Interim treatment change options during the COVID-19 pandemic, endorsed by NHS England

The aim of the interim treatment changes are to allow for greater flexibility in the management of cancer during COVID-19 pandemic.

These interim treatment regimens are based on clinical opinion from members of the Chemotherapy Clinical Reference Group and cancer pharmacist and endorsed by NHS England and NHS Improvement.

The responsibility for using these interim treatment regimens lies entirely with the prescribing clinician, who must discuss the risks and benefits of interim treatment regimens with individual patients, their families and carers. All patients who start on an interim treatment during the COVID-19 pandemic should be allowed to continue the treatment until they and their clinician jointly decide it is appropriate to stop or to switch to a different treatment.

Treatment regimens will revert to the standard commissioned position once the emergency measures put in place to address the COVID-19 pandemic are no longer necessary.

These interim treatment changes to do not constitute NICE guidance.

Indication	**Treatment changes**

General	• Give prophylactic daily granulocyte-colony stimulating factor (G-CSF) or a biosimilar PEGylated G-CSF to prevent neutropenic fever and reduce admissions (for example, for patients on chemotherapy regimens with a greater than 10% risk of neutropenic fever*)*
	• After an assessment of the risks and benefits to the patient, consider stopping:
	  ○ later-line palliative treatment to reduce the need for admission
	  ○ adjuvant therapy for low-risk patients, for example those with breast, lung or colorectal cancer, to reduce the need for immune-suppressive therapy

Breast cancer	• Suspend treatment with adjuvant bisphosphonates to reduce inpatient visits • Reduce the course of adjuvant trastuzumab treatment from 12 months to 6 months • Give pertuzumab plus trastuzumab for neo-adjuvant therapy, adjuvant therapy, locally recurrent or metastatic disease without chemotherapy to reduce the risk of neutropenia

Indication	Treatment changes
	• Switch to oral capecitabine from intravenous taxanes with anti-HER2 therapies for metastatic disease to reduce the risk of neutropenia • Substitute albumin-bound paclitaxel (Abraxane) for paclitaxel or docetaxel to reduce toxicity and potential for admission
Colorectal cancer	• Allow intermittent treatment with chemotherapy regimens that contain cetuximab or panitumumab to reduce the need for immunosuppressive treatment
Non-small cell lung cancer	• Stop maintenance pemetrexed in combination with pembrolizumab to reduce treatment toxicity and risk of neutropenia • Allow pembrolizumab to be given as a single agent as a first-line treatment for squamous or non-squamous NSCLC and a PDL-1 score of less than 50% to reduce treatment toxicity and risk of neutropenia • Allow durvalumab be given 4 weekly in patients eligible for durvalumab following treatment with chemo-radiotherapy to reduce the number of hospital visits • Switch to carboplatin and paclitaxel from day 8 treatments such as gemcitabine and carboplatin and cisplatin and vinblastine
Small cell lung cancer	• Stop first-line chemotherapy for stage IV SCLC after 4 cycles to reduce hospital admission and risk of neutropenia
Melanoma	• Give oral therapy as first-line treatment for BRAF-positive patients in preference to immunotherapy to reduce admission for IV therapy • Stop immunotherapy doublet (ipilimumab and nivolumab) and switch to single agent nivolumab or pembrolizumab to reduce toxicity
Neuroendocrine tumours	• Give oral temozolomide and capecitabine instead of intravenous streptozocin and 5-fluorouracil to reduce toxicity and admissions for treatment
Ovarian cancer	• Give olaparib or other poly-ADP-ribose polymerase (PARP) inhibitors instead of chemotherapy plus maintenance PARP at first relapse for BRCA-positive PARP-naive patients to reduce admissions and risk of neutropenia
Renal cell cancer	• Stop first-line immunotherapy using nivolumab with ipilimumab in intermediate and poor risk groups, and

Indication	Treatment changes
	switch to either first-line single agent nivolumab or use oral therapy as first-line and nivolumab with ipilimumab as second-line therapies to reduce toxicity • Use first- and second-line oral tyrosine kinase inhibitors and switch nivolumab from second- to third-line to delay use of IV immunotherapy (hospital visits)
Non-Hodgkin's lymphoma	• Suspend subcutaneous rituximab maintenance to avoid patients attending hospital • Suspend subcutaneous obinutuzumab maintenance to avoid patients attending hospital
Myeloma	• Allow oral pomalidomide with dexamethasone as second- or third-line therapy instead of intravenous treatments in patients previously treated with lenalidomide to reduce the need for chemotherapy and reduce admissions and risk of neutropenia • Allow first-line lenalidomide and dexamethasone for transplant eligible myeloma patients in preference to regimens that require more hospital attendances and parenteral administrations to reduce toxicity of treatment and number of admissions required for treatment • Allow second-line lenalidomide and dexamethasone for patients who have not been previously treated with bortezomib