSC patients with poor performance score [15].

- All definitive and adjuvant radiotherapy should be planned using hypo fractionated schedules, e.g. 32.5 Gy in 4 # instead of 35 in 5#, 40 Gy in 8# instead of 45 in 10#, 50 Gy in 15# instead of 55Gy in 20#. Consider ultra-hypo fractionation in elderly patients and/ or patients with poor performance score.

- Special consideration needs to be given to immunocompromised patients, including post-transplant, in whom the risk of contracting the virus and developing COVID-19 is
substantial. Carefully weigh benefit of postoperative radiotherapy versus the risk of exposure to the virus and consider deferred radiotherapy or close clinical monitoring, particularly in closely excised lesions.

- Consider using HDR brachytherapy (applicators/flaps/surface moulds), where facilities and expertise exist, as it potentially allows treatment over shorter duration of time [16].

Palliative treatment

Palliative radiotherapy

- Palliative radiotherapy should only be delivered where the benefits clearly outweigh current risks.

- Currently palliative radiotherapy is regarded as priority 4, where “alleviation of symptoms would reduce the burden on other healthcare services”. Consider using single fraction or shorter fractionated schedules, depending on the clinical scenario

- Metastatic spinal cord compression is priority 2 (“urgent palliative radiotherapy in patients with malignant spinal cord compression who have useful salvageable neurological function”). Departments should consider how they will deliver radiotherapy to NMSC patients who are Covid-19 positive, or suspected on clinical grounds.

- Consider Stereotactic radiotherapy (SABR) for patients with oligometastases. SABR is being rolled out across England to further reduce the burden on other treatment modalities and reduce travel for patients [17].

- For palliative radiotherapy consider 20Gy in 4# instead of 20Gy in 5#, 30Gy in 8# instead of 30 in 10# or single fraction of 8-10 Gy (e.g. in bleeding or fungating disease).

Palliative systemic treatment

Individuals with cancer, especially those who are receiving systemic anticancer treatments, are deemed to be at an increased risk of mortality from COVID-19. However, there is emerging evidence to suggest that cancer plus COVID-19 mortality is principally driven by advancing age and the presence of other non-cancer comorbidities.

Immunotherapy has been postulated to protect from infection as its immune mechanism is similar to those involved in the immune response against viral infections [18]. Other considerations for use of immunotherapy are: systemic steroids used for immune mediated toxicity could hamper the immune response against the virus, The interstitial pattern of immune mediated pneumonitis mimics COVID pneumonia making it difficult to differentiate between the two [19]. A recent meta-analysis of clinical trials of critically ill patients with COVID-19, has shown a lower 28-day all-cause mortality with use of systemic corticosteroids, compared with usual care or placebo [20].

In a UK wide prospective cohort study, Lee et al have concluded that withholding effective cancer treatments from many cancer patients during the pandemic runs the risk of
increasing cancer morbidity and mortality, much more so than COVID-19 itself. They have reported no significant effect on mortality for patients treated with immunotherapy, hormonal therapy, targeted therapy and radiotherapy use [21]. Similar reassuring findings have been reported from Italy [22].

- Consider starting cemiplimab or avelumab in patients with advanced cSCC and Merkel cell carcinoma, respectively.

- In some patients best supportive care may be the most appropriate management.

Other resources of advice

BAD  http://www.bad.org.uk/healthcare-professionals/covid-19


References


