UKCLL FORUM

FINDING A CURE TOGETHER

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Practical guidelines for managing CLL in COVID pandemic

1. Avoid face to face consults: consider telephone or video conference appointments if feasible.
2. Watch and Wait and stable/non-progressive- 'phone rather than postpone' to avoid a big backlog later, also gives reassurance to the patients.
3. Watch and Wait and query progressing- at the next scheduled appointment perform local blood test with "bleed and go" with f/u telephone consult.
4. Stage B/C needing treatment- review if treatment truly essential now, aim to delay. NHSE discussions with Prof Peter Clark ongoing regarding whether all patients needing treatment can have Ibrutinib, we will update this document as soon as this is confirmed. AstraZeneca have launched an acalabrutinib CLL program for treatment naïve patients, contact antara.ghosh1@astrazeneca.com for more details.
5. Non-trial patient/ if patient needs immediate chemo-immunotherapy now: avoid Fludarabine and Bendamustine, consider Chlorambucil Obinutuzumab as alternative for all. Consider pausing after 3 cycles.
6. If on oral BTKi or Venetoclax- perform telephone consult , prescribe medication in advance, "bleed and go" on day with immediate prescription pick up or preferably home delivery and locally performed blood tests, to ensure home delivery for vulnerable and elderly patients register on www.gov.uk/extremely-vulnerable; increase intervals for patients being seen
7. Postpone Rituximab component of Venetoclax Rituximab during Rituximab phase of treatment (also see https://www.nice.org.uk/guidance/ng161/chapter/7-Modifications-to-usual-service)
8. If initiating relapse therapy, oral BTKi would result in less hospital attendance, therefore preferable to VR in this situation.
9. If commencing Venetoclax, review level of monitoring needed for TLS monitoring (suggest discuss with center). Do not stop Ibrutinib if patient is progressing on this treatment; consider overlapping with the next line of therapy.
10. Postpone IVIG infusions as risk of exposure to COVID19 may outweigh benefit of infusion during pandemic period. Consultant to assess on case by case basis. Consider stopping IVIG and give prophylactic antibiotics for 6 months instead. If they have required two rescue courses of antibiotics within this time then IVIG could be reinstated. For those on SC preparation: continue; for those we felt needed IVIG (and had received 6 months antibiotics trial), to try and get SC if possible and if not, to bridge with prophylactic antibiotics to avoid day unit attendance in the interim.
11. Regarding FLAIR entry and continued treatment:
    a. do not consent patients until you are ready to screen and treat.
    b. if a patient is stable on Ibrutinib or I+V then this should continue.
    c. if on I+V arm but before Venetoclax starts then just prolong Ibrutinib until the crisis is over and then introduce Venetoclax.
    d. if a patient has had two or more cycles of FCR and is in a clinical remission then suggest defer the subsequent cycles of FCR (advice to be circulated soon).
    e. if after first FCR only then you need to make a decision depending on the patient's state – Prof P Hillmen is happy to discuss.
12. Please help us with the CLL patients' survey filled out by patients https://forms.gle/3KcPk956GbuXKoTK9 , for the clinical survey of CLL patients who had Covid test positive or negative please fill this form https://redcap.swan.ac.uk/surveys/?s=NL3LMLAWXJ or please contact Fegancd1@cardiff.ac.uk.

If there are any queries regarding management and not covered by this guideline, please send the query through the website and we will try to respond in a timely manner.

This advice is the consensus view of a body of experts in CLL in current UK practice to mitigate the consequences of the Covid19 pandemic, advice presented here is not part of routine practice but we are hoping to help mitigate the risk of infection in haematology patients.

Version 2, 8/04/2020