Peer review comments – Systemic anticancer treatments: shared decision making with individual patients

COVID-19 rapid guideline: delivery of systemic anticancer treatments (NG161)

(August 2022 update)

Peer review organisations

For this topic, stakeholder organisations were invited to comment on the updated recommendations.

Overarching category	Guideline section	Theme of comments	Action taken
General comments	Recommendation: Do not routinely delay starting systemic anticancer treatment (SACT), or pause SACT that is already underway, because of the risk of contracting COVID-19	One stakeholder commented it is important not to routinely delay SACT.	Thank you for your response. No changes have been made to this recommendation.
General comments	Recommendation: Discuss the risks and benefits of SACT with people with cancer and their families and carers, taking into account current dominant COVID-19 variants and COVID-19 prevalence. Topics to cover include: • that the limited evidence available suggests most people who have	One stakeholder did not agree with this bullet in the recommendation. The stakeholder commented that the risks of hospitalisation and death are increased for people having chemotherapy, particularly in people with blood and respiratory cancers. In support of their comment, they cited the QCOVID-2 study by Hippisley-Cox et al. (2021).	An evidence review was developed for the panel to consider as part of this guideline update. The review protocol for this evidence review was agreed by the panel and specified that SACT be delivered within 4 weeks before COVID-19 diagnosis in eligible studies. The study by Hippisley-Cox et al. (2021) describes the development of the QCOVID

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	SACT do not go on to have worse outcomes from COVID-19 infection, should they develop it (NB: comment related to this bullet only)	A second stakeholder concurred with this view but noted that the risk for people having SACT was lower than for therapeutically immunosuppressed patients, for example, transplant patients, people with rheumatoid arthritis, and people with haematological malignancy.	living risk prediction algorithm. This study was identified in our searches and considered against the review protocol for the evidence review. However, the study was not eligible for inclusion in the evidence review because it was stated that chemotherapy was received in the previous 12 months and so this study was not included in the evidence review. The evidence review included 11 cohort studies comparing the effects of different types of SACT on mortality, COVID-19 severity, hospitalisation, ICU admission, and requirement for mechanical ventilation in people with cancer and laboratory-confirmed COVID-19. The panel considered this evidence and noted that most available data did not show statistically significant associations between receipt of SACT and worse outcomes from COVID-19 but noted the uncertainty in the evidence. The panel discussed this evidence alongside their clinical experience and concluded that most people who have SACT do not go on to have worse outcomes from COVID-19. The evidence to decision text for this recommendation has been revised to indicate that this conclusion was based both on the limited evidence identified and the panel's clinical experience.

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General comments	Recommendation: Discuss the risks and benefits of SACT with people with cancer and their families and carers, taking into account current dominant COVID-19 variants and COVID-19 prevalence. Topics to cover include:… • factors that may affect their risk of becoming severely ill with COVID-19, including vaccination status, underlying conditions, male sex, ethnicity and cancer symptoms (NB: comment related to this bullet only)	One stakeholder commented that this recommendation should also include i) cancer type (particularly blood and respiratory cancers) and ii) administration of chemotherapy (noting the QCOVID-2 paper by Hippisley-Cox et al. (2021). A second stakeholder agreed with this view.	As noted above, the study by Hippisley-Cox et al. (2021) was identified in our searches but was not considered eligible against the review protocol for the evidence review performed for this update (because in this study SACT was not received within 4 weeks of COVID-19 diagnosis). The panel discussed the evidence included in the evidence review alongside their clinical experience to make their conclusions on the risks associated with having SACT. The factors for discussions in shared decision making suggested in this recommendation are not intended to be an exhaustive list and so discussions between the healthcare professional and the person may also include other factors, such as cancer type, as appropriate.
Population	Recommendation: Discuss the risks and benefits of SACT with people with cancer and their families and carers, taking into account current dominant COVID-19 variants and COVID-19 prevalence. Topics to cover include:… • that there is some limited evidence that people with myeloma who have immunomodulatory SACT may have worse outcomes from COVID-19	One stakeholder stated that this bullet should not only refer to myeloma but all lymphoid malignancies, noting that in B-cell lymphomas responses to COVID-19 vaccination are least good. The reviewer flagged a study by Rubinstein et al. (2022) to support their comment. A second stakeholder also queried whether this recommendation bullet should cover people with myeloma only, or people with other haematological conditions.	The study by Rubinstein et al. (2022) was not identified in searches and was not included in the evidence review. This study was based on the CCC19 cohort, which was also used in the studies by Kuderer et al. (2020) and Grivas et al. (2021) that were included in the evidence review. However, this study is not considered eligible against the review protocol for the evidence review performed for this update. The review protocol specified that SACT be delivered within 4 weeks before COVID-19 diagnosis. In this analysis, people were treated for cancer within 1

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	(NB: comment related to this bullet only)	A third stakeholder commented that differentiating immunocompromised patients is essential. A fourth stakeholder queried whether evidence that some leukaemia and other blood cancer patients are also at increased risk of COVID-19 had been considered.	year of COVID-19 diagnosis, with the authors stating that this timepoint was chosen as B-cell repletion following anti-CD20 treatment can take up the 12 months. Therefore, this study was not included in the evidence review. Evidence was described in the evidence review for individual cancer types (including leukaemia) where reported in the included studies. This evidence was available for the panel to consider in their development of recommendations. This recommendation has been revised to include other types of haematological cancer following consideration of peer review comments and confirmation with the panel. The evidence to decision text for this recommendation has also been revised to indicate that panel discussions were based on both evidence and clinical experience.
Population	Recommendation: For people with myeloma, discuss treatment strategies with a specialist team before giving immunomodulatory SACT.	One stakeholder commented that this recommendation should include people with haematological malignancies. A second stakeholder agreed with this view. A third stakeholder noted that the patient would be cared for by the haematology team and queried whether this recommendation related to care by a tertiary team. They stated	This recommendation has been revised to include other types of haematological cancer following consideration of peer review comments and confirmation with the panel. We have clarified the specialist team that the recommendation relates to.

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		that this recommendation should specify which team this recommendation relates to.	
General	General	One stakeholder commented that patients often ask primary care clinicians questions about SACT, although treatments are not initiated in primary care. They highlighted the need for timely care and advice from the team initiating and monitoring SACT to answer questions on individual treatments.	Thank you for your comment. Recommendation 3.2. relates to discussions between people with cancer, their families and carers and their cancer specialist rather than with their general practitioner. We acknowledge the need for timely care and advice from the clinical specialist and this recommendation also states to follow relevant national guidance on communication, providing information and shared decision making.
General	General	One stakeholder commented that a recommendation should be added that clinicians provide advice to patients on how to reduce their risk of catching COVID-19 while on treatment.	Recommendation 3.2. has been revised to state that advice on how to reduce risk of catching COVID-19 while having SACT be provided as part of the shared decision making process.
Infection control and prevention	Recommendation 3.4	One stakeholder noted that the use of personal protective equipment and lateral flow tests was a continuing area of anxiety for patients and staff delivering SACT. They commented that there was no recommendation related to these and queried whether this should be included, for example to recommend to follow local processes. A second stakeholder commented that there is variation between centres in local infection	Recommendation 3.2 has been revised to state that advice on how to reduce the risk of catching COVID-19 while on treatment should be included in shared decision making discussions. The panel discussed testing approaches before cycles of SACT but determined that this is now generally agreed at a local level.

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		control and prevention policies and suggested it would be useful to signpost to related national guidance to provide clarity, particularly relating to testing before first and subsequent SACT cycles.	
General	General	One stakeholder suggested including advice on the timing of COVID-19 vaccinations during and/or following SACT. They commented that research shows that people who have had SACT in the previous 6 months are unlikely to have antibodies or develop an antibody response to vaccination (citing a study in people with lymphoma (Lim et al. 2021)). They noted that patients' clinical teams were well placed to give tailored advice and individualised treatment plans, but that general guidance may be useful.	The study by Lim et al. 2021 was not eligible against the review protocol for the evidence review, as it did not address the review question and did not compare outcomes in people with cancer and laboratory-confirmed COVID-19 who had received SACT within 4 weeks of COVID-19 diagnosis with those who had not. Timing of COVID-19 vaccination is outside the scope of this guideline. However, recommendation 3.2. lists factors that should be discussed with patients in the shared decision making process, which includes vaccination status.
General	General	One stakeholder expressed disappointment that the guideline did not refer to remote working and consultation, as they considered this to have had benefit for patients.	Thank you for your comment. It is considered that remote working and consultation is now embedded in local ways of working and so this has not been added to the guideline.

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General	General	Five stakeholders did not provide specific comments but stated that they supported the recommendations.	Thank you for your responses.
General	General	Three additional stakeholders did not provide specific comments but responded to say they had no comments.	Thank you for your responses.
General	Research recommendation	One stakeholder commented that the following research recommendation for this guideline was out of date: Are patients with cancer and COVID-19 who are receiving/have recently received systemic anticancer treatment (SACT) (that is, within the 4 weeks preceding a diagnosis of COVID-19) at increased risk of severe COVID-19 illness or death? The reviewer considered that the research had been addressed in the QCOVID study.	Thank you for your comment. As discussed above, the QCOVID study included chemotherapy within the previous 12 months, rather than the 4 weeks before COVID-19 diagnosis specified in this research question. The panel agreed that there was uncertainty in the evidence identified in the evidence review and so this research recommendation will be retained.