Joint Statement from ABS and UKBCG on Neoadjuvant Chemotherapy during the COVID-19 pandemic

As we are likely to be past the peak of the COVID-19 pandemic, and across the country we are moving towards a 'normal' service, it is time to reappraise the guidance for neoadjuvant chemotherapy.

Neoadjuvant chemotherapy generally involves exposure to the same or very similar regimens as would be given in the adjuvant setting. Deferring chemotherapy until after surgery delays but does not diminish any increased risk arising from COVID-19 infection in the immunosuppressed patient. The most significant risk of neoadjuvant chemotherapy is that a serious COVID infection may occur resulting in a prolonged convalescence during which time neither chemotherapy nor surgery is possible. On the other hand, neoadjuvant chemotherapy may permit optimal surgery and provides actionable prognostic information. Neoadjuvant chemotherapy should routinely be supported with GCSF during the COVID-19 pandemic.

1. Neoadjuvant chemotherapy should only be given where it is clear that chemotherapy is indicated, and would be given in the adjuvant setting.
2. Neoadjuvant chemotherapy is the standard of care for patients with locally advanced breast cancer (T≥3 and/or N≥2, and M0), if triple negative or HER2+.
3. Neoadjuvant chemotherapy should be considered for patients with tumours more than 2cm and triple negative or HER2+ disease. Giving neoadjuvant chemotherapy improves access to new treatments that improve outcome, such as capecitabine, pertuzumab and trastuzumab emtasine.
4. Neoadjuvant chemotherapy is not recommended during the pandemic for patients with tumours less than 2cm and node negative unless surgery is not possible.
5. For patients with locally advanced ER+ HER2- breast cancer (T≥3 and/or N≥2, and M0), neoadjuvant chemotherapy should be considered, to facilitate curative treatment, in combination with surgery and radiotherapy. Endocrine therapy (+/- a CDK4/6 inhibitor) could otherwise be considered.

All patients need to be discussed in an MDT. The risk/benefit ratio needs to be then discussed with the patient at an individual level. Where available and as recruitment resumes appropriate clinical trials should be considered.

Date of Statement: 15.5.20

To be reviewed again on 1.9.20

Endorsed by ABS and UKBCG

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