

17B. Cancer Care



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Guidelines for Clinical Care of Patients with Cancer During an Influenza Pandemic



Cancer Service Planning Assumptions

This plan is for cancer patients who do not have influenza but require cancer treatment and/or services.

The process for patients with influenza symptoms or urgent medical (non cancer) issues will be as per the local hospital pandemic plan.

(For general planning assumptions for an influenza pandemic, see OHPIP Chapter 3.)

Clinical Programs

These consist of:

1. Screening Programs
 - Ontario Breast Screening Program
 - Familial Oncology / Genetics Clinics
2. Palliative Care Program
3. Radiation Treatment Program
4. Surgical Oncology Program
5. Systemic Therapy Program

Preamble

A system to determine a priority for consultation and treatment of patients with cancer is necessary to have a consistent approach across the province. It is important to avoid, as far as possible, having different levels of care. Currently there are no disease specific influenza pandemic plans available. A cancer patient priority classification has been developed by the clinical programs to assist cancer programs in the management of patients referred with a cancer diagnosis.

Local or regional circumstances and the availability of resources may influence a cancer program's ability to follow the criteria. If some regions are hit harder than others, a re-referral system is recommended for patients with potentially life-threatening or rapidly progressing curable cancers.

There is a definite possibility that centres will have the capacity to treat only a small proportion of patients, so an ethical framework for decision making is required.

Ethics Guidelines

In a situation of very limited human resources the *principle of justice* will be the prominent principle to which one will appeal within a context of *respect for the patient's autonomy* (respecting the patient's wishes regarding his or her treatment), *beneficence* (doing good for the patient) and *non-maleficence* (not harming the patient unnecessarily). The principle of justice, which connotes treating people fairly, was first articulated by Aristotle as "Equals ought to be treated equally and unequals unequally." Whereas everyone is morally equal, not everyone is equal in some other ways. For instance, children of very wealthy parents are less likely to need government help in paying for their education. People who are well need less medical care than those who are sick. Someone with a cold and sore throat in the ER ought not to be seen before the person with chest pain because his need is, in all probability, less than the person who may be having a myocardial infarct. Our criterion for deciding who is "more or

less" equal in medical care is *need* and *efficacy of treatment*. In some instances this is very easy to determine – and in some instances, not at all easy. In the situation of cancer care, many have a life threatening condition and therefore can be argued to be in equal need. However, even within the context of cancer there are some who can reasonably wait longer than others for care.

Priority Classification of Cancer Care Needs

In this document we are offering a priority classification in which justice is used as the essential principle to which one appeals, with *need* and *efficacy of treatment* used to determine the terms under which patients are treated, where they are treated and when they are treated.

Priority A defines those whose needs are deemed critical, whose condition is immediately life threatening, and for whom treatment is available. Their immediate need is greatest and we must find ways (either in the geographic area of the pandemic or elsewhere) where treatment can be instituted or continued.

Priority B defines those whose needs are deemed to be non-life threatening and for whom services can be deferred during a pandemic wave (6-8 weeks). Physicians will determine that these patients are not put at undue risk. If their priority changes they will be moved to priority A and treated at a cancer centre somewhere in the province or country.

Priority C defines those for whom services may be discontinued for the duration of the pandemic. These patients are, for the most part, undergoing routine follow-up or screening and can reasonably wait until the pandemic is over.

It is the ethical responsibility of the

practitioner, often with consultation, to fairly evaluate individual patients using the fundamental criteria of need and efficacy of treatment to categorize him or her as Priority A, B, or C.

It is the ethical responsibility of the clinical subcommittee of the CCO Pandemic Planning Committee to fairly evaluate programs using these same criteria to determine their standings as Priority A, B, or C

Appeals of decisions regarding prioritization of patients or programs will be decided by a local appeals committee made up of: the Medical Director, the relevant Program Director, a bioethicist if available, and others relevant to the particular decision.

It is anticipated that each wave of the pandemic will occur in a particular geographic area so that other area cancer clinics and hospitals will be utilized for Priority A patients when necessary. In the event of a wide spread pandemic where this is not possible, the same criteria will be used to prioritize but even all Priority A patients may not receive prompt treatment.

Table 17B.1: Cancer Patient Priority Classification

| Priority | Description | Examples |
|--------------------------|---|--|
| <p>Priority A</p> | <p>Patients who are deemed critical and require services/treatment even in the event of a pandemic because their situation is immediately life threatening. The following is a list of situations in which patients need priority assessment. Such patients may need admission depending upon resources and the severity of the condition. The list is not limited to these situations. The important factor is that a patient has a condition that is potentially life-threatening.</p> | <ul style="list-style-type: none"> • Spinal cord compression requiring emergency MRI and radiation oncology consultation and ongoing symptom management • Superior vena cava (SVC) syndrome, requiring radiation oncology consultation • Pathologic fractures of an anatomical location requiring orthopedic assessment regarding fracture stabilization, radiation oncology consultation, and ongoing pain management • Acute and massive GI bleed or hemoptysis – requiring aggressive analgesic and anxiolytic admission, possible investigation to identify source of bleeding, possible radiation oncology consultation depending on site and etiology of the bleed • New onset, acute delirium – probably requiring assessment of patient to determine etiology and appropriate treatment of delirium • Acute, new onset or progressive dyspnea – requiring assessment; depending on etiology and performance status, the patient may need radiation, thoracentesis, chest tube drainage, possibly pleurodesis, and possibly palliative chemotherapy, or, if intervention is not appropriate or possible, then symptomatic management of dyspnea will be needed • Malignant bowel obstruction or bowel perforation – requiring assessment and alleviation of acute symptoms, may need radiology services, and may need nasogastric tube (NGT) decompression of G-tube or surgical decompression • Septic shock • Metabolic crisis – hypo- and hypercalcemia • Acute pain crisis – requiring assessment to determine etiology of acute pain and initiate appropriate pain control measures • Rapidly progressing tumours such as brain, acute leukemia, aggressive lymphomas, and some head and neck cancers require assessment. Such patients may have priority for ambulatory radiation or chemotherapy if their cancer is potentially curable |
| <p>Priority B</p> | <p>Patients who require services/treatment but whose situation is deemed non-life threatening; in the event of a pandemic, services/treatment could be discontinued for the period of the pandemic wave (6-8 weeks).</p> | <p>Within Priority B, sub-categories of patients will emerge – patients would receive services/ treatment based on availability of resources and anticipated clinical outcomes (i.e., potential for cure adversely affected by delay in treatment; risk to patient if he or she develops influenza during treatment)</p> |
| <p>Priority C</p> | <p>Patients whose condition is deemed non-life threatening and for whom services can be discontinued for the duration of the pandemic.</p> | <ul style="list-style-type: none"> • Ontario Breast Screening Program • Familial oncology/ genetics clinics • Well follow-up clinics • Non melanoma skin clinics • Prevention clinics |

Clinical Program Criteria for Classifying Patient Needs

1) Screening Programs

a) Ontario Breast Screening Program

Most Ontario Breast Screening Program (OBSP) clients can be deferred for the entire pandemic since screening activities for the healthy population would not be recommended while there is pandemic activity in the province. Only previously screened clients with highly suspicious findings or an abnormal screening result in mammography requiring assessment should be seen. The feasibility of an assessment during the 6–8 weeks of a pandemic wave will depend upon availability of resources.

Priority A: There are no Priority A patients.

Priority B: Patients already screened who have highly suspicious findings. Clients who have an abnormal screening result on mammography requiring assessment are unlikely to be seen until the pandemic wave is over, unless staffing is unaffected.

Priority C: From the start of the pandemic, all booked screening clients. They do not need screening until the pandemic is over.

b) Familial Oncology / Genetics Clinics

Priority C: From the start of the pandemic, all familial oncology/genetics clinics.

2) Palliative Care Program

The Palliative Performance Scale (PPS) and the Edmonton Symptom Assessment System (ESAS) will be used as a screening tool to classify patients into priorities A, B and C.

The PPS is a reliable and valid tool used for palliative care patients. The PPS is

divided into 11 categories that are measured in 10% decremental stages (100% to 0%). These categories are organized into three stages: 1) Stable, 2) Transitional and 3) End-of-Life. The PPS provides a framework for measuring progressive decline over the course of illness.

The ESAS is a valid and reliable self-assessment tool to assist in the assessment of nine common symptoms experienced by cancer patients. The tool is designed to assist in the assessment of: pain, tiredness, nausea, depression, anxiety, drowsiness, appetite, well-being and shortness of breath. The severity at the time of assessment of each symptom is rated from 0 to 10 on a numerical scale, with 0 meaning that the symptom is absent and 10 that it is the worst possible severity.

Selected ESAS scores such as pain, nausea and dyspnea can also be used to identify an oncology emergency that requires urgent attention. The PPS can be used to help identify which patients should be seen in a clinic or a home visit. When utilizing the ESAS and PPS tools, the emphasis may have to be on the change in a patient's scores with time rather than the absolute scores.

Priority A:

- Emergent palliative care symptoms in high functioning patient (PPS >60–70).
- Any PPS score with an oncologic emergency
- Any selected ESAS >7/10

Priority B

- Moderate problems with pain management necessitating medication adjustment – minor to moderate dose adjustments or switching of opioids could be done by telephone

communication by the MD or visiting RN (in consultation with the MD as necessary). Home visits or outpatient clinic appointments may be needed

- Ascites – managed in the home setting or outpatient clinic with the use of diuretics and possible paracentesis as needed.

GI complaints such as nausea and constipation can be managed with telephone consultations most of the time (e.g., utilize CCO Telephone Nursing Practice and Symptom Management Guidelines). See:
<http://www.cancercare.on.ca/NursingTelephonePracticeGuidelines.pdf>.

- Anxiety and depression can initially be managed by a home assessment by visiting RN or by MD, and follow-ups thereafter can be done by phone. If concerned regarding the status of the patient, then the RN or MD will need to make another home visit
- Patients with bony metastases or possible pulmonary embolus/deep vein thrombosis (PE/DVT) based on clinical judgment alone and PPS <30 if ESAS scores <5
- Caregiver stress and burnout could be managed and facilitated through the use of hospice volunteers.

Priority C: Palliative patients with ESAS scores <3 who are stable.

3) Radiation Treatment Program

All Radiation Programs in Ontario have explicit or implicit prioritization and wait list management systems in place. These should be reviewed regularly, documented and discussed with local disease site teams. These have been developed due to the chronic shortfall in consultation and radiation planning and

treatment capacity over many years. The efficacy of these systems is demonstrated by the Cancer Care Ontario internal wait time data and publicly posted wait times (see CCO website:

<http://www.cancercare.on.ca>), which show that some types of cancer (such as head and neck, lung and GI) are treated sooner than others (such as adjuvant treatment for breast cancer). These prioritization and wait list management systems will be beneficial when dealing with capacity shortfalls during a pandemic. The local Radiation Program prioritization criteria, as well as the CCO Priority Categories (1, 2 and 3) would determine in which priority category (A, B or C) patients will be classified (see below)

It should be possible to determine at the time of consultation whether the risks of the pandemic infection outweigh the risks of delaying treatment for that individual patient. It should be noted that a delay in instituting radiation treatment should be as short as possible and that evidence suggests that there is no safe delay period, so that the decision rests on an assessment of relative risks for an individual patient

Patients on follow up should be grouped into low and high risk and the low risk patients rescheduled to an appointment after the pandemic is over.

Priority A: CCO Priority Categories 1 and 2

- All emergency and urgent patients where alternative management to radiotherapy is not possible (e.g., patients with cord compression not amenable to surgery) would need to be treated, but patients with bone pain might be able to be managed temporarily with adjustments to pain medication

- Patients with rapidly progressing, potentially curable tumours
- Patients already on treatment.

For Priority A patients, there would need to be sufficient staff in all departments / professional groups (radiation oncologists, radiation therapists, medical physics, nursing and support staff) within the radiation program to achieve safe quality consultation, planning and treatment. Staff should not be pulled to work in other parts of the hospital. They are needed for Priority B as well as Priority A patients, because in principle we would want to treat as many patients as possible, as the outcome of patients with cancer will be affected by delays in treatment.

Priority B: CCO Priority Category 3

- All other patients with cancer needing radiotherapy. Within this priority level, subcategories would be determined using the local priority methodology (as described above). Patients should be followed by telephone where possible to ensure they have not progressed to Priority A.

Priority C: Includes the rare patient with benign disease needing radiation treatment, such as pituitary adenoma and meningioma. It may be possible to delay these cases until the pandemic is over. Referral information should be reviewed and a decision made as to whether their consultation can be delayed.

Patients on follow up should be grouped into low risk and high risk, and the low risk patients rescheduled to an appointment after the pandemic is over. Telephone follow up for high risk cases should be utilized as far as possible.

4) Surgical Oncology Program

Overall criteria for surgical oncology

priorities are:

Priority A: Patients in whom a delay in surgery would result in either an immediate threat to life or limb, or would significantly alter the patient's prognosis (CCO Priority Categories 1 and 2, emergent and very aggressive tumours).

- Patients with obstructions, bleeding or perforations
- Slightly less urgent (B+) patients would be those with a narrow window of opportunity for definitive surgery, such as those who have been on neoadjuvant protocols. A significant delay for the neoadjuvant patients could negatively impact on their outcome by allowing for recovery of residual cancer and thus losing the benefit invested in the neoadjuvant approach.

Management of a Priority A case would require preoperative laboratory work up and radiology services as well as medical consultation in some cases (e.g., cardiology and respiratory specialist availability). Surgery itself requires anesthesiology staff, surgeon and assistant, operating room nursing, pathology services, recovery room nursing, and inpatient care nursing. As Priority A patients will represent the sickest of our population, there will be requirements for ICU and step down care for post operative management of some of these patients. A functioning operating room will require some level of ongoing support from the hospital's material management and services sections (sterilizing and processing instruments, etc.). Capacity to undertake care of Priority A patients may be severely limited due to lack of ICU and inpatient beds. Focus may be for life-threatening situations for patients with potentially

curable cancers.

Priority B: Individuals for whom a delay of a number of weeks would not be anticipated to have an impact on survival or outcome (CCO Priority Category 3).

- Most solid tumour cases (e.g., breast, colon, lung, genitourinary [GU], gynecological, head and neck, gastrointestinal [GI]) – provided delays were in the range of weeks.

Priority B patients would have to be followed, as excessive delay, evidence of unexpected progression, or the onset of symptoms (e.g., bleeding, obstruction) would mandate reclassifying as Priority A.

Priority C: People for whom a delay of months would be unlikely to affect outcome (CCO Priority Category 4).

- indolent tumours
- well differentiated thyroid cancers, early prostate cancers and non melanoma skin cancers.

The ability to undertake cancer surgery that requires inpatient care will depend on the availability of beds for surgical patients (many beds may be occupied by symptomatic influenza patients and few, if any, ICU beds available) as well as staff and support services to manage these patients.

Wait lists will require regular review to determine priorities in light of bed and resource availability.

In critical bed and resource situations, the surgical priority may need to be on life-saving procedures for those patients whose long-term prognosis for survival from cancer is good.

Outpatient cancer surgery for Priority A or B patients should be included in hospital plans, if resources are available.

Hospitals may plan to discontinue most outpatient surgery, as it is not urgent.

5) Systemic Therapy

New patients who fall into Priority A should continue to be seen to determine if treatment is urgent/curative. Local disease site teams will determine which patients are deemed curative and/or urgent (CCO Priority Categories 1 and 2).

New patients who fall into Priority B can be deferred for several weeks. A mechanism is required (e.g., by phone) to ascertain that new problems have not developed if the decision is not to treat urgently, and for patients to contact the treatment centre to be assessed if problems arise (CCO Priority Category 3).

In situations where there are insufficient resources to treat all curative and/or urgent cases, patients with life-threatening symptoms who have potentially curable cancers will be given priority.

Priority A: CCO Priority Categories 1 and 2)

- Those patients being treated who have aggressive tumours, e.g., some leukemias, lymphomas, tumours of the central nervous system, or transplant
- Patients with life-threatening situations, e.g., leukemic leucostasis, or medical emergencies such as febrile neutropenia and hypercalcemia
- Some patients already receiving treatment

In situations where there are no hospital beds, ambulatory treatment strategies may be required in situations where inpatient care is the normal approach.

Priority B: CCO Priority Category 3

- The majority of patients requiring chemotherapy (who are not Priority A or C). Recognizing that there are little to no data supporting long delays, this will be a judgment call for each new patient
- Patients already receiving therapy will need to be assessed as to whether they require ongoing treatment (Priority A) or can possibly wait weeks before continuing treatment.

Priority C

- Patients receiving oral hormone therapy, especially in the adjuvant setting
- Well follow-up patients
- Patients on IV bisphosphonates, if that is the only IV treatment required.

Unless there is a life-threatening situation, patients who exhibit influenza symptoms will not be treated with chemotherapy.

Criteria to determine whether a program/service should cease operating

1. Ontario Breast Screening Program

Cancellation of all breast screening services, since screening is elective and targets well women.

2. Palliative Care Program

The primary issue when planning for an influenza pandemic is the issue of human resource management. A screening tool would be required to triage patients by telephone. It would be important to identify which patients need to be seen and which patients could be managed via telephone. The telephone will have to be utilized more in the event of a flu pandemic.

In the event of a flu pandemic resulting in limited resources (e.g., physicians, community nurses, and hospital beds), using unoccupied hospital outpatient clinic space (most ambulatory clinics will be closed during the pandemic wave) may have to be considered. This might help to ensure higher efficiency for staff, while utilizing fewer nurses and physicians. The clinic could be supplied with “holding beds” and nasogastric tubes, etc., for use until the patient is stabilized and sent back home. Patients with PPS>60% could be seen in the expanded clinic for assessment. For patients with PPS<50%, consider using symptom response kits in a somewhat expanded version. These would be equipped with the necessities to manage a pain crisis in the home (e.g., subcutaneous [sq] meds, nasogastric tube for bowel obstruction, expanded sq meds). Telephone triage could be used to determine if a home visit is necessary.

3. Radiation Treatment Program

If there are insufficient staff in any department or professional group to ensure safe and quality planning and treatment, and if other professional groups are unable to cover this work, then that aspect of care would need to cease. Radiation planning and treatment is a multiple-step and complex process, so disruption of any aspect can cause complete cessation of care. Re-referral of patients to other centres may be an option, depending on the extent of the pandemic and regional access.

4. Surgical Oncology Program

Purely elective procedures and screening procedures (elective screening endoscopy) should be put on hold. Examples of services that would be suspended are elective joint replacements, elective general surgery (non-incarcerated hernias,

non-acute gallbladders), and cosmetic surgery. Essentially all non-urgent and non cancer surgery should come to a standstill until urgent and cancer cases are looked after, and the post pandemic cancer backlog is addressed.

5. Systemic Therapy Program

The program would cease to function if insufficient staff were available to ensure that all safety standards would be met.

Cancer Program Operational Recommendations

Symptomatic patients

A process is necessary to determine whether patients booked for the next day's clinic have 'flu symptoms' for which they will be advised to follow the hospital's process for patients with respiratory symptoms. Patients with influenza will not attend a clinic.

To protect staff and other patients, a protocol will be necessary for those patients attending a clinic who have respiratory symptoms thought to be cancer related or a treatment side effect, in case the patient does have influenza.

Cancellations

- Follow-up patients for visits greater than six months
- Non melanoma skin clinics
- Familial oncology clinics
- Prevention clinics
- Program Priority C patients and OBSP clients.

New patients

A triage process for new patient referral is necessary.

A process should be established to review referrals following their receipt at the

cancer centre to determine priority A, B or C.

Priority A patients should be contacted with an appointment. If resources are not available, patients should be treated as per Priority B protocols.

Priority B patients should be contacted by an individual responsible for triage (preferably an oncologist or a nurse) to undertake a phone consultation and to explain process for appointments. Patients should be put onto a list and informed that they will be contacted again for an appointment. It will be necessary to verify referral information and provide the patient with a number to call if the clinical condition changes.

Each centre should determine how the triage will work within their organization depending upon their available resources.

Treatment patients

Where possible, patients already on treatment should continue therapy.

Patients in Priority A should be treated.

Waiting lists should be created for Priority B patients requiring treatment.

Patients should be contacted by a triage nurse to discuss the situation; treatment should be initiated as soon as feasible.

As treatment slots become available, patients on the 'waiting list' should be contacted. Patients should be given a telephone number to call in the event that their condition changes.

Discussion should occur with the patient regarding the balance between any delay in initiating treatment versus the adverse effect of contracting flu with risk of complications if the patient is immunocompromised by the therapy (especially chemotherapy).

A cancer telehealth line

A cancer telehealth line should be set up in each centre and staffed appropriately for patients to call if they have any questions.

a) patients with life-threatening and potentially curable cancers, and

b) patients who have waited longer than 12 weeks for radiation or systemic therapy.

Patient communication

It will be up to organizations to determine how they prefer to deliver a message to patients. It is suggested that there be direct communication to patients as well as a letter.

It is recommended there be a phone call to patients conveying key messages.

The individual handling triage should call the patients who have been waiting four weeks, and complete an assessment over the phone to determine whether it is appropriate to continue the wait for treatment.

Key messages for patients

- Your referral has been received.
- There is a process to triage referrals; you will be contacted with an appointment.
- You will be put on a waiting list. You will be assigned to a priority. [Note: It is not necessary to provide patients with too much detail regarding where they fit into the priority system; instead, inform patients that the priority is determined based on the safest approach for patients.]
- You should call us at X telephone number if your condition changes.

Re-referral

If there is a regional disparity in the impact of the pandemic on a cancer program's ability to see and treat patients, a re-referral process is recommended. Cancer Care Ontario will establish a re-referral process for: