BRITISH ASSOCIATION OF UROLOGICAL SURGEONS

COVID-19 strategy for the Interim management of Prostate Cancer
Prepared by the BAUS Section of Oncology

This document is a pragmatic approach to the management of prostate cancer and provides guidance for areas with a significant level of COVID-19.

If you are working in a locality where Covid-19 is not yet impacting on your hospital, then normal diagnosis and treatment should be maintained.

PRINCIPLES OF CARE

- **Continue with current diagnostics and treatment protocols as long as possible but the diagnostic and treatment pathway may not be sustainable.**

- Minimise outpatient attendance at time of high COVID-19 virus prevalence to reduce risks to patients and hospital staff.

- Minimise risk of missing significant prostate cancer and minimise risk of disease progression in those already diagnosed.

- Minimise risks of sepsis and general anaesthesia at prostate biopsy. Avoid biopsy in men with significant frailty and co-morbidity.

- Minimise imaging requests as radiology staff likely to be deployed to emergency services.

- MRI scanners could be a potential source of COVID-19 transmission due to their enclosed space with reduced access/availability to cancer patients and CT scanners are likely to be vital resources for the respiratory/ITU teams.

- Chemotherapy is to be avoided during peak period of COVID-19 crisis due to immunosuppressive risks. We will use 12 week window for upfront docetaxel cases.

- Assumption that PSA blood testing remains available. If patients are elderly/frail it may be most appropriate to not attend for blood

testing at present. For patients on primary ADT, need for F/U PSA can be put back to 6 monthly.

- Radiotherapy should be avoided unless urgent necessity due to rapid loss of function e.g. spinal cord compression

- Need to expedite access to 6 monthly preparations of ADT/LHRH agonists and supply of enzalutamide in lieu of docetaxel chemotherapy.

- We acknowledge that we will be exposing an increasing proportion of men to hormone therapy who would not ordinarily have chosen this modality.

- Good communication is essential to explain the potential trade-offs that will result from instituting these guidelines with respect survival, quality of life and functional outcomes, and risk of acquiring COVID-19 and the resulting sequelae.

GUIDANCE AND RECOMMENDATIONS

1. New Patients referred to Urology Clinics with suspected prostate cancer

COVID-19 policy recommendation 1: PSA > 20 (category 1): Patients with a PSA >20 +/- worsening urinary symptoms should undergo assessment and a bone scan or PSMA scan to evaluate for metastatic prostate cancer. If metastatic disease identified or suspected patients should be initiated on hormone therapy with a repeat PSA in 3 or 6 months depending on the COVID situation.

COVID-19 policy recommendation 2: PSA <20 High PSAD (category 2): Treat as normal pathway until services restricted. Patients with a raised PSA less than 20/ normal DRE could have an ultrasound (abdominal or TRUS)/DRE and estimation of prostate volume performed in line with ESPRC guidelines. Where the PSA density (PSA/prostate volume) is greater than 0.15ug/l/cc, patients should be offered a prostate biopsy (potentially limited core numbers, providing available in outpatient department). Note no MRI imaging will be available so a systematic 'Guy's/Ginsberg protocol' perineal biopsy should be performed if available. TRUS biopsy should be avoided if possible.

COVID-19 policy recommendation 3: PSA <20 Low PSAD (category 3): Patients with a raised PSA <20ug/l should have an ultrasound/DRE and estimation of prostate volume performed in line with ESPRC guidelines. Where the PSA density (PSA/prostate volume) is LOW <0.15ug/l/cc, all patients should be reassured, discharged and have a repeat PSA in the primary care setting in 6 months with re-referral if the repeat PSA in 6 months provides a PSA density >0.15ug/l/cc. This PSA value should be listed in hospital correspondence.

COVID-19 policy recommendation 4: DNAs:
A significant number of patients may not attend either as they are self-isolating due to having suspected COVID-19 or wish not to take the risk of attending hospital and so increasing their risk of getting COVID-19. All non-attenders should have a letter dictated to the patient and copy to GP suggesting a repeat PSA in 3-6 months and re-referral if the patient is sufficiently well and has a persistently raised PSA. Category 1 and 2 patients will be telephoned by the clinical/prostate team.

2. Patients Diagnosed with Prostate Cancer

COVID-19 policy recommendation 5: Treatment Low/Intermediate Risk Non Metastatic Prostate Cancer.
Patients diagnosed with low and intermediate risk prostate cancer should be placed on active surveillance with a PSA test and consultation at 6 months. Patients unhappy with receiving no treatment can be offered Bicalutamide 50mg OD with careful explanation of potential side effects.

COVID-19 policy recommendation 6: Treatment High Risk and unfavourable intermediate risk Non Metastatic Prostate Cancer
Patients should be offered on hormone therapy (LHRH or Bicalutamide 150mg (the latter if avoiding nurse-led injection administration)) until a time is available to offer them curative therapy (radical prostatectomy/ radical radiotherapy). Patients identified to have high risk prostate cancer can be offered either staging bone scan, staging PET scan, or PSMA can depending on availability. Tamoxifen can be used for gynaecomastia for patients on bicalutamide.

COVID-19 policy recommendation 7: Treatment Metastatic Prostate Cancer

Men with metastatic disease will commence hormone treatment following bone scan or other imaging if available. Ideally 6/12ly LHRH preparations should be considered. Primary chemotherapy should be deferred during this time and reassessed when situation stabilises and requires assessment of duration post hormone commencement. There may need to be flexibility re: 12 week window. Patients already commenced on chemotherapy will need to liaise with their clinical team regarding the risks of finishing early or continuing with treatment.

3. Patients on Surgical Waiting List:

Continue to operate whilst capacity available. Patients with low and intermediate risk prostate will continue to await surgical treatment, as the risk of progression is low. Patients with low and intermediate risk may be offered hormone treatment if they are unhappy about the treatment delay. If there is no surgical capacity, patients with high risk disease should be offered hormone treatment to minimise progression.

4. Follow up

a. Patients post external beam radiotherapy or post brachytherapy

COVID-19 policy recommendation 8- To minimise direct patient contact - Telephone consultation 6 weeks post treatment.

PSA test to be performed 3 months post treatment.

Telephone consult following repeat PSA in urology nurse led clinic in 6 months post brachytherapy.

Telephone consult following repeat PSA in Advanced Practitioner Radiographer led clinic in 6 months post EBRT.

b. Pre-existing active surveillance patients

COVID-19 policy recommendation 9: Patients on already established on active surveillance will have periods between reviews temporarily lengthened to avoid attendance at hospitals/GP surgeries for blood tests. A new appointment will be scheduled after return to normal hospital activity.

c. Post radical prostatectomy patients

COVID-19 policy recommendation 10: Patients with a previously undetectable PSA (<0.03ug/l) (Comment some centres use <0.01) within the last 6 months will have the standard repeat PSA blood test and appointment deferred by 3-6 months. Those awaiting first post-operative appointment at 6-8 weeks can have a PSA and a telephone consultation.

COVID-19 policy recommendation 11: Patients with a detectable PSA within last 6 months of >0.03ug/l but <0.2ug/l will have a repeat PSA and will have a telephone consult to discuss the result or be deferred 3 months.

COVID-19 policy recommendation 12: Patients with a detectable PSA within last 6 months of greater than 0.2ug/l will either be offered hormone therapy in view of needing salvage prostate bed radiation therapy once available (provided the patient appropriately fit) or have ongoing PSA observation at sequential 3 monthly time points with a plan to perform a PSMA PET scan or other imaging once PSA >0.5ug/l (when imaging available).

d. FU for patients on systemic therapy - COVID-19 policy recommendation 13

- Consider treatment options that minimise interaction with health care service. This may include use of bicalutamide as part of combined androgen blockage in castrate resistant disease and use of enzalutamide instead of abiraterone where indicated

- Primary chemotherapy will likely be deferred during this time and reassessed when situation stabilises. This will require assessment of the duration post hormone commencement. Some people may still be offered chemotherapy

- Do not consider starting new cytotoxics unless absolutely necessary. We advise against use of cabazitaxel and minimise duration of docetaxel where possible (i.e. 10 to 6 cycles). Consider enzalutamide instead of docetaxel where both options exist.