

Adult Neuro-Oncology Service Provision during COVID-19 outbreak

These are extremely difficult times for everyone in the health service. Although our aim would be to run a neuro-oncology service, it is unlikely that we are going to be able to do this in the coming weeks / months. With the potential shortage of medical staff and theatres, we are all going to have to adapt and prioritise the order in which brain tumour patients receive surgical and oncological treatment.

Triage of referrals and change to treatment are likely to be necessary. This document provides a framework for how to implement the measures locally. It is important to clearly document the rationale for all clinical decisions made. As the situation is rapidly evolving and we advise following national guidance as it develops.

At a glance - guidance for clinicians

- Stop all out-patient face to face contact except for new patients with malignant tumours and /or patients that need urgent surgery
- Use letter, e-mail, phone, or teleconsultation instead
- Reserve surgery for urgent cases and minimize length of stay (day case, single night stay)
- Minimize and triage chemo and radiotherapy for those most likely to benefit
- Maintain MDT but reduce attendance to key decision makers
- Record the reasons why you are not offering standard treatment to patients
- Continue to support all patients even those who may now not get treatment

Triage all referrals

- See only referrals where there is MRI confirmation of malignant brain tumours, providing there are staff to run clinics.
- Write to or phone referrals with MRI confirmation of non-malignant brain tumours e.g. meningioma, vestibular schwannoma
- Use non face-to-face consultation where possible and minimise hospital visits

New Brain Tumour Patients

High surgical priority

- Reduce impact on in-patient resources by using day-case surgery where possible (e.g. biopsy, selected craniotomy) and short-stay overnight surgery for all other routine oncology procedures without admission to critical care (unless ventilation or respiratory support required or invasive monitoring)

- Resection of malignant glioma in patients suitable for adjuvant oncology treatment
- Posterior fossa tumours (malignant or non-malignant) causing symptomatic or life-threatening hydrocephalus
- Meningioma causing major mass effect and neurology (e.g. hemiparesis) or which are life-threatening
- Supratentorial symptomatic brain metastases
- Rare brain tumours (e.g. lateral / third ventricle, pineal) causing hydrocephalus – consider temporising measures such as ETV or VP shunt and delaying definitive surgery (exceptions are germ cell tumours and pineoblastoma)
- Consider non-operative approaches in patients least likely to gain significant benefit from treatment e.g. elderly patients with clear diagnosis of high-grade glioma on MRI (e.g. best supportive care).

Low surgical priority – consider postponement

- Low grade glioma (resection and biopsy) where a period of interval monitoring with MRI is a reasonable management option (in the likely event of 3-6 months delay consider adding in a 3-month interval scan to ensure no tumour progression, if not already done)
- Skull base tumours (e.g. meningioma, vestibular schwannoma) with minimal symptoms where an elective scheduled procedure was already planned

Oncology high priority

- High grade glioma for treatment with radiotherapy and chemotherapy – consider reducing course and fractions of treatment where this will not significantly worsen prognosis. Consider increasing use of oral chemotherapy rather than regimes that require IV administration.
- Chemotherapy may be omitted in MGMT unmethylated glioblastoma patients
- Brain metastases for stereotactic radiosurgery or whole brain radiotherapy
- Radiotherapy for other rare malignant tumour (e.g. anaplastic astrocytoma, pineoblastoma, PNET)

Oncology low priority - consider postponement

- Radiotherapy and chemotherapy for low grade glioma where an initial period of monitoring is a reasonable option
- Radiotherapy for atypical meningioma or recurrent meningioma

Follow up brain tumour patients

- Continue follow-up for malignant brain tumours but consider reducing face-to-face reviews where possible – use email, telephone, skype instead
- Stop patients attending clinics for routine review of non-malignant brain tumours.
- Postpone appointments where appropriate and introduce telephone reviews for those where review is required

Non-malignant brain tumours

- No surgery for non-malignant, asymptomatic (or minimally symptomatic) brain tumours to be performed as elective services close.

MDT Meetings

- Maintain weekly MDT; can be done remotely if needed. Aim to minimise the number of staff present at the MDT to senior decision makers only. Limit to 2 surgeons, 2 oncologists, 1 radiologist, 1 pathologist, co-ordinator and 1 specialist nurse maximum.

Research Activity

- NIHR CRN advice is that studies addressing the COVID-19 pandemic are being prioritised. It is likely that recruitment into brain tumour trials will be suspended for the foreseeable future

Also

- Liaise with other disciplines
- Liaise with your colleagues regarding the feasibility and practicality of providing radiotherapy, chemotherapy and targeted treatments and adapt your service appropriately
- Liaise with your radiology colleagues regarding post treatment surveillance MRI
- To reduce the need for patients to attend GP surgery
 - Consider providing 4-8 weeks of medication on discharge
 - Consider absorbable subcuticular sutures for scalp closure

Clearly there is a hierarchy of need, and how many of these measures need to be implemented will be dependent upon how severe the pandemic is and what the local capacity is. Please keep up to date with both local and national advice.