FRENCH CONSENSUS ON MANAGEMENT OF HEAD AND NECK CANCER SURGERY DURING COVID-19 PANDEMIC

GUIDELINES OF CLINICAL PRACTICE OF THE FRENCH SOCIETY OF HEAD AND NECK CARCINOLOGY AND OF THE FRENCH SOCIETY OF OTORHINOLARYNGOLOGY, HEAD AND NECK SURGERY (SFORL)

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1. Surgery

- The rule is to limit surgical indications as much as possible, taking into account: the degree of urgency, the difficulty of the surgery, the risk of contaminating the nursing team (tracheotomy) and the local situation (whether or not the hospital and intensive care services are overstretched).

- Three **groups of patients can be defined**, based on the treatment timescale:
    - **Group A**: life-threatening emergency (shortness of breath, haemorrhage)
        - Immediate treatment
        - If possible: screening with RT-PCR -based detection of SARS-Cov-2 from nasopharyngeal swabs + chest CT-scan less than 24 hours before surgery
        - If this preoperative work-up cannot be done, the patient must be regarded as COVID-positive and the appropriate precautions are required (please refer to the following document http://www.yoifos.com/sites/default/files/sforl_-_tracheostomie_0.pdf).
    - **Group B**: cancer treatment with risk of loss of chance in the short or medium term (4 weeks): squamous cell cancer of the upper aerodigestive tract, aggressive cancers of the salivary glands, aggressive skin cancers

- If no need for a tracheotomy
  - ✓ If possible, no delay in treatment
  - ✓ Group together hospital-based activities (scans, dental treatment before RT, PAC, etc.) so as to minimise comings and goings to the hospital
  - ✓ If treatment is impossible due to the pandemic, possibly direct the patient to another centre capable of performing the cancer surgery
- **If there is a need for a tracheotomy: WARNING**
  - ✓ High risk of contamination of the nursing staff
  - ✓ If possible, postpone surgery or opt for a non-surgical alternative

- **Group C**: cancer treatment with low risk of loss of chance in the medium term (6-8 weeks): well-differentiated thyroid cancers, non-progressive skin cancers such as basocellular cancers, some slow-growing cancers of the salivary glands or an atypical nodule in the salivary gland not formally classified as malignant from the preoperative assessment, leukoplakia and superficial lesions of the vocal cords: reassess the patient after 6 to 8 weeks and adapt the treatment program according to the tumor growth velocity and to the evolution of the COVID-19 pandemic.

2. Consultations

- Post-cancer face-to-face follow-up consultations should be postponed as much as possible

- Use a phone call or a remote consultation to check that the patient has no symptoms indicative of a relapse that, if present, would mean the consultation should still take place.
- Postpone any non-urgent investigations (MRI, CT-scan,…)

- New case of cancer, symptomatic patient or treatment adjustment (assessment after induction chemotherapy, first post-treatment assessment): face-to-face consultation should be maintained

3. Organizational aspects

- Consultations
  - Restrict the number of flexible naso-endoscopies and laryngoscopies
  - During any face-to-face consultation, the patient should be regarded as potentially COVID-positive, and the ENT specialist should wear an FFP2 mask (N95), a cap, a gown, protective goggles, and gloves. All disposable material must be eliminated through the infectious waste circuit.

- Hospitalisation/surgery
  - If possible: diagnostic work-up for COVID-19 should systematically be performed less than 24 hours prior to surgery (RT-PCR testing +/- chest CT-scan)

- In COVID-positive, the surgery should possibly be postponed if possible, and the patient must be referred to a structure or a team specialized in the management of COVID-19

- Postponement of surgery:
  - The decision to postpone a surgical procedure for a head and neck cancer should be made on a case-by-case basis, by the surgical team and in agreement with the patient. Besides the above-mentioned Group C, the final decision of postponement should ideally be taken during **a Tumor Board Setting** with a written report addressed to all the doctors involved in the patient's care.
  - The patient should be called by his ENT consultant who will explain the reason for the postponement, inform him or her of the probable delay before surgery and organize a remote follow-up which will allow, in case of suspicion of rapid tumor growth or of clinical complications, to consider anticipating surgery.
  - It is advisable to draw up a list of patients waiting for treatment, in order of priority.
  - It would also be advisable to set up a phone line or dedicated email address that would allow the patient to contact the surgical team whenever needed.

Bibliography

1. Liang W, Guan W, Chen R, et al. Cancer patients in SARS-CoV-2 infection: a nationwide analysis in China. Lancet Oncol 2020; 21:335-337

2. Ueda M et al. Managing Cancer Care during the COVID-19 Pandemic: Agility and Collaboration Toward a Common Goal. J Natl Compr Canc Netw. 2020 Mar 20:1-4. doi: 10.6004/jnccn.2020.7560.

NB: These clinical practice guidelines are naturally likely to be modified on a day to day basis, following the evolution of the epidemic, the technical means available and scientific evidence concerning SARS-Cov-2.