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Editorial

Challenges and Consequences of COVID-19 in the Management of Anorectal Cancer: Coming Together Through Social Distancing

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SARS-CoV-2 (COVID-19) requires little introduction. COVID-19 has already had, and will progressively have, profound consequences on our practice during the pandemic and beyond. As oncologists, we pride ourselves that our practice is evidence-based. However, we are increasingly making decisions with limited or an absence of high-quality evidence. We aim to discuss how the pandemic is currently affecting our patients, multidisciplinary working and treatment choices, and consider the longer term consequences.

Our patients are vulnerable. The impact of the comorbidity of cancer on mortality is based on preliminary, emerging data [1–4]. However, colorectal cancer is a disease of age and, unequivocally, COVID-19 carries a high case fatality for older patients (China: 8 and 14.8%; Italy: 12.8 and 20.2% for patients over the age of 70 and 80 years, respectively) [1]. Previous data from pandemic influenza and early modelling work from Imperial College suggest that the cancer and chemotherapy immunosuppression are risk factors for death [5,6]. Lei *et al.* [7] reported increased surgical risks, with a 21% operative mortality of 34 patients who acquired COVID after elective surgery for a range of conditions. Minimising hospital visits is crucial, with some studies indicating over 40% of COVID-positive patients contracted it in hospital and reporting a higher incidence in those attending a cancer centre than the general population [8,9].

Implications of COVID-19 on our Multidisciplinary Team

Multidisciplinary team working faces numerous challenges as the availability of different components of care are likely to change simultaneously. Web-based meetings require technological solutions to facilitate multidisciplinary review of imaging and pathology. The differences between video-conferencing and face-to-face discussion require adjustment where the perception and ascertainment of peer support may be diminished. The weekly meeting also allows different specialties to update the status of their department, allowing the team to contemporaneously balance strategies for patient care on the functionality of different departments.

The workforce will decline due to the increasing impact of infection, self-isolating, childcare responsibilities and redeployment. The latter is particularly affecting nurse specialists and palliative care.

Perhaps the biggest impact will be on surgical practice. Procedures requiring high dependency, intensive care input or significant inpatient stay will be increasingly deferred. National guidance suggests limiting radiological and endoscopic investigations to emergencies only; confirming even investigations of suspected cancer may not be possible during the pandemic [10,11].

Suggestions for Management

In these unprecedented times we must work together to determine the best clinical decisions that we consider to be in the best interest of the patient. The Royal College of Radiologists' online forum has offered a platform for clinicians around the country to share experience and local strategies

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(<https://www.rcr.ac.uk/network/colorectal-chemotherapy-light-covid-19-0>).

General Principles

- Manage expectations of patients by offering clear explanations of what is and is not possible. Decide amongst the multidisciplinary team who will speak to patients and what will be said to avoid duplication.
- Work in teams so if a team member becomes unwell it is relatively easy for others to pick up their work. Alternating days in the hospital may avoid all team members falling unwell at once.
- Develop a method for keeping track of patients where decisions have been influenced by COVID-19 for future audit, and outstanding investigations and treatments that will be carried out when 'normal' service resumes.
- Follow-up should be carried out where possible by telephone. New patient telephone consultations may be appropriate for some patients.
- Working within a cancer alliance may allow distribution of services, particularly surgery, in different hospitals that may have more capacity.

Rectal Cancer

A European expert panel has recently published evidence-based, consensus guidance for use during the pandemic on the management of rectal cancer using the framework of the European Society for Medical Oncology (ESMO) guidelines [12]. Below we describe our perspective in a UK context. Radiotherapy for localised rectal cancer fulfils priority 3 under recently published National Institute for Health and Care Excellence (NICE) guidance [13].

Early and Intermediate Rectal Cancer

Consensus guidance suggests that Total mesorectal excision (TME) continues to be standard of care for early rectal cancer and TME alone or short course radiotherapy (SCRT)/chemoradiotherapy (CRT) if good-quality mesorectal excision cannot be assured. Despite the NICE guidelines suggesting that radiotherapy should not be given to T1/2N0 patients [14], we are fortunate to have level 1 evidence that hypofractionation with 25 Gy in five fractions and delay is an oncologically sound approach [15]. Due to diminishing surgical capacity, we suggest that this will result in an increased use of this strategy, allowing surgery to be carried out at a time when there is available capacity. In addition, a multi-centre UK cohort study using SCRT and local excision in early stage cancer showed a pathological complete response rate of 32% [16]. If imaging is limited, a single magnetic resonance imaging scan at 2–3 months will guide further management.

Locally Advanced Rectal Cancer

In non-margin threatening disease, consensus guidance strongly suggests the use of SCRT instead of long course radiotherapy (LCRT) with a delay to surgery for 4–8 weeks after SCRT in keeping with Stockholm III [14]. A longer delay can be considered in responding patients.

In disease threatening or involving the margin or pelvic side wall disease, the consensus guidance suggests three options: LCRT, SCRT and delay or SCRT with a period of neoadjuvant chemotherapy, similar to the Polish trial [17]. Although LCRT is the most established treatment in this group, there is no level 1 evidence that LCRT is superior to SCRT in reducing local recurrences and is not an 'under treatment'. Should a patient acquire COVID during LCRT, there is the risk of the infection itself but also the risk of compromised radiotherapy treatment due to treatment gaps. As such, LCRT should only be considered as an option for young, fit patients without comorbidities with appropriate consent and isolation advice. We acknowledge the right decision for each patient will depend on the patient and their risk factors, the tumour and the situation in the department at the time. Post-treatment imaging will depend on availability; however, imaging can identify patients in whom a further delay can be safely considered. Surgery should proceed if appropriate, as and when it is possible safely.

Adjuvant Chemotherapy

Adjuvant chemotherapy in rectal cancer should be limited, as it is in many other countries routinely, due to the evidence suggesting no or limited benefit [18]. 'Adjuvant' chemotherapy following metastatectomy is not advised.

Metastatic Disease

National Comprehensive Cancer Network (NCCN) guidelines suggest similar measures to those already brought in nationwide [19]. Palliative chemotherapy should be given to those with large disease burden, rapid progression or those showing systemic symptoms of malignancy. Level 1 evidence suggests that breaks in treatment do not affect outcome, so 3 months of palliative chemotherapy can be followed by a break [20]. NHS England now allows treatment breaks of biological agents. Metastasis-directed therapy in oligometastatic disease could be delayed in those with metachronous disease and a long disease-free interval. For those where the benefit of immediate treatment of oligometastatic disease outweighs the risk, stereotactic ablative radiotherapy (SABR) may be preferable as it does not require inpatient stay or anaesthetic support.

All patients currently on chemotherapy require conversations about the altered risk–benefit ratios and advice regarding isolating.

Anal Cancer

Most anal cancers are cured by definitive CRT and it a priority 1 radiotherapy treatment per NICE guidance [16]. The risk–benefit ratio favours treatment for anal cancer. Therefore, it is appropriate to offer current standard of care. Clinical trial recruitment will be limited by resources, but for those still able to offer it, all three arms of PLATO remain open [21]. Two-thirds randomised into ACT4 will receive 1 week less treatment. In elderly patients or those with a poor performance status, a less intensive treatment schedule should be considered. There are published data for 30 Gy in 15 fractions concurrent with chemotherapy [22,23]. Further hypofractionation using 30 Gy in 10 fractions concurrent with chemotherapy may also be considered, although we lack prospective data on this regimen.

Beyond COVID-19

Despite the challenges of COVID-19, there is a real opportunity to learn from the novel and amended approaches for treatments being used. Although undoubtedly of interest to service providers, it is vital we maintain the impact on patients, particularly cancer outcomes and toxicities, as a central focus of induced changes in anorectal treatments beyond COVID-19.

The Clinical and Translational Radiotherapy Research Working Group (CTRad) COVID radiotherapy initiative is working with radiotherapy centres across the UK to capture the impact of COVID-19 on radiotherapy outcomes. In rectal cancer, the aim is to capture alterations in the treatment pathway, chosen regimens and treatment compliance to assess the impact of the decisions on outcome. We also support the UK national coronavirus cancer monitoring project [24].

This represents a once in a generation challenge. Professionally, we must ensure we are collectively discussing management widely, as hospital pressures and the knowledge base evolve over coming weeks and months; understandably we are all finding our footing in a constantly shifting terrain and there are few known wrong, or right, answers. Beyond our professional responsibility, we have to acknowledge that we are all trying our best and support our colleagues, friends and families. If ever there was a time to come together, this is it.

Conflicts of Interest

The authors declare no conflict of interest.

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