



BASO~The Association for Cancer Surgery

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Pragmatic Management of Breast Cancer during COVID-19

During the COVID-19 crisis, difficult decisions are being taken about management of other diseases and even management of cancer is being altered. At such time, there can be a temptation to use unproven treatments, often without consultation with patients. Having considered the evidence, and keeping the length and quality of life as the prime outcomes that patients would care about, we have come up with some recommendations, in consultation with Professor Jeffrey Tobias, Professor of Clinical Oncology, and Professor Bob Leonard, Professor of Medical Oncology, to be used in conjunction with the guidance already issued by Association of Breast Surgery (ABS) for the management of breast cancer patients during Covid-19:

1. Discontinue all mammography screening. Patients diagnosed with only DCIS should be regarded low priority for surgery
2. Breast MRI should be avoided where possible in view of the known risk of increased interventions and hospital visits.
3. For patients suitable for breast conservation, and in patients who are considering mastectomy in order to avoid EBRT, intra-operative radiotherapy (TARGIT-IORT) could be considered where available. EBRT over 5 days could be considered as published evidence unfolds.
4. Neo-adjuvant chemotherapy should not be recommended unless tumours are inoperable AND ER negative
5. Delayed reconstruction should be offered as the first option with immediate implant reconstruction, only considered in selected patients, subject to local theatre capacity and low complication rate. Prolonged autologous reconstruction should not be offered.
6. When surgical capacity is compromised, primary systemic therapy for ER positive or HER2 positive cases, with surgery reserved only for triple negative cases may have to be resorted to.
7. The challenges of treating chemotherapy-related complications in coming months should be taken into consideration by multidisciplinary teams/ tumour boards whilst balancing the relative benefits from chemotherapy. Extending gene-expression analysis to include node positive patients may help in this regard. For safety with any chemotherapy, growth factors should be considered to minimise the risk of neutropenic sepsis. With rising incidence, adjuvant chemotherapy may need to be completely avoided or discontinued.
8. Patients should be encouraged to accept remote consultations, as much as possible. Encourage prospective cohort studies about remote consultations.
9. All follow ups (and follow up imaging) should be stopped unless patients have specific breast symptoms or are at high risk of relapse.
10. Genetic testing and risk-reducing surgery should be deferred for 3-6 months, unless it has direct immediate impact on management of known cancer.

We strongly support the current campaign to a) improve the availability of personal protective equipment (PPE) b) testing of all HCW c) potentially test patients for COVID 19 and d) try and abrogate the introduction of infection to hospitals by visitors.

With Best Wishes,

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