

Non-melanoma skin cancer (NMSC) and COVID-19

Authors: Agata Rembielak, Andrew Sykes, Kate Fife, Amarnath Challapalli and Jenny Nobes

The current COVID-19 pandemic is an unprecedented living memory and is affecting everyone, including our patients. It is increasingly important to provide the optimal management for patients with different non melanoma skin cancers (NMSC). NMSC cancer surgery has almost completely ceased over the recent weeks. This is affecting already overstretched radiotherapy departments, with increasing numbers of patients being referred for definitive radiotherapy. Capacity and demand analysis and forecasting is taking place almost daily in radiotherapy departments across the UK in an attempt to manage this. We have put together the following guidance for management of NMSC patients in radiotherapy department taking into consideration the risk patients face from both cancer and from infection.

General advice

- Many patients diagnosed with NMSC are elderly and frail with multiple comorbidities. Most patients who present with BCC pathology usually have a long standing condition and are asymptomatic, or only mildly symptomatic, from their NMSC. In view of the real threat from the coronavirus, particularly in elderly patients and/or with co-morbidities, including life threatening condition, their treatment with radiation should be deferred for at least 3–4 months, pending further review of the situation.
- Individual treatment centres should follow the recently published “COVID-19 rapid guideline: delivery of radiotherapy” guidelines and adapt their strategy based upon staffing, capacity and structure. <https://www.nice.org.uk/guidance/NG162>.
- Discuss proposed changes to current treatment pathways within your Skin LMDTs and SMDTs and communicate effectively with the colleagues and patients any unforeseen consequences of COVID-19.
- 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

- All radiotherapy treatments for BCC, definitive and postoperative, including incompletely excised should be halted during the COVID-19 pandemic.
- SCC, MCC and rare skin pathologies - definitive treatment should be considered for radiotherapy (priority 1 to 3) with modified fractionation, if possible.

- SCC, MCC and rare skin pathologies incompletely excised should be considered for deferred radiotherapy in 2-3 months. These patients are generally elderly and should avoid hospitals wherever possible.
- 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 omitting adjuvant radiotherapy where the benefit is likely to be limited and may be outweighed by the risks e.g. patients with closely excised cSCC <1 mm or with minor risk factors who would normally have been considered at lower/intermediate risk of recurrence (Priority 5).
- Patients with closely excised SCCs at high risk of recurrence could have clinical review by referring surgeon / dermatologist in 3-4 months regarding possibility of further surgery or adjuvant radiotherapy.
- Consider hypofractionated radiotherapy regimens to reduce the number of patient visits to hospital. This will reduce the risk of exposure to the virus for both patient and staff and reduces overall burden to radiotherapy departments 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#.

Palliative treatment

- 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.
- Carefully consider the risk benefit of palliative immunotherapy or chemotherapy in patients with metastatic or recurrent NMSC and discuss with patients on an individual basis. In some patients presenting with metastatic SCC or Merkel cell cancer, it may be reasonable to wait for a few months before starting cemiplimab or avelumab. However, in some patients with aggressive disease it may be necessary to start in

spite of the risks, as the authors appreciate that a substantial number of patients get long term control of their advanced SCC or MCC.

- The need for systemic steroids in single agent PD1 / PDL1 inhibitors is relatively low. Main risk poses repeated visits to hospital and theoretical risk of increased cytokine response to COVID-19 (no data currently available). In some patients best supportive care may be the most appropriate treatment given the circumstances.
- For patients already receiving palliative immunotherapy or chemotherapy, consider stopping treatment or increasing the gap between cycles given the risk of the virus infection and immune status of the patients. NICE guidance has recently relaxed the 12 week break rule allowing patient who had break of more than 12 weeks can still restart their treatment. <https://www.nice.org.uk/guidance/ng161/chapter/7-Modifications-to-usual-service>

Other resources of advice

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

BAOMS https://www.baoms.org.uk/professionals/omfs_and_covid-19.aspx

BAPRAS <http://www.bapras.org.uk/media-government/news-and-views/view/covid-19-bapras-secretariat-update>

References

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<https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/specialty-guide-acute-treatment-cancer-23-march-2020.pdf>
2. Zaorsky NG, Lee CT, Zhang E, Keith SW, Galloway TJ. Hypofractionated radiation therapy for basal and squamous cell skin cancer: A meta-analysis. *Radiother Oncol.* 2017 Oct;125(1):13-20.