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Running a breast service with ongoing Covid-19 restrictions: Recommendations from the Association of Breast Surgery

Throughout the UK during the last six months we have all had to adapt to working with the risk of Covid-19, and how we deliver breast cancer services in this 'new normal'. It has become apparent over the last few weeks that this situation is set to continue for the foreseeable future. The degree to which the new winter rise in Covid-19 cases will affect our ability to deliver a breast service is unknown and is likely to vary between regions.

Current Situation

Breast units throughout the UK continue to be extraordinarily proactive in providing appropriate care for all of their patients.

Regional Representatives and ABS Trustees have recently reported to the ABS Executive that:

- All regions are managing to deliver a one stop service for patients referred with a high suspicion of cancer
- All regions are managing to operate on cancer patients and the use of primary endocrine therapy is back to pre-Covid-19 levels
- Most, if not all breast units, are now performing oncoplastic procedures such as therapeutic mammoplasties and local perforator flaps
- Immediate breast reconstruction including free flap reconstruction has restarted in most regions, but the amount undertaken is very variable and is dependent upon theatre capacity
- Many regions are still using private capacity to enable on-going operating, although many services have now moved to designated 'cold sites' in the NHS

We have been able to deliver safely a breast service in this 'new normal'.

Due to social distancing the numbers of patients able to attend clinics will be reduced for the foreseeable future. Many of the novel ways we have developed in managing referrals with a low index of suspicion of cancer and follow up consultations have become an accepted method of delivering breast services and this has been recognised by Public Health England.

Going forward – Recommendations from the Association of Breast Surgery

GP referrals

1) For patients who have a fever, cough, loss of smell or shortness of breath, local and national guidance on self-isolation should be followed and a further appointment offered following this time.

2) In units where capacity is an issue continue to triage new patient referrals with prioritisation according to the risk of cancer.

3) See all patients face to face where there is a higher index of suspicion of cancer.

4) The exception to this is frail, elderly patients in nursing homes or with co-morbidities who should not be seen in clinic **if** there is a marked local rise in Covid-19 hospital admissions. These patients are at highest risk of death from coronavirus. They may be started on Letrozole empirically and be seen once the risk of developing coronavirus decreases.

5) Patients referred with a lower index of suspicion of cancer e.g. breast pain or gynaecomastia do not need to be seen in a one stop clinic.

This is an opportunity to continue to use what we have learnt during Covid. It should now be accepted practice that these patients do not need to have a face to face consultation. In the first instance direct GPs and patients towards good quality information (please see ABS Gynaecomastia guidance **on the website**.) If a consultation is required a telephone conversation is appropriate. If patients require imaging, then this is arranged out with the one-stop clinic freeing up slots in the one stop clinic for patients with a high index of suspicion of cancer.

Follow-up appointments

Prior to Covid-19 we were moving towards supported patient led follow-up.

NICE guidance states that people who have had treatment for breast cancer should have an agreed, written care plan, which should be recorded by a named healthcare professional (or professionals). A copy should be sent to the GP and a copy given to the person. This plan should include:

- Designated named healthcare professionals
- Dates for review of any adjuvant therapy
- Details of surveillance mammography
- Signs and symptoms to look for and seek advice on
- Contact details for immediate referral to specialist care **and**
- Contact details for support services, for example, support for people with lymphoedema.

This method of follow up should now be the norm and the vast majority of patients should not be attending breast clinics for routine clinical review.

Where review is required consider telephone consultations. This is especially important for frail elderly patients on primary endocrine treatment **if** there is an increase in Covid-19 admissions.

Surgery

It is essential that all surgeons operate with the appropriate PPE following guidance issued by the Royal Colleges.

Surgical Prioritisation

It is still important in this constantly changing situation to consider:

- The availability of theatre space, taking into account collaboration with other specialties to prioritize all patients requiring surgery
- Urgency of the procedure and risk to patients of attending hospital
- Co-morbidities which may impact on outcomes if Covid-19 is contracted
- Complications associated with a procedure and subsequent risks these may pose to patients and staff

The most recent surgical prioritisation document can be **accessed here**

All breast cancer surgery is now priority 2 or 3. Risk Reducing surgery for high risk patients has also moved into priority 3. Benign breast surgery, secondary oncoplastic procedures such as symmeterisation and lipomodelling and delayed reconstruction remain in category 4. However, in units where there is surgical availability these cases can be considered. At present due to theatre availability there is still a reduction in the number of reconstructions that can be performed and it looks as if this is set to continue.

We need to continue to look at ways of reducing mastectomies in appropriate patients by considering;

- Neoadjuvant chemotherapy in patients most likely to respond; ER- and Her2+ patients
- Neoadjuvant endocrine therapy in strongly ER+ Her2- patients

Neoadjuvant endocrine therapy is a period of endocrine therapy given for 6 – 12 months prior to surgery with the intention of downsizing the tumour to either make conservation surgery easier or avoid mastectomy. It is not bridging endocrine therapy, which is given for a short period because an operation is not possible in a timely manner, which was done at the height of Covid. It is not primary endocrine therapy, which is given to patients who are very unfit or frail and who could not safely have an operation.

Make maximum use of oncoplastic procedures.

Breast units who do not routinely perform oncoplastic procedures should collaborate with plastic surgeons and other breast units to ensure that this is available for all appropriate patients.

Neoadjuvant chemotherapy and endocrine usage should now be back to at least pre-Covid levels.

All patients should be discussed at the MDT with clear documentation of treatment plans and whether these have been changed due to Covid-19.

Benefits of the recommended treatment and risks associated with Covid-19 should be discussed with patients especially in those undergoing IBR.

The ongoing Covid-19 pandemic remains a challenge to delivering the quality of breast services, which we are used to. Despite this, breast services are being run to a high standard throughout the UK. Local spikes of infection will intermittently affect service delivery and units will have to respond to this. Although we hope that breast services will continue to run to as near to normal as possible, local peaks may result in services again needing to prioritise cases as was done earlier in the year. **See the ABS website for May statement.**

This pandemic has been a stressful and difficult time for us all. Please look after yourself and your colleagues, be kind and help those who are struggling.

Julie Doughty
ABS President
28th October 2020