



FOUNDATION for HEAD and NECK ONCOLOGY

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Dear Colleagues,

We are facing testing times due to COVID-19 pandemic. In the midst of lockdown, risk of infection and possibility of increase in number of patients with COVID-19 infection requiring care, management of head and neck cancer patients is a challenge. FHNO task force has suggested guidelines which may help in decision making. Please note, this is a dynamic situation and guidelines are likely to change frequently. Central, state and local government and medical council instructions should supersede these guidelines in case of a conflict.

Stay safe, Stay healthy

Best Wishes,

FHNO Governing Council and Executive Committee

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Foundation for Head and Neck Oncology (FHNO) Advisory for management of head and neck cancers during COVID-19 epidemic period

Indian scenario and need for optimizing resources and treatment decisions

- Testing of COVID-19 is limited and cannot be performed in all patients.
- All HN procedures including simple clinical examination is aerosol generating and considered high risk.
- *Protective supplies, such as N95 masks, PPE gowns, gloves and other protective materials are in short supply or unavailable in many institutions.*
- As the illness progresses our systems may be burdened with potential shortage of beds and health care manpower.
- Difficulty and uncertainty in transport of patients due to the lockdown and quarantine.
- Availability of blood and blood products may become a challenge.
- ICU Bed/ ventilators may be at a premium and scarce.
- Cancer patients are likely to be more vulnerable to COVID-19.
- **Risk benefit ratio should be considered during the epidemic period.**

Keeping all of these in mind, Foundation of Head and Neck Oncology (FHNO), India has attempted to put some guidelines for diagnosis, treatment and follow up of patients during the COVID-19 pandemic

Please note:

These guidelines are only a framework on which individual oncologists and institutions can guide their decision making in patients with head neck cancers during the COVID-19 pandemic. Oncologists should weigh the pros and cons of following these guidelines in their respective institutions and practice, balancing safety of the patients with available infrastructure and personal protection. All governmental and institutional policies on COVID-19 pandemic policies that are not in accordance with these guidelines supersede these guidelines.

Section 1: Basic principles

Multiple guidelines are available but majority are from the developed world. In India, we have different levels of health care and hence we need to optimize our resources and tailor guidelines to our needs. What applies to well-funded institutions may not be applicable to smaller centers in our country. Some of the general issues that we should be aware of :

- All patients must be considered potential carriers. A great emphasis must be placed on history (flu like symptoms, contact with potential carriers and travel history) to help triage patients into high risk.
- COVID-19 testing of suspected individuals to be done as per updated recommendation of central and state government.
- Protective supplies, such as N95 masks, PPE gowns, gloves and other protective materials are scarce and must be judiciously used.
- Minimize outpatient visits and elective follow up of previously treated patients. These can be deferred.
- Avoid crowding in outpatient waiting area by implementing strict appointment system. Social distancing to be maintained in waiting area.
- Minimize the number of accompanying persons entering the hospital and the consultation rooms.
- All health care workers with patient contact should have mask, sanitizers and patient areas need to be sanitized regularly.
- Hospitals should have a plan for backup medical staff in case of exposure/COVID infection of working staff.
- Special consent may be obtained keeping in mind the high infectivity rate and chances of acquiring this infection during procedures in the hospital.
- Dedicated Operating room, ICU and ward isolation for COVID-19 positive cases.
- Contingency plan for isolating COVID positive patients or shifting to appropriate facility.
- Crowding of hospital staff for meetings, MDTs etc should be strictly discouraged. Instead teleconsults or video conferencing should be used for MDTs.
- Medical council of India has approved teleconsults during epidemic period. Please refer to MCI and state council recommendation.

Section 2: Diagnostic work up

Limit diagnostic work up in patients to a minimum. Clinical examination, with a combination of imaging and biopsy, when feasible, should form the basic framework of diagnostic evaluation of patients during the COVID-19 pandemic.

- i) **Fibreoptic Laryngoscopy (FOL)** - As the nasal cavity and nasopharynx have a high colonisation of COVID-19, even in asymptomatic patients, it is recommended **to avoid FOL unless absolutely mandatory**.

In case FOL is mandatory and cannot be avoided, the following precautions should be taken:

- Use of adequate local anaesthetic in the form of nasal jelly, lignocaine spray of the posterior pharyngeal wall (give adequate time for action).
- Avoid looking through the lens of the scope and it would be preferable to attach it to a monitor.
- Limit the number of staff in the room at the time of FOL. No person should be within two metres of the patient.

- Use appropriate/best available PPE to cover head, mouth, nose and eyes while performing the procedure.
- Preferable to perform the procedure in hospital scrubs.
- Follow correct procedure to disinfect scopes.

ii) Biopsy

- Avoid biopsies in benign lesions.
- Perform FNACs from neck nodes for obtaining diagnosis, in case of laryngeal/hypopharyngeal primaries, where biopsies will entail some form of endoscopy.
- Image guided (USG/CT guided) biopsies can be attempted.

iii) Direct laryngoscopy:

- Not recommended in the current scenario.
- May use appropriate PPE in case of need to perform a direct laryngoscopy.

Section 3: Treatment

Surgery:

Decisions regarding surgery on cancers of the head neck should take into consideration, the goals and likely outcomes of surgery, the likelihood of curing the cancer, safety considerations and utilisation of infrastructure which may be required for management of COVID-19 related emergencies. All patients should be considered as asymptomatic carriers and adequate precautions to be taken prior to performing any surgical procedure.

- Delay/postpone surgery in patients with low grade tumors (differentiated thyroid cancers, medullary thyroid cancer, low grade parotid neoplasms, benign tumors etc).
- Avoid any form of surgery on a COVID-19 positive patient (unless in medical emergencies like stridor, uncontrolled bleeding etc, with adequate precautions).
- Avoid extensive surgery in patients with advanced age (>65 years) with comorbidities like uncontrolled hypertension, diabetes mellitus, COPD, immunocompromised/immunosuppressed.
- Avoid surgery with doubtful cancer outcomes.
- Avoid complex microvascular reconstructive surgery requiring long hours. Use of local and regional flaps for reconstruction should be considered.
- Avoid performing surgeries that require elective tracheostomies.
- Avoid surgeries that require powered instrumentation (bone cutting instruments, saws, micromotors, drills etc.).
- Check preoperative hemoglobin values and avoid surgeries on patients with low Hb to avoid the use of blood and blood products.
- Day care surgery and surgery for early lesions is highly recommended as surgery of choice during this period.
- Use appropriate/best available PPE for all surgical procedures.

Emergency Tracheostomy guidelines: (Very high-risk procedure)

- Take history from patient/ relatives on fever, cough (non- cancer related), travel, contact with COVID-19 positive patient.
- Use N95/shield masks/plain spectacles for surgeons, anesthetists, nurses and OT staff, as per availability. Please cover the N95 mask with a regular OT mask to enable reuse of the mask (not ideal), if need arises. N95 masks do not give protection for the eyes and any mask should be combined with goggles/shield masks. If

appropriate masks are not available, use a plastic sheet to cover nose and eyes and wear a regular mask over the sheet.

- If time permits, make all preparations in the OT **with the patient outside the OT**. Wheel in the patient only after trays, tracheostomy tubes, cautery, personnel with protection, anesthesia trolley etc is ready.
- Intubate and paralyze all patients, where intubation is feasible.
- If patient cannot be intubated, inject lignocaine into the trachea prior to incision of the trachea and wait, if possible, for the lignocaine to act. This will decrease coughing during tracheostomy.
- Use only cuffed tracheostomy tubes. If available, use a double lumen cuffed tube. This will prevent requirement for repeated suctioning, post procedure.
- Attach a catheter mount to the tracheostomy tube during insertion. This will prevent aerosol spray in case the patient coughs.
- Delay first tube change to 7-10 days. If feasible, obtain a steel/portex double lumen tube for the first change.

Radiotherapy:

- Patients due for radiotherapy treatment, simulation and commencing treatment should be triaged and prioritized based on their diagnosis, prognosis and urgency for initiating treatment.
- Hypo-fractionation schedules have proven to be equivalent in many clinical scenarios in head and neck cancers and should be pursued where appropriate.
- Palliative radiotherapy treatment for symptomatic relief can be delivered in single fraction or weekly once regimens.
- In patients with suspected or proven COVID-19 infection (symptomatic as well as asymptomatic) treatment may be deferred until resolution or till they are deemed non-contagious by local health bodies. If the indication for treatment is urgent /time sensitive in this category of patients, then it should be commenced taking all necessary precautions.
- The decision to use concurrent therapies like chemotherapy/ targeted therapy should be taken judiciously (expected benefit of the concurrent therapy to overall outcomes vis a vis the risk of the patient acquiring COVID-19 infection and succumbing to it).
- Appointments of patients on treatment can be staggered throughout the day to avoid congestion at the machine area. Patients may be distributed on all available machines to reduce overcrowding.
- On-board imaging may be minimized to reduce treatment time. If at all Image guidance must be performed in the presence of consultants at the machine console to hasten image guided procedures.
- In the face of shortage of manpower, RTTs can also be empowered to execute few of these procedures on their own, based on their training and/ or under remote supervision.
- In case of availability, infected patients may be treated on a separate machine/ or in a separate time slot with all necessary precautions for the technologists and other care providers, to minimize the number of personnel exposed.

Chemotherapy

Most oncologists believe that there is no consensus/guidelines for the management of patients with cancer, receiving systemic chemotherapy, during the COVID -19 pandemic. Moreover, the evidence to delay or administer systemic therapy, is lacking at this time. Majority of the guidelines including ASCO and NICE believe that it is the doctor-patient communication that will drive appropriate cancer treatment.

General principles:

- Individualise decision making.
- Avoid chemotherapy in patients with advanced age and uncontrolled comorbidities.
- There is no data on substitution of chemotherapy with targeted therapy.
- Neoadjuvant CT to be used judiciously in a selected, good risk population.
- Growth factor prophylaxis is required when myelosuppression is more than 20%.
- No role of antiviral prophylaxis.
- Palliative CT/Immunotherapy to be avoided unless benefit is substantial.
- Metronomic palliative CT may be considered after discussion with patients.

Dental Extraction, Restoration and Rehabilitation

- Asymptomatic patients requesting removal of disease-free teeth should be re-scheduled.
- Only those patients who have an impending treatment (definitive/adjvant radiation) may be taken up for extraction under precaution and as per the routine protocol to minimize the risk of ORN.
- Patients requiring grinding of sharp cusps can be undertaken with PPE to prevent any traumatic ulcer development.
- Post-Surgery patients requiring Oral/Maxillofacial rehabilitation should not be done and re-scheduled.

Section 4: Follow up

- Minimise all follow up appointments.
- Defer follow up for patients with low risk of recurrence (e.g. 18-24 months post treatment).
- Prioritise patients in immediate post-treatment period and those high risk for recurrence.
- Consider longer intervals between follow ups.
- Consider teleconsultation for follow up where possible to triage follow up requirements.

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