Ontario Health
Cancer Care Ontario

Memo

Date:
April 13, 2021

To: Regional Vice Presidents, cancer services

From: Dr. Chris Simpson, Executive Vice President, Medical, Ontario Health
Dr. Jon Irish, Provincial Clinical Head, Cancer Care Program and Quality Initiatives, Ontario Health (interim)
Elaine Meertens, Interim Executive Lead, Clinical Institutes & Quality Programs
Dr. Linda Rabeneck, VP, Prevention and Cancer Control

Re: Clinical Guidance for cancer surgeries, gastrointestinal endoscopy, colposcopy and breast screening and assessment through the Ontario Breast Screening Program

Further to the memo of April 8, 2021 from Matt Anderson, President & CEO, Ontario Health, regarding ramp down of elective surgeries and non-emergent and non-urgent acute care activities, this memo provides clinical guidance on cancer surgeries, gastrointestinal endoscopy, colposcopy and breast screening and assessment through the Ontario Breast Screening Program. This clinical guidance considers the extraordinary pressures on critical care capacity in Ontario and lessons learned from waves 1 and 2 of the COVID-19 pandemic.

Maintaining services as previously outlined in Ontario Health's document entitled *Optimizing Care Through COVID-19 Transmission Scenarios*[i] that reflect resource availability is important where a patient's outcome will be affected by delay in care.

Cancer Surgery

Cancer surgeries are time-sensitive surgeries and procedures that should be maintained as long as there is availability of resources in the hospital including ICU capacity, hospital beds and human resource:

- Surgeries that should not be delayed include Priority A or Wait Times Information System (WTIS) Priority Categories 1 and 2 and some Priority Category 3
- Cancers that have a more rapid tumour doubling time (head and neck mucosal, lung esophagus, gastric, HPB, bone sarcoma and high grade gynecological cancers) should be prioritized and not deferred.
- Consideration for delay can be given to Priority B or some WTIS Priority Category 3 and discretionary Priority level 4
- See Table below for examples of the types of cases that could be deferred following discussion with the surgeon.
- It is strongly emphasized that triage decisions are performed in collaboration with members of the surgical division/department or in Multidisciplinary Cancer Conferences
- It is strongly encouraged that hospitals and surgeons develop a communication plan to inform patients who have had their surgical care delayed due to the ramp down.

Table 1:

Priority Level	Description	Examples of what should not be deferred	Examples of what could be deferred
Priority A WTIS Priority Categories 1 and 2 and some Priority Category 3, emergent and very aggressive tumours).	Patients in whom a delay in surgery would result in either an immediate threat to life or limb, or would significantly alter the patient's prognosis.	Patients with obstructions, bleeding or perforations requiring immediate surgery Other patients would be those with a narrow window of opportunity for definitive surgery, such as those who have been on neoadjuvant protocols. A significant delay for the neoadjuvant patients could negatively impact on their outcome by allowing for recovery of residual cancer and thus losing the benefit invested in the neoadjuvant approach. Cancers that have a more rapid doubling time (head and neck mucosal, lung esophagus, gastric, HPB, bone sarcoma and high grade gynecological) should be prioritized and not deferred.	
Priority B WTIS Priority Category 3 and some Priority Category 4 tumours.	Patients for whom a delay of <4 weeks from target would not be anticipated to impact significantly on survival or outcome		Some solid tumour cases (e.g., breast, colon, GU, GI and lower grade tumours in lung, HNK and gynae) provided delays were in the range of 4 weeks
Priority C WTIS Priority Category 4, indolent tumours.	Patients for whom a delay of 2 months would be unlikely to affect outcome		Well differentiated thyroid cancers, early prostate cancers and non-melanoma non-squamous cell skin cancers.

For additional information to guide prioritization of cancer surgeries please refer to Table 3: Cancer Surgery Prioritization, By Disease Site[ii] included in Ontario Health's document entitled *COVID-19 Supplemental Clinical Guidance for Patients with Cancer.*

Important Considerations:
It is important that all patients are listed in the WTIS to allow the hospital and province insight to significant delays.

As Priority 1 and 2 patients may represent the sickest of our population, there will be requirements for ICU and step-down care for post-operative management of some of these patients.

All priority patients, especially Priority 3, would have to be followed as excessive delays, evidence of unexpected progression, or the onset of symptoms (e.g., bleeding, obstruction) would mandate escalation.

Gastrointestinal (GI) Endoscopy Services

As outlined in the Ontario Health *Tip Sheet -09 – Guidance for Increasing GI Endoscopy Services*, certain high priority endoscopy procedures should be maintained as long as there is availability of resources in the hospital. The Tip Sheet was developed to support resumption of services after wave 1, however, the same framework can be used by hospitals during wave 3.

- Priority levels A and B1 should not be deferred:
    - **Priority level A**: Patients who are deemed critical and require GI endoscopy because their situation is unstable, is causing unbearable suffering and/or is immediately life threatening (e.g., overt or suspected upper or lower GI bleed with hemodynamic instability)
    - **Priority level B1**: Non-critical patients who require services/treatment for conditions that may cause early negative impact on quality of life or functional status (e.g., fecal immunochemical test (FIT)-positive colonoscopies, endoscopy to support other planned therapeutic interventions)
- Where there is availability of resources, discretionary Priority Levels B2 and C could be performed
- It is strongly recommended that Priority level D (e.g., primary colonoscopy screening for people at average risk of developing colorectal cancer, surveillance colonoscopy in people with low risk adenomas) are not performed and that these patients are instead screened with the FIT
- Please see the Tip Sheet for a list of procedures in each priority level

Colposcopy Services

As outlined in the *Ontario Health Tip Sheet -12 – Guidance for Increasing Colposcopy Services*, some high priority services should be maintained as long as there is availability of resources in the hospital. The Tip Sheet was developed to support resumption of services after wave 1, however, the same framework can be used by hospitals during wave 3.

- Priority level B1 should be maintained as long as there is availability of resources
    - **Priority level B1**: Patients with high grade cytology result (i.e.: ASC-H, HSIL, AGC, AIS)

- Where there is availability of resources, discretionary Priority level B2 could be performed
- It is recommended that patients with referrals for first time ASCUS or LSIL cytology results are rescreened in primary care with cytology within approximately 12 months, rather than seen in colposcopy
- Please see the Tip Sheet for more detail in each priority level

Ontario Breast Screening Program (OBSP) Services

As outlined in the *Ontario Health Tip Sheet-13 – Guidance for OBSP Screening and Assessment Services,* the prioritization framework for mammography, MRI and ultrasound in the OBSP should be followed where there are capacity or resourcing challenges. The Tip Sheet was developed to support resumption of services after wave 1, however, the same framework can be used by hospitals during wave 3.

- **Mammography**: breast assessments (in particular BI RADS 4 and 5) should be prioritized, followed by High Risk OBSP mammograms, then OBSP average risk mammograms
- **MRI and ultrasound**: breast assessments (in particular BI RADS 4 and 5) should be prioritized, followed by High Risk OBSP MRI or ultrasound (where MRI is not medically appropriate)
- Please see the Tip Sheet for more detail in each priority level

[i] https://www.ontariohealth.ca/sites/ontariohealth/files/2020-10/Optimizing%20Care%20Through%20COVID-19%20Transmission%20Scenarios_EN.pdf

[ii] https://www.ontariohealth.ca/COVID-19/Health-System-Response-Resources > Cancer Care