UK MDS Forum guidance during COVID-19 outbreak

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COVID-19 virus is highly infectious and produces severe life-threatening pneumonia. The epidemiology is becoming clearer, resulting in the definition of patient groups at highest risk for severe disease.
The general advice on Patient Support websites should be followed

https://mdspatientsupport.org.uk/coronavirus-mds-blood-cancer-advice/

The rapid guidance from NICE for systemic anti-cancer therapy in the COVID-19 outbreak should be followed

https://www.nice.org.uk/guidance/ng161

As the daily number of new cases and deaths from COVID-19 infection falls, the NHS is starting to resume stalled activity. There is considerable geographic variation in the prevalence of COVID-19 infection, and each NHS organisation must decide if continuing with the following recommendations remains appropriate for them or whether they have a sufficiently reduced COVID-19 prevalence, and the capacity and staff resources to safely resume standard management of MDS patients.

The UK MDS Forum proposes the following more specific guidance for the interventional management of MDS patients during the period of continuing risk from infection with COVID-19. There is a limited (or no clear) evidence base for the majority of these recommendations which are practical and consensus in this unprecedented time of crisis.

Hypomethylating agents - azacitidine

New diagnoses of IPSS INT-2/High patients

- Almost all patients will become neutropenic during the first 1-3 cycles of azacitidine therapy
- Therefore consider whether a delay in initiating azacitidine could be acceptable to the patient and clinician. In the AZA-001 registration study, only 52% patients were treated within one year of original diagnosis (which for some, may have been lower-risk). Patients' management should be assessed by the MDT on an individual basis and then discussed with the patient. Delay may be acceptable for the following groups but this is not an exhaustive list:
    - Patients with relatively well preserved blood counts (e.g. neutrophils >1)
    - Patients with stable blood counts for the preceding 3 months and neutrophils > 1
    - Patients with lower blast count (<10%)
    - Patients lacking good-risk 'AML' genetic / genomic characteristics
- If azacitidine therapy deemed immediately necessary, consider using G-CSF and / or antibiotic prophylaxis through cycles 1 & 2 in order to try to prevent hospitalisation with neutropenic sepsis.
    - Where feasible and subject to local guidelines for home administration of azacitidine, consider alternative models of care to minimise hospital attendance for azacitidine injections
    - Blood count monitoring should not be reduced, continuing per local guidelines, but samples taken in the patient's home where possible and attendance to hospital following, based on local blood product transfusion policy.

Patients already on azacitidine

- Beyond cycle 3, if patients are deemed to be having clinical benefit, consider increasing interval between cycles to 6 weeks, or continuing 4-weekly but reduce to 5 days azacitidine per cycle. Note that there is no trial evidence for a switch from 4-weekly to 6-weekly intervals, but there is some (under-powered) randomised trial evidence that 5-day azacitidine cycles may be less efficacious than 7-day cycles.

Lenalidomide

- For newly diagnosed patients with isolated del(5q) MDS who may be candidates for lenalidomide therapy, defer therapy and continue transfusional support
- For responding patients established on lenalidomide, continue therapy

Intensive chemotherapy

- No generalised guidance can be provided other than to suggest an individual patient risk:benefit assessment for delaying intensive therapy or considering alternative lower intensity therapy in the light of likely greater risk of treatment related mortality from COVID-19 infection after intensive chemotherapy.

Allogeneic stem cell transplantation

- Again no generalised guidance can be provided other than to suggest an individual patient risk:benefit assessment for delaying stem cell transplant in the light of likely greater risk of treatment related mortality from COVID-19 infection

G-CSF

- Patients with profound neutropenia and recurrent infection may temporarily be candidates for G-CSF provided this can be self-administered and does not increase attendance to hospital.

Transfusion

- In an attempt to reduce hospital attendance all transfusion-dependent patients should be reviewed to assess if increased intervals between transfusions is possible without significant medical risk.

Writing group: UK MDS Forum and NCRI MDS subgroup.
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This is a set of consensus recommendations created to bridge the unprecedented burden that the COVID-19 pandemic is placing on the NHS. The guidance will be reviewed at the end of July 2020 and will expire when the COVID-19 infection is deemed to no longer be clinically significant for MDS patients.