



Royal College of
Obstetricians &
Gynaecologists

Joint RCOG/BGCS Guidance for Care of Patients with Gynaecological Cancer during the COVID-19 Pandemic

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Summary of changes from version 3.0 to version 4.0

1. Change of reference in Section 1
2. Data from UKCCMP study added to Section 2
3. A statement on mutual aid in Section 2:
4. Addition of advice on outpatient appointments in patients receiving systemic anticancer therapy in Section 3:
5. Following additions have been made to Section 4.1.4
 - I. Addition of BGCS BAGP consensus document on BRCA testing
 - II. Advice on PARP inhibitors and Bevacuzimab
 - III. A section on management of recurrent ovarian cancer
6. Advice on systemic therapy added to Section 4.2.1: ii) Uterine Cancer
7. Change of reference in Section 4.1.5
8. Section 5 on Vaccination has been added
9. Advice on Signposting to charities has been added in Section 6
10. Section 8: Self-care has been expanded to include statement on recording incidents
11. A section on COVID 19 vaccination has been added in Section 9

1. Background

The British Gynaecological Cancer Society (BGCS) suggests the following guidance for gynaecological cancer centres and cancer units in the UK to aid in provision of care of women during the COVID-19 pandemic. This guidance adheres to principles laid out by NHS England.^{1,2}

In the event the facility for cancer services is compromised owing to factors such as staff sickness, lack of theatre availability and supply chain shortages, this guidance encompasses inpatient and outpatient activity, diagnostics and management, across all modalities of anticancer treatment and palliative care. In putting together this guidance, the working group gave high weighting to: procedures and treatments with the most robust evidence of benefit; the potential for cure or progression beyond operability where survival was expected to be more than 12 months; symptom relief for women with symptoms not amenable to alternative measures; and cancer types where cure or survival more than 12 months would be compromised by delay in treatment.

Since the publication of version 3 of this guidance (5 May 2020), both the emergence of new, more transmissible variants of SARS-CoV-2 and the approval of effective vaccines has impacted on planning for cancer care. As the pandemic evolves, the impact on decisions taken around investigation and treatment of gynaecological cancers differs across the UK, depending on local resource availability and the scale of the pandemic-affected population.

2. General principles

In the event of disruption to cancer services, clinicians may need to prioritise treatment for those most in need. It is important that all decisions taken are done so with multidisciplinary input and clearly communicated with patients. Deviations from what would normally be considered standard of care may be appropriate in the context of what is safely deliverable during a pandemic. These variations in decision-making should be recorded by the multidisciplinary team (MDT) and the reasons clearly documented. It is recommended that the BGCS prioritisation category is recorded at the MDT meeting. Women with a diagnosis of cancer must remain tracked within MDTs, even if a decision is made to defer treatment. Appendix I provides an example of a harms template. MDTs will need to meet in alternate ways, such as virtual meetings.

The following factors will underpin the safe delivery of cancer care for women with gynaecological cancers: regular communications within the MDT team, working closely with NHS management, timely communication with women and carers, as well as regular reviews of the progressing situation. MDTs are encouraged to work collaboratively, both regionally and nationally to discuss decisions that are very challenging.

COVID green pathways – the term given non-COVID areas of a hospital – have been established in most hospital trusts to reduce the risk to those undergoing elective surgery; data from large studies³ show this is safer than caring for patients in *hot sites* during the pandemic.

In women considered to be at high risk, (e.g. because of a combination of age, performance status, comorbidities, cancer load, and frailty), an individualised decision must be made, with full patient involvement, to understand the potential pros and cons of anticancer treatment versus delaying definitive treatment during the pandemic and this should be documented by the MDT. The need for perioperative intensive care support should be incorporated into any decision-making processes, owing to the high risk of such support not being available because of emergency care requirements.

The informed consent process should include and clearly document: the increased mortality and morbidity risks from a potential COVID-19 infection caused by embarking on cancer surgery or anticancer treatments during the pandemic; and the options of deferring surgery or nonsurgical treatments.

The UK Coronavirus Cancer Monitoring Project (UKCCMP) study⁴ reported that mortality from COVID-19 in cancer patients appears to be principally driven by age, gender, and comorbidities. The study did not identify evidence that cancer patients on cytotoxic chemotherapy or other anticancer treatment are at increased risk of mortality from COVID-19 disease compared to those matched for other comorbidity factors not on active treatment.

In an international multicentre study⁵ of patients undergoing surgery with perioperative SARS-CoV-2 infection, data from 1128 patients showed a 25% mortality rate. The development of pulmonary complications was a particularly high-risk predictor of mortality. Individuals undergoing surgery must be informed of this. There were no deaths in patients younger than 50 years in this cohort. Treatment Escalation Plans (TEPs) and resuscitation plans for a range of different scenarios should be discussed with the woman and their carers and clearly documented.⁵

A regularly updated source of information and studies is available via the [Cochrane COVID-19 Study Register](#). Where conservative methods of treatment have been demonstrated to show efficacy, e.g. levonorgestrel-releasing intrauterine system (LNG-IUS) for early-stage uterine cancer in women with comorbidities/elderly/unfit for treatment, these should be actively considered and discussed with women.

Greater utilisation of nonsurgical options, including radical radiotherapy or neoadjuvant chemotherapy, may allow a delay in major resection surgery until there is greater availability of services, such as intensive care unit (ICU) support. Where decisions about adjuvant treatment need to be made, prioritisation of what is deliverable safely locally may need to take precedence over a small additional survival benefit.

Utilisation of procedures such as sentinel lymph node assessment, where this has previously been audited in the Trust, may enable selected women to be spared full lymphadenectomy. The BGCS has previously issued a [consensus statement](#).

Enhanced recovery pathways should be employed to facilitate early discharge thereby minimising the risk to women and the impact on healthcare services.

Subject to local arrangements, cancer units and centres will need to make joint decisions on location of cancer surgery so that capacity can be utilised between sites. For instance, women with uterine cancer who do not need lymph node assessment may, after careful discussion and agreement across cancer centres and units, be able to have their surgery performed at cancer units. Latest NHS advice recommends cancer surgery should be continued at *clean sites* separate from hospitals caring for individuals with SARS-CoV-2-infection. Sharing of resources, such as theatre and ward capacity, within cancer alliances is recommended to enable individuals to receive access to appropriate and timely care.

3. Outpatient activity

Hospital in-person visits should be minimised and alternatives for routine follow-up, such as virtual consultations or patient-initiated follow-up, should be implemented. Pre-assessment visits, including pre-systemic anticancer therapies can be performed virtually by non-medical prescribers or medical staff, where appropriate. [BGCS guidance](#) on patient-initiated follow-up is available and can be modified based on availability of local resource and clinical decision-making. For women receiving active systemic treatment, in-person contact should also be minimised and this should be incorporated into oncology treatment/follow-up guidelines.

3.1 Two-week wait referrals for suspected cancer

[NHS guidance](#) has been issued on the diagnosis and treatment of cancers during the pandemic.

Two-week wait (2WW) referrals may need to be triaged at Trusts with the consent of the referring primary care professional to prioritise individuals who need to be seen urgently and investigated within the 2WW pathway. These deviations from standard 2WW pathways should be documented and reasons provided. Safety-netting mechanisms should be in place for individuals whose referrals are downgraded. Consideration of initial virtual consultations or straight-to-test strategies can be made to minimise individuals needing to physically attend hospital and may provide additional information to aid triage decisions. Ideally, these consultations should be performed so that friends/family can also attend, either virtually (e.g. videoconference or teleconference), or be with the woman, if this is feasible and in keeping with patient choice.

However, an appointment to ‘break bad news’ may be best done at an in-person appointment and with access to Clinical Nurse Specialist (CNS) support. This will enable signposting to services and transparent communications. Where women are required to attend appointments alone due to visiting restriction, virtual involvement of relative/friends should be considered.

3.1.1 Post-menopausal bleeding

This section needs to be read in conjunction with the RCOG/BSGE/BGCS guidance on the [management of abnormal uterine bleeding during the COVID pandemic](#).

For those with post-menopausal bleeding, a care plan will be determined dependent on the results of an ultrasound scan and virtual consultations. Women may not be able to access an examination by their GP, so those with a low risk profile, normal cervical screening history and an endometrial thickness less than 4 mm could be managed by patient-initiated follow-up over a 3–6-month period. Women who report continuing bleeding during the follow-up period can be invited for clinical examination. A record of all of those on patient-initiated follow-up should be maintained and clinical review considered, if required, once the peak in the pandemic has passed.

Performing the most definitive investigation(s) at the first in-person visit (e.g. outpatient hysteroscopy/pipelle) and allocating the most experienced hysteroscopists to these clinics will minimise need for further investigation under general anaesthesia, since this may not be available for a considerable period. Insertion of a LNG-IUS in those with suspicious findings at initial hysteroscopy, prior to histology being available, may limit in-person contact and might mitigate the effects of delaying definitive treatment where surgical treatment is constrained owing to service pressures.

3.1.2 Ovarian cysts

Use of magnetic resonance imaging (MRI) or International Ovarian Tumour Analysis (IOTA) ultrasound (simple rules or ADNEX risk model) to delineate likelihood of malignancy in women with raised risk malignancy index (RMI), but clinically low risk of malignancy (e.g. premenopausal women with likely endometriosis) may be utilised to triage women for surgery.⁶ Women with masses identified by careful triage as likely benign, after MDT discussion for difficult cases, can have surgery deferred by 3–6 months. Those with RMI less than 200 could be considered for virtual consultations and follow-up during a peak in the pandemic.

4. Prioritisation of procedures

4.1 Surgery

4.1.1 Categorisation of patients

Table 1. BGCS prioritisation of surgery procedures

Priority level	
Level 1a	<p>Emergency operation needed within 24 hours to save life, e.g. surgery for complications such as anastomotic leak, bowel perforation, peritonitis, or burst abdomen.</p> <p>Torsion or rupture of suspected malignant pelvic masses.</p> <p>Heavy bleeding from molar pregnancy requiring initial or repeat surgical evacuation or hysterectomy.</p>
Level 1b	<p>Urgent operation needed within 72 hours, e.g. surgery for acute mechanical intestinal obstruction/impending perforation in women with gynaecological cancer with an obvious single transition point in the imaging and where lines of life-prolonging treatment exist.</p> <p>Life-threatening bleeding from cervical or uterine cancer, where there is reasonable expectation of surgery being curative and conservative measures have failed or are unavailable.</p> <p>Urgent radiotherapy may be more appropriate in some cases.</p>
Level 2	<p>Elective surgery with expectations to cure, to be performed within 4 weeks to save life/progression of disease beyond operability. Further prioritisation within this category should be based on urgency of symptoms, complications (such as local compressive symptoms), and biological priority (expected growth rate) of individual cancers.</p> <p>For gynaecological cancers, this may include: suspected germ cell tumours, intrauterine brachytherapy for cervical cancer, pelvic confined masses suspicious of ovarian cancer, early-stage cervical cancer, high-grade/high-risk</p>

	uterine cancer, delayed debulking surgery (timed to chemotherapy schedules) for advanced epithelial ovarian cancer where ICU/HDU capacity permits, if required, and resection of primary vulval tumour.
Level 3	<p>Can be delayed by 10–12 weeks with no predicted negative outcome.</p> <p>In some patients, delaying surgery to a point where there is greater availability of ICU support or theatre capacity may be advisable and of limited impact on the survival outcome from malignancy. Or where risk to the patient from surgery during the pandemic outweighs benefit. Women in this category include those with early-stage, low-grade uterine cancer managed conservatively with LNG-IUS and/or oral progestogens. Women with low volume cervical cancer completely excised at loop excision.</p>

4.1.2 Guidance on laparoscopic surgery

This section needs to be read in conjunction with the [RCOG/BSGE statement on laparoscopic procedures and COVID-19](#). [Collated data](#) on the presence of virus in the reproductive tract and viraemia suggests that the risk of transmission of SARS-CoV-2 from laparoscopic surgery for gynaecological procedures that do not involve the gastrointestinal (GI) tract is very low.

Given the data to date, it seems advisable to continue laparoscopic surgery in women with gynaecological cancer who have tested negative for COVID-19 or have been asymptomatic for 14 days prior to surgery. Where surgery is likely to involve the gastrointestinal tract, given the higher prevalence of virus, open surgery is recommended.

4.1.3 Testing and personal protective equipment

Public Health England guidance on [personal protective equipment](#) (PPE) should be followed, as well as [guidance on discharge from hospital](#).

4.1.4 Advice specific to ovarian cancer

Women with ovarian cancer pose a particular challenge. Treatment for advanced ovarian cancer is aimed at delaying progression, prolonging remission and improving survival and many women will achieve long and durable remissions (median survival 4–5 years). However, at first presentation,

surgery to achieve complete removal of all visible cancer often requires prolonged surgical time and possible multivisceral resection, potentially necessitating ICU support and prolongation of postoperative stay; ICU capacity may be unavailable and surgical time limited because of prioritisation of other services.

In situations where primary surgery is not feasible, the BGCS proposes:

- Neoadjuvant chemotherapy either with single-agent carboplatin or carboplatin/paclitaxel. Consideration should be given to the routine use of filgrastim to reduce the incidence of neutropenia in patients receiving combination therapy. Where possible, this should be considered Priority 2. Neoadjuvant bevacizumab should be used with caution, as it has not been shown to improve survival and may be associated with a greater risk of bowel perforation in extensive disease involving the bowel. In much of the UK, glomerular filtration rate (GFR) measurements to calculate carboplatin dose are based on radionuclide excretion. Cockcroft-Gault or Wright methods for calculating GFR should be considered in lieu of radionuclide methods at this time. Image-guided biopsy facilities may be constrained because of pressure on radiology services and it may be necessary to rely on cytology, preferably with a cell block to confirm diagnosis of malignancy prior to treatment.
- Women scheduled for delayed debulking surgery (DDS) can be assessed after three cycles with CT scan (+/- diffusion-weighted MRI) or consideration of laparoscopy and proceed to DDS, if there is a potential for macroscopic cytoreduction. Women may also be counselled to continue with chemotherapy and the decision for surgery reviewed after six cycles of chemotherapy, depending on resource availability. Evidence supports DDS after three cycles of chemotherapy rather than after six cycles and this should continue, where possible.
- There is very little information about the outcome of those receiving surgery following the completion of chemotherapy. Decisions about this should be made on an individual basis depending on the volume of residual disease, symptoms and comorbidities.
- Poly (ADP-ribose) polymerase (PARP) inhibitor maintenance therapy with niraparib is now available through the NHS England Cancer Drugs Fund (CDF) for women with newly-diagnosed stage III or IV ovarian cancer responding to surgery and chemotherapy. Olaparib (NICE-approved) is available for women with a *BRCA* mutation and this (germline and somatic) should continue to be tested. Please refer to the [BGCS/BAGP consensus guidance](#) for further details. Niraparib (NICE-approved) is available for women as maintenance in the first-line setting, regardless of *BRCA* mutation status. PARP inhibitors should be started at the end of chemotherapy and continued for up to 3 years, unless persistent disease for niraparib, or 2 years for olaparib, unless there is disease progression. During the pandemic, some patients may access PARP inhibitors before the opportunity for surgery arises. Similarly, consideration needs to be given to stopping maintenance

bevacizumab and substituting niraparib in situations where it is impractical for women to attend hospital, or hospital day care facilities are severely affected by the pandemic.

For recurrence, the BGCS proposes:

- Secondary debulking surgery in selected women may be considered in light of unpublished results of improved overall survival in this setting (DESKTOP 3 trial). These women would be classified as priority level 3, as other therapeutic options may be safer to consider in those who have relapsed during a peak in the pandemic. Where possible, chemotherapy for platinum-sensitive relapse should be prioritised for symptomatic patients. Platinum based chemotherapy is standard of care in women with platinum-sensitive relapsed ovarian cancer. CDF provides the option to give trametinib for advanced low grade serous ovarian carcinoma as oral alternative to intravenous chemotherapy and to reduce risk of immunosuppression.
- Chemotherapy for platinum-resistant disease is low priority, particularly in the absence of symptoms; alternative strategies to manage symptoms should be considered. For any women already on treatment, consider stopping earlier than planned (there are no data to suggest five cycles of first-line therapy are inferior to six or more). If women are eligible for PARP inhibitors following good response to chemotherapy, starting oral therapy early after cycle four may be considered. Chemotherapy for non-serous, non-endometrioid ovarian cancers and low-grade cancers offers limited benefit and adjuvant chemotherapy in these women is of lower priority. For low-grade serous carcinoma of the ovary, oral trametinib, a MEK inhibitor, is an option instead of chemotherapy, approved during the pandemic by the CDF. Endocrine therapies may be considered where appropriate, and chemotherapy in the recurrent setting deferred where clinically possible.

4.1.5 Resumption of surgical and diagnostic services over the course of pandemic

The status of the pandemic in the UK impacts on cancer surgery and diagnostic services, and efforts to mitigate this should be pursued wherever possible. [Guidance issued by NHSE](#) is useful in this regard.

It must also be recognised that theatre throughput has reduced because of multiple factors: operating in unfamiliar environments with a new theatre team; the need for air change during the theatre list; recovery in theatre; need to wear PPE. All of these factors slow surgery and make it significantly more tiring. Where possible, utilisation of spinal/regional anaesthesia is encouraged to enable safer operating and a reduction in pulmonary complications.

Guidance for perioperative care includes self-isolation for 14 days, asymptomatic for 7 days and COVID-19 swab within 72 hours prior to surgery. There will be a proportion of patients who have occult infection or acquire infection in the immediate postoperative period despite

screening/precautions. The rate of this infection will depend upon the prevalence of disease in the local population. This should be taken into account when planning theatre lists. Operating teams may also need to consider restricting themselves to clean COVID sites and may need testing at regular intervals as advised in above guidance.

In the absence of robust antibody testing and widespread implementation to identify populations that are immune, it is likely cancer systems will need to retain capacity and flexibility for both increases in COVID-19 and conversely continuing/increasing activity to manage cancer treatment provision.

4.2 Chemotherapy and radiotherapy

In the event of limited chemotherapy capacity, clinicians will be advised to follow local guidance and NHS England recommendations. This will require a detailed discussion with the patient, which should consider the benefit of chemotherapy and the risk of SARS-CoV-2 infection while on chemotherapy. Where possible, alternative and less resource-intensive regimens (such as single-agent carboplatin or PARP inhibitors) should be considered where appropriate, or the use of prophylactic growth factors with combination therapies may be warranted.

As general principles, women receiving curative radiotherapy for locally-advanced disease should be prioritised over women receiving adjuvant therapy. Where adjuvant therapy is likely to reduce local recurrence, but not likely to prolong survival, women should be carefully counselled and radiotherapy withheld.

Given the anticipated resource constraints on image-guided biopsies, a pragmatic decision to rely on a cell block to confirm malignancy may be necessary. If possible and relevant, the cell block may be used for additional testing such as *BRCA* status.

4.2.1 Chemotherapy

Considerations for chemotherapy for women with gynaecological cancer during the COVID-19 pandemic:

i) Ovarian cancer

Chemotherapy for germ cell tumours should be offered to all newly-diagnosed patients as high priority. See section 4.1.4.

ii) Uterine cancer

For women with advanced, high-grade, endometrial cancer, adjuvant chemotherapy may increase the chance of cure and should be considered if resources allow or deferred in some cases for up to 3 months. In lower risk endometrial cancers, the benefit of adjuvant chemotherapy is less significant and may be deferred or omitted. In women with stage IV disease, chemotherapy may be offered, where possible, dependent on the availability of resources and the use of prophylactic filgrastim or single-agent chemotherapy may be warranted. Endocrine treatment may be an appropriate alternative. In relapsed disease, treatment should be considered based on the individual's symptoms and risk factors. Again, endocrine therapy or treatment delay should be considered where appropriate.

There are some additional treatment options to consider, outlined by NHS England.⁷

iii) Endometrial cancer

Option to give nivolumab instead of chemotherapy for microsatellite instability-high tumours to reduce toxicity and risks of treatment.

iv) Gestational or placental site trophoblastic tumour

Option to give pembrolizumab first-line or subsequent line instead of combination chemotherapy (change of sequence) to reduce the number of admissions and reduce the risk of neutropenia.

v) For cervical and vulval cancers

Chemoradiotherapy for locally advanced cervical, vaginal or vulval cancer is a high priority and should be delivered wherever possible, as local resources allow. Palliative chemotherapy in metastatic cervical cancer should be considered where resources allow, but second-line treatment and beyond is of limited benefit and low priority. First-line chemotherapy for metastatic vulval cancer should be considered based on the individual's symptoms and risk factors, but second-line treatment and beyond is of limited benefit and low priority.

NHS England recommendations for chemotherapy are summarised below.

Table 2. Summary of NHS England recommendations for chemotherapy

Priority level	
Level 1	<p>Curative therapy with a high (more than 50%) chance of success.</p> <p>Adjuvant (or neo) therapy which adds at least 50% chance of cure versus surgery or radiotherapy alone or treatment given at relapse.</p> <p>For gynaecological cancers, this includes chemotherapy for germ cell tumours and gestational trophoblastic tumours. Concurrent chemoradiation for cervical cancer.</p>
Level 2	<p>Curative therapy with an intermediate (15–50%) chance of success.</p> <p>Adjuvant (or neo) therapy which adds 15–50% chance of cure versus surgery or radiotherapy alone or treatment given at relapse.</p> <p>For gynaecological cancers, this may include chemotherapy for women with high-grade serous or endometrioid ovarian cancer, particularly where the woman is known to have a <i>BRCA</i> mutation, low volume disease or good performance status.</p>
Level 3	<p>Curative therapy with a low chance (10–15%) of success.</p> <p>Adjuvant (or neo) therapy which adds 10–15% chance of cure versus surgery or radiotherapy alone or treatment given at relapse.</p> <p>Non-curative therapy with a high (greater than 50%) chance of more than 1 year of life extension.</p> <p>For gynaecological cancers, this may include chemotherapy for some women with high-grade serous or endometrioid ovarian cancer, newly-diagnosed or first platinum-sensitive relapse.</p> <p>Women with advanced, high-grade, endometrial cancer.</p>
Level 4	<p>Curative therapy with a low (0–15%) chance of success.</p> <p>Adjuvant (or neo) therapy which adds less than 10% chance of cure versus surgery or radiotherapy alone or treatment given at relapse.</p> <p>Non-curative therapy with an intermediate (15–50%) chance of more than 1 year life extension</p>

	For example, chemotherapy for cervical and endometrial cancer in first recurrence with good performance status, or advanced previously untreated disease. Some women with platinum-sensitive relapsed ovarian cancer.
Level 5	Non-curative therapy with a high (more than 50%) chance of palliation/temporary tumour control but less than 1 year life extension For example, chemotherapy for platinum-resistant ovarian cancer and recurrent endometrial cancer.
Level 6	Non-curative therapy with an intermediate (15–50%) chance of palliation/temporary tumour control and less than 1 year life extension For example, chemotherapy for metastatic or recurrent cervical cancer or endometrial cancer in second recurrence.

4.2.2 Radiotherapy

This section should be read in conjunction with the Royal College of Radiologists (RCR) [Guidance for radiotherapy for gynaecological cancer and COVID-19](#).

There may be reduced radiotherapy availability, requiring prioritisation of women depending on local resource and demands. With the possibility that all cancer surgery is suspended, definitive radiotherapy will be required to treat some early-stage cancers. Changes to practice during the pandemic may be required to reduce departmental workload.

General measures to consider include:

- Using the most clinically appropriate hypo-fractionated schedule.
- Simplified techniques for planning and treatment verification may be used with appropriate adjustment of target volumes.
- Chemotherapy access for chemoradiotherapy treatments should be prioritised as outlined in NHS England Chemotherapy Priority Category 1.
- Anaesthetic availability may be the determining factor for capacity for some radiotherapy, e.g. intrauterine brachytherapy.
- The number of intrauterine insertions should be minimised, delivering multiple fractions per insertion if possible. Simplification of technique may be necessary depending on imaging and planning availability.
- Consider omission of adjuvant radiotherapy when there is no or limited survival advantage, e.g. adjuvant brachytherapy for intermediate risk endometrial cancer.

NHS England recommendations for radiotherapy are summarised below.

Extending the total treatment time of radiotherapy can have a deleterious impact on tumour control. The RCR defines tumours where survival is impacted by any delays in treatment as category 1, and those where short delays have less effect as category 2.

Table 3. Summary of NHS England recommendations for radiotherapy

Priority level	
Level 1	<p>Women with category 1 tumours being treated with chemotherapy-radiotherapy and brachytherapy for category 1 tumours on external beam radiotherapy.</p> <p>For gynaecological cancer, this includes radical radiotherapy for cervical, vaginal and vulval cancers, and intrauterine brachytherapy for cervical cancer.</p>
Level 2	<p>Urgent palliative radiotherapy to save loss of function/life.</p> <p>Examples include urgent palliative radiotherapy in women with malignant spinal cord compression, who have useful salvageable neurological function, and palliative radiotherapy to stop bleeding.</p>
Level 3	<p>Radical radiotherapy for category 2 tumours where radiotherapy is the first definitive treatment OR postoperative radiotherapy where there is known residual disease following surgery in tumours with aggressive biology.</p> <p>This includes adjuvant radiotherapy for residual disease, positive resection margins or nodal involvement in cervical, vaginal, vulval and endometrial cancers. Definitive radiotherapy for uterine tumours may be necessary for selected cases.</p>
Level 4	<p>Palliative radiotherapy for symptom control.</p> <p>This includes palliative radiotherapy for metastatic disease and pelvic masses.</p>
Level 5	<p>Adjuvant radiotherapy.</p> <p>This includes postoperative radiotherapy for fully resected high-risk endometrial cancer.</p>

5. Vaccination

5.1 Vaccination and surgery

Vaccination has been used in many patients and has been shown to be very low risk. Some patients may have a slight fever 1–2 days after vaccination, especially after the second dose. For elective surgery, allowing a few days (at most a week) between vaccination and surgery would allow better identification of cause for a raised temperature or symptoms. Emergency surgery, however, should not be delayed.

There are currently no head-to-head trials comparing COVID-19 vaccines and, therefore, patients are encouraged to accept whichever they are offered first, unless there are specific contraindications.

Data from the Pfizer vaccine study suggested there is a good level of immunity 10–12 days after first vaccination.⁸ Given the risks of contracting COVID-19 around the time of surgery, ideally, all individuals about to have surgery should be offered vaccination prior to surgery, as these individuals could be viewed as ‘extremely vulnerable’. However, there is currently no policy established for prioritising those scheduled for elective procedures.⁹ The [Royal College of Surgeons](#) has provided useful advice on vaccination of patients awaiting surgery.

5.2 Vaccination and chemotherapy

Individuals who are undergoing active chemotherapy or receiving PARP inhibitors are in priority risk group 4 for vaccination (aged 16–65 years; those who are older are in groups 1–3).¹⁰ Individuals with immunosuppression may not make a full immune response to vaccination. As there is no evidence on response in immunosuppressed individuals, there is also no evidence upon which to base advice on the optimal timing of delivery. All such individuals are advised to have the vaccine. Specialists may advise individuals based on their knowledge and understanding of their immune status and likely immune response to vaccination, but should also consider the risk from COVID-19 and the individuals’ likelihood of exposure. Until further information becomes available, all those vaccinated who are immunosuppressed should continue to follow advice to reduce the chance of exposure.¹⁰

6. Support for women

Women undergoing investigation and treatment for gynaecological malignancies usually have the support of a CNS. The CNS is crucial to support women at this time, provide information, answer questions and support complex decision-making. They help to navigate complex pathways. They are a key patient advocate liaising with clinical teams about patient choice and preferences. However, as hospitals will be facing unprecedented demand on nursing care, this role will inevitably be redeployed to support inpatient clinical care

This is going to be a frightening and worrying time for women who are currently undergoing treatment, those who relapse and those newly-diagnosed. A key member of the team may not be available. Departments should consider how support will be offered to women. The charitable sector

has made a significant contribution to the care of women with gynaecological cancers and it is anticipated their role at this time will be crucial. The BGCS will be working closely with gynaecological cancer charities to enable women to be best supported at this difficult time.

The BGCS has coordinated with all the national gynaecological cancer charities to release a [list of reliable information links](#), which may be usefully signposted by hospital trusts. Charities are also able to signpost women (their partners, families and carers) to additional support services, including to those women who are shielding.

Our feedback from charities is that calls from individuals for support has increased in this time. Providing a summary of diagnosis and treatment administered to an individual empowers them to seek help appropriately. An example of this can be found in Appendix II. A modified version of the *End of Treatment Summary* may also be helpful.

The BGCS recommends that:

- Where more than one CNS is available, ward work is alternated to allow one CNS to work as a CNS.
- Cancer units could consider cross-cover of CNSs through generic working of CNSs across tumour sites.
- Trusts should consider who will take CNS telephone calls, i.e. administrative staff and cancer care coordinators, and have mechanisms in place for a clinical member of the team to review and respond to these. Alternatives, such as the use of email by CNS staff, may allow remote working where possible.
- Safety-netting is in place so that women can be contacted by a CNS when normal service resumes.
- Departments/Trusts consider signposting women to other sources of support, i.e. the charitable sector. Suggestions would be to contact clinical teams with clinical concerns/queries, contact the charitable sector with emotional concerns when a CNS is not available.
- Innovative ways of working to access charitable sector support, with patient consent and trust permissions, to discuss concerns may need to be considered.

7. Palliative care

For women and their families/carers requiring palliative care input during the COVID-19 pandemic there are published guidelines from [Hospice UK](#).

Women and their families/carers will understandably be anxious regarding arrangements for end-of-life care. Early liaison with hospices, and communication with women and their families/carers on access to best supportive care and management of troublesome symptoms will be important. Some

hospitals are allocating areas for end-of-life care for COVID-19 and non-COVID-19 patients – this is likely to be valued by women and their families/carers.

8. Impact on staff and self-care

These are challenging times for all those working to provide services for women with suspected or confirmed gynaecological cancers. Many will experience anxiety for themselves, their loved ones and patients at the same time as providing much needed care. A strategy to seek help and a readiness to signpost colleagues, when vulnerable, to support services, will be important to ensure wellbeing during and after the pandemic.

Services may also be impacted adversely because of sickness levels, causing reduction in quality of care, across all levels of administrative and clinical staff. These need to be recognised and contemporaneously recorded, so any subsequent incidents can be appropriately assessed in context. Updated risk assessments detailing the impact on the capability of individual services are recommended.

9. Research on impact of COVID on cancer care

Participation in national and international efforts, such as UKCOGS (bcc-ukcogs@qmul.ac.uk) and CovidSurg-Gynaecological Cancer (gocovidsurg@gmail.com) and UK Coronavirus cancer monitoring project, is strongly encouraged. These studies will enable planning for future responses and maintenance of gynaecological cancer care. It is also vital that cancer clinical trials continue during the pandemic, as these offer potentially valuable treatment options. Capacity to support these trials must be sought from local research and development departments.

Appendix I: Harm review template

Patient name			
Hospital number NHS number Date of MDT discussion			
Date of birth			
Cancer site (dropdown list)	Vulval		
	Vaginal		
	Endometrial		
	Uterine		
	Ovarian type		
	2WW referral		
	Other		
Tumour diagnosis (Pathology and Stage)			
WHO PS =	Rockwood Frailty Score =	BGCS surgical priority level/chemotherapy priority level/ radiotherapy priority level	
Standard MDT decision			
Revised MDT decision			
Rationale			
Plan for mitigation			
MDT recorded			
Patient contacted			
Plan for review			
Database completed			
Potential Impact	Negligible	Significant but justified	Unknown
Date		Completed by	
SIGNED			

Appendix II: Patient summary sheet – Gynae-oncology

Patient name:

Hospital number:

1	You have been diagnosed with: Cervical / Endometrial / Ovarian / Vaginal / Vulval Cancer (please circle)	
2	Initial histology shows the grade of your cancer to be (if known):	
3	Radiological imaging shows the staging of the cancer to be (if known):	
4	Imaging required: CT scan – Chest abdomen & pelvis MRI – Pelvis PET scan Chest X-ray	
5	Biopsy required? Yes / No	
6	Blood tests required: Please state: Where should these be taken:	
6	Discussion at MDT (weekly clinical meeting) Known date: Anticipated date (if not known): Your CNS will contact you after this meeting to advise you of the treatment plan. This may mean you undergo further investigations.	
7	Any questions, please call your CNS	

Signed:

Clinical Nurse Specialist

Signed:

Patient

Date:

Date:

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