BRITISH ASSOCIATION OF UROLOGICAL SURGEONS

COVID-19 Strategy for the Interim Management of Testicular Cancer
Prepared by the BAUS Section of Oncology

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

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

It is recognised that individual hospital circumstances will differ, and not all measures will be required in every unit. All units should continue with their normal pathways as long as possible.

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1. DIAGNOSTICS

a. Two-week wait (existing EAU guidelines for suspected testicular mass)

CURRENT PROVISION	STEP 1 (REDUCED SERVICE PROVISION)	STEP 2 (SEVERELY REDUCED SERVICE PROVISION)
Two-week wait clinic	Two-week wait clinic	Two-week wait clinic or telephone/video consultation
Local staging with clinical examination, ultrasound, tumour markers, fertility assessment ± semen storage	Clinical staging with ultrasound & tumour markers	Clinical staging if restricted access to imaging & blood tests
Regional staging with CT	Regional staging with CT	Clinical staging if restricted access to imaging

b. Multidisciplinary team (MDT) discussion

Clear documentation of clinical stage, tumour markers & grade
Clear documentation of treatment plan
Document if treatment plan is modified in response to COVID-19

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2. TREATMENT

a. Primary treatment (existing EAU guidelines for new testicular cancer)

CURRENT PROVISION	STEP 1 (REDUCED SERVICE PROVISION)	STEP 2 (SEVERELY REDUCED SERVICE PROVISION)
Inguinal orchidectomy ± testicular prosthesis	Inguinal orchidectomy	Inguinal orchidectomy when access permits

b. Adjuvant treatment (existing EAU guidelines)

i. Adjuvant carboplatin chemotherapy in pure seminoma

CURRENT PROVISION	STEP 1 (REDUCED SERVICE PROVISION)	STEP 2 (SEVERELY REDUCED SERVICE PROVISION)
Offer to high-risk group	Active surveillance with strong emphasis on compliance, but consideration given to patients with both risk factors for adjuvant carboplatin (provided they understand the need to self-isolate)	Active surveillance

ii. Adjuvant single-cycle BEP in high-risk NSGCT

CURRENT PROVISION	STEP 1 (REDUCED SERVICE PROVISION)	STEP 2 (SEVERELY REDUCED SERVICE PROVISION)
Offer to high-risk group (LVSI)	Consider surveillance in highly compliant patients. If BEP is given, use GCSF & warn patients of the need to self-isolate	Active surveillance

c. Metastatic disease

EXISTING EAU GUIDELINES	CURRENT PROVISION	STEP 1 (REDUCED SERVICE PROVISION)	STEP 2 (SEVERELY REDUCED SERVICE PROVISION)
Seminoma (Stage 2a/b)	Offer BEP x 3 chemo or radiotherapy in low-volume disease. If carboplatin is used with radiotherapy, consider GSCF & inform patients of need to self-isolate	Offer BEP x 3 chemo or radiotherapy	Offer chemo when facilities exist
Seminoma (Stage 2c to 4)	Offer BEP x 3 chemo	Offer BEP x 3 chemo	Offer BEP x 3 chemo

NSGCT (Stage 2)	Offer BEP x 3 chemo or RPLND	Offer BEP x 3 chemo	Offer BEP x 3 chemo when facilities exist
NCGCT (Stage 3 to 4)	Offer BEP x ¾ chemo	Offer BEP x 3 chemo	Offer BEP x 3 chemo
Recurrence post-chemo in NSGCT	RPLND	Defer RPLND & consider further chemo	Defer RPLND & use 2nd-line chemo

BEP – consideration must be given to omitting Bleomycin in view of known pulmonary risks and issues with high-flow oxygen: this is especially important in older men with metastatic seminoma.

3. FOLLOW-UP

Post-surgery follow-up by telephone
Defer standard post-chemo follow-up for 3-6 months with bloods & CT
Treat relapse according to symptoms in the interim