BRITISH ASSOCIATION OF UROLOGICAL SURGEONS

COVID-19 strategy for the interim management of penile cancer
Prepared by the BAUS Sections of Oncology & Andrology

This document has been produced to outline two contingency plans for how penile cancer service provision may need to deviate from the internationally accepted standard of care, during the current COVID-19 pandemic.

Step 1 reflects response to reduced service provision whereas **Step 2** reflects response to severely reduced service provision.

It is recognised that individual hospital circumstances will differ and not all measures will be required in every unit.

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1. DIAGNOSTICS

a. Two-week wait referrals

Potential new penile cancers will likely require clinical assessment.

Referrals for *in situ* disease will likely **not** need clinic attendance with face-to-face assessment.

b. Potential new penile cancer (existing EAU guidelines)

CLINICAL SITUATION	CURRENT PROVISION	STEP 1 (REDUCED SERVICE PROVISION)	STEP 2 (SEVERELY REDUCED PROVISION)
Suspected penile cancer	Two-week wait clinic	Two-week wait clinic	Two-week wait clinic
Staging of primary lesion	Local staging with clinical exam with MRI ± ultrasound	Clinical staging if restricted access to imaging	Clinical staging if restricted access to imaging
Staging of regional & distant disease	Staging with CT or ultrasound	Staging with CT or ultrasound	Clinical staging if restricted access to imaging

c. Potential new PeIN (current EAU guidelines)

CLINICAL SITUATION	CURRENT PROVISION	STEP 1 (REDUCED SERVICE PROVISION)	STEP 2 (SEVERELY REDUCED SERVICE PROVISION)
Suspected PeIN	Urgent clinic review	Telephone consultation with emailed photo	Telephone consultation with emailed photo

d. MDT

- MDT should be quorate but with minimal number of clinicians
- Teleconferencing preferable
- Clear documentation of clinical stage & grade
- Clear documentation of treatment plan
- Document if the MDT treatment plan has been modified in response to COVID-19

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2. TREATMENT

a. Primary penile cancer / PeIN (existing EAU guidelines)

Surgical treatment of the primary tumour should remain unchanged, providing that there is theatre access, with the exception of *in situ* disease.

CLINICAL SITUATION	CURRENT PROVISION	STEP 1 (REDUCED PROVISION)	STEP 2 (SEVERELY REDUCED PROVISION)
Ta / T1 tumour	Circumcision / wide local excision	Circumcision / wide local excision	Circumcision / wide local excision
T2 tumour	Glansectomy ± distal corporectomy	Glansectomy ± distal corporectomy	Glansectomy ± distal corporectomy

T3 tumour	Partial / total penectomy	Partial / total penectomy	Partial / total penectomy
New PeIN	Circumcision / topical chemotherapy / localised surgery	Topical chemotherapy / surveillance	Topical chemotherapy / surveillance

b. Inguinal nodes (existing EAU guidelines)

Perform CT chest, abdomen & pelvis for those patients being treated with curative intent.

CLINICAL SITUATION	CURRENT PROVISION	STEP 1 (REDUCED PROVISION)	STEP 2 (SEVERELY REDUCED PROVISION)
Palpable, mobile inguinal nodes	Radical inguinal node dissection	Radical inguinal node dissection	Radical inguinal node dissection
Impalpable nodes (Tis, Ta T1 G1 disease)	Surveillance	Surveillance	Surveillance
Impalpable nodes (> T1 G2 disease)	Sentinel node biopsy	Sentinel node biopsy for G3 in absence of significant co-morbidity Radiological surveillance for G2 or men with significant co-morbidity	Radiological surveillance

c. Metastatic disease (including pelvic nodal disease)

Advanced disease should be managed on a case-by-case basis, depending upon the age of the patient, access to operating theatres & the known immunosuppressive risk of chemotherapy.

3. FOLLOW-UP

Clinic attendance may be necessary for wound, drain or catheter management.

For most other patients, telephone follow-up will suffice, with bloods ± scans as dictated by symptoms.