

Gastrointestinal cancer pathways may breakdown due to COVID-19

In 2018/2019, 587 517 patients in England were referred on an urgent gastrointestinal (GI) two-week-wait (2WW) cancer pathway.¹ Patients attend straight-to-test endoscopy procedures, or urgent clinic appointments.

Upper GI cancer pathways have a cancer yield of 3%, lower GI 7%.² General practitioners (GPs) and hospital clinicians are accustomed to a high volume of referrals with low yield. This has been mutually beneficial, improving GI cancer outcomes for the population, ease of referral in primary care, and generating income for secondary care. Consequently, the majority of patients investigated have benign conditions. These services are pressured due to significant resource and workforce constraints, 90% of patients in 2018/2019 were seen within 14 days (target 93%).¹

COVID-19 swept through Europe killing tens of thousands. The peak of the first wave was mid-April 2020 in the UK, subsequently surpassing 40 000 COVID-19-related deaths. Hospitals initially pivoted their services to boost critical care capacity, including suspension of outpatient endoscopy services as per British Society of Gastroenterology (BSG) guidance. Resumption of endoscopy services post peak is not straightforward. There will be a backlog of case. Staffing has been depleted due to redeployment, sickness with COVID-19 or socially isolating due to chronic health conditions.

Personal protective equipment (PPE) requirements for endoscopy services are high as upper GI endoscopies are aerosol-generating procedures, posing a significant risk to endoscopy staff. Lower GI endoscopies are thought to be lower risk despite coronavirus RNA being detected in faeces (probably non-viable virus).³ There has to be confidence of PPE supply to endoscopy units, while maintaining critical stocks for inpatient teams.

The BSG have issued guidance on how services may resume; outlining a strategy of screening and testing for COVID-19. Environments need to be tailored to allow for social distancing in waiting and recovery areas. Inevitably endoscopy departments will run at reduced capacity.⁴ Other parts of the cancer pathways are restricted too. Radiology services have similar backlogs and need

to adapt environment. Surgeons have limited major cancer surgery due to reduced availability of critical care beds, and adverse outcomes when operating on patients with COVID-19. Oncologists have limited treatment provision due to potential adverse patient outcomes.

Through the pandemic, GPs have continued referring patients to 2WW pathways, using pre-pandemic referral criteria. The consequences of COVID-19 have caused a bottleneck within hospitals which will persist till a vaccine is available. Without fundamental change, services could become overwhelmed and ultimately breakdown, with consequential impact on patient care.

A solution is to adjust referral criteria with the aim of delivering a lower volume, higher yield service. Concerns about missed cancer pathology would rise but must be considered through the prism of the pandemic. This could be achieved by raising of faecal immunochemical test threshold scores, and qualifying red flag symptoms with evidence-based thresholds. New pathways should be considered and funded, such as GPs requesting CT scans for patients over 70 with red flag symptoms, with positive findings being referred in.

Change is required quickly. An awareness of the issue and clear dialogue between stakeholders is essential if breakdown of services is to be averted. Sustainable change may benefit services post pandemic.

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