Guideline for Schooling and Other Activities for Children and Young People Receiving Immunosuppressive Cancer Treatment

Information for Shared Care Centres and Community Staff

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Intended Audience

This document contains information and clinical guidelines for management of children attending the Sheffield Children’s Hospital Oncology and Haematology department or designated shared care centres. It is to be used by staff within the Trust, the Shared Care Trust or the community whenever they are caring for these children either in hospital or at home.

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1. Aim

To ensure that children and young people receiving cancer treatment have optimal opportunity for social, psychological and academic development, whilst ensuring their safety during immunosuppressive treatment.

2. Patients Included In This Guideline

Children receiving standard dose or maintenance chemotherapy, or radiotherapy, or within 6 months of completing either.

This policy does not cover:

- Children who have undergone haemopoietic stem cell transplantation
- Children who have received high dose chemotherapy with autologous haemopoietic stem cell rescue
- Children undergoing treatment for acute myeloid leukaemia (AML)

Children in these 3 groups will be specifically advised by their own consultants regarding the appropriate time to return to school and other social activities.

3. Attendance at School and Other Social Groups

(NB “School” is used here to cover schools, nurseries, colleges and other social groups such as sports clubs, scouts etc.)

Return to school should be encouraged as soon as possible after diagnosis provided that the child is well enough.

Children should attend their usual school or nursery regardless of neutrophil count, taking the precautions described below, provided they are otherwise well.

If school attendance is likely to be impossible for a prolonged period of time, home tuition should be considered. Where possible this should be in conjunction with occasional school visits to ensure that children remain in social contact with their peers.

With the permission of parents and the child/young person themselves, schools and other social groups should be offered written and/or verbal information about the condition from a member of the child’s treatment team (usually an oncology outreach nurse or one of the social workers). This information may be given verbally by telephone, at a school visit, or in writing in a booklet form.


Advice to schools should include methods of ensuring the child’s physical health in school. Advice should be given to help the school accommodate any changes in the child as outlined below.
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<table>
<thead>
<tr>
<th>Aspect</th>
<th>Effect</th>
</tr>
</thead>
<tbody>
<tr>
<td>appearance</td>
<td>hair loss, weight gain/loss</td>
</tr>
<tr>
<td>physical capacity</td>
<td>reduced mobility, pain, anaemia, increased risk of bruising and bleeding, reduced vision/hearing/speech ability</td>
</tr>
<tr>
<td>intellectual ability</td>
<td>poor concentration, missed schooling, provision for exams, potential for long-term cognitive deficits which may require a statement of special educational need</td>
</tr>
<tr>
<td>emotional capacity</td>
<td>anxiety, mood swings etc</td>
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4. Advice on Infections

Schools should be encouraged to promote good hand and general hygiene within the class. Teachers should be reassured that the everyday cough and cold does not constitute a major risk to children receiving cancer treatment, but that the child on treatment should be kept apart from other children who have signs of other infections during the school day (e.g., diarrhoea, sickness, sore throat).

Where children do not have immunity to chickenpox at diagnosis it is advised that letters are sent out to the families of all children who share a classroom area with the child on treatment, asking their parents to inform the school if their child develops chickenpox or shingles. News of such contacts will then be passed from school to the child’s parents or professionals. If there has been direct indoor contact for at least 15 minutes between the patient (A) and the child with chickenpox (B) during the period from 48 hours prior to that child (B) developing spots until the vesicles have crusted over, then the patient (A) should receive prophylaxis. For shingles prophylaxis this is only required if there is direct contact with exposed lesions. (As per RCPCH Best Practice Statement):

http://www.rcpch.ac.uk/sites/default/files/asset_library/Publications/I/Immunocomp.pdf

All schools, nurseries and other social groups should be aware of the need to inform parents/professionals if a child comes into direct contact with a person developing measles, in the period of 5 days before or 4 days after the rash develops. The diagnosis of measles should be confirmed clinically and preferably virologically. Prophylaxis is generally required regardless of previous antibody titres. Even though this will be less effective after 72 hours, it is still recommended that prophylaxis is given for contacts up to 14 days previously.

More detailed information is available in the Prophylaxis and Vaccination Guideline.

Schools should be encouraged to have a low threshold for contacting parents should the child show signs of becoming unwell during the school day. For younger children particular attention should be paid to children complaining of being too hot or too cold at normal room temperature, sudden aches and pains, sleepiness and changes in behaviour.

Specific advice on care of central venous lines, nasogastric tubes etc. should also be given where appropriate.

All schools should be given a name and contact number at the hospital.