Medical Oncology Guidance for Cancer Therapy During the COVID-19 Pandemic
Last Update: 22 March 2020

For all of our patients, we want to balance risk of COVID-19 infection with the risk of cancer progression or recurrence. We anticipate, at this juncture, the guidance below will not change the treatment plan for the majority of patients, who will be continuing cancer-directed therapies. There are some factors which strongly favor continuing treatment on time and on schedule, particularly treatments for curative intent or treatments with significant palliative benefit. We provide some thoughts, based on experience at other cancer centers struggling with the same tradeoffs, to help guide your decision-making with your patients.

Clinic Visits and Treatment:

Considerations for every visit:

- Re-assessment of risk and benefit of treatment given anticipated prognosis (absent COVID) and risk of infection ("re-informed consent").
- Acknowledgement that COVID risk will not be resolved in a few weeks; plan for several months.
- Emphasize and document shared decision making with patients who may have strong perspectives regarding their relative COVID or cancer risk.
- Ensure documentation of HCP and MOLST (advanced care planning, ACP).
    - This may be particularly important for patients with good prognosis who wish to be full code. Completion of a MOLST does not equate with DNR/DNI.
    - ACP can be conducted remotely during telemedicine visits with a witness.
- Please specify if regimens are curative or palliative, providing a range of life expectancy where possible.
    - Again, this may be particularly important for patients with long prognosis.
    - If you have a concern about OpenNotes, you can put a separate note that documents prognosis and save as a "monitored note".

No change in timing of visit/treatment:

- Patients on curative chemotherapy regimens.
- Newly diagnosed cancer (except those who do not need chemotherapy; see below).
- Recurrent patients with symptoms needing urgent treatment.

For these patients, consider consolidation of visits (same-day imaging) or increased use of home care or satellite sites (IF available) to minimize visits to Boston.

Likely no change in timing of visit/treatment:

- Patients on palliative chemotherapy regimens, if they are ECOG 0-1, normal counts, no major co-morbidities.
- Patients on palliative chemotherapy regimens for whom treatment could prevent short-term symptom burden or loss of functional status, or provide substantial survival benefit.

For these patients, consider consolidation of visits (same-day imaging) or increased use of home care or satellite sites (IF available) to minimize visits to Boston.

Consider delaying treatment or completing a regimen early:

- Patients on palliative chemotherapy regimens who are ECOG 2+, age > 70, or major co-morbidities.
- Patients on palliative chemotherapy regimens who require additional visits for fluids, electrolyte management, transfusion, or other support in order to receive treatment.
- Recurrent patients who are asymptomatic.
- Adjuvant chemotherapy regimens with small incremental benefit; consider hormone therapy, non-immunosuppressive therapy, or no adjuvant therapy.
- Maintenance chemotherapy in patients who achieved remission.

For these patients, discuss and carefully document shared decision-making regarding relative COVID-19 and cancer risks (SEE COVID-19 CHEMOTHERAPY CONSENT MACRO)*.*

Strongly prefer telephone consultation for:

- Patients on oral chemotherapy (especially maintenance). Consider local labs. In person visits only for toxicity concerns or monitoring that cannot be done remotely (i.e. EKGs).
- Surveillance patients. Delay imaging and visits 1-3 months (within NCCN guidelines).
- Patients with newly diagnosed cancer for whom guidelines do not recommend treatment (eg some Stage I/II cancers, carcinoid or low-grade neuroendocrine tumors).
- Second opinion visits. Note that since clinical trial enrollment is halted, clinical trial consultation is not possible at this time.
- Hospice / symptomatic management patients.
- End of life discussions.

Please refer to telemedicine guidelines.

Chemotherapy selection and supportive care considerations:

- Try to reduce/avoid palliative usage of regimens that lead to significant lymphopenia (eg cyclophosphamide, taxanes), as this has been linked to increased mortality from COVID.
- Consider switching patients on IV chemotherapy to oral alternatives.
- Consider decreasing the frequency of immunotherapy regimens Q4-6W.
- Minimize infection risk:
    - Consider increasing use of G-CSF to avoid neutropenia.
        - Enter OMR order ≥3 days prior to administration given insurance barriers.
    - Consider increasing use of prophylactic antibiotics (Levaquin 750mg daily x 5-7 days) if patients do become neutropenic.
- Reduce port flush visits:
    - Consider extending time between port flushes to 12 weeks (based on phase 2 data; Diaz et al, JOP 2016)
    - Consider helping set up flushes by VNA or at a local satellite (if available)
    - Port removal is currently considered an elective procedure and on hold.
- Defer treatments for long-term complications (e.g., IV iron, zoledronic acid)
- Given anticipated shortage of blood products, minimize use of palliative chemotherapy that requires frequent transfusion support.
- Consider getting CBC with differential (instead of CBC with ANC) and LFTs on treatment patients to look for lymphopenia and LFT elevation; both can be signs of COVID-19 infection.
- Contact/virtually evaluate patient before in person clinic visit if surveillance or re-staging scans shows evidence of bilateral interstitial infiltrates/GGOs

Per NHS NICE Guidance:

Table 1 Prioritising patients for systemic anticancer treatment

Priority level	Categorisation based on treatment intent and risk:benefit ratio of treatment
1	Curative treatment with a high (more than 50%) chance of success
2	Curative treatment with an intermediate (15% to 50%) chance of success
3	Non-curative treatment with a high (more than 50%) chance of more than 1 year extension to life
4	Curative therapy with a low (0% to 15%) chance of success or non-curative therapy with an intermediate (15% to 50%) chance of more than 1 year extension to life
5	Non-curative therapy with a high (more than 50%) chance of palliation or temporary tumour control and less than 1 year expected extension to life
6	Non-curative therapy with an intermediate (15% to 50%) chance of palliation or temporary tumour control and less than 1 year expected extension to life

References

https://jnccn.org/fileasset/jnccn1804-Ueda_20118_preprint.pdf

https://www.asco.org/asco-coronavirus-information

https://www.asco.org/sites/new-www.asco.org/files/content-files/blog-release/pdf/COVID-19-Clinical%20Oncology-FAQs-3-12-2020.pdf

https://www.hemonc.org/wiki/COVID-19_coronavirus_and_cancer

https://www.fredhutch.org/en/news/center-news/2020/03/coronavirus-what-cancer-patients-need-to-know.html

https://www.nejm.org/doi/full/10.1056/NEJMoa2002032

https://covid-19.uwmedicine.org/Pages/default.aspx

https://dailynews.ascopubs.org/do/10.1200/ADN.20.200068/full/?cid=DM4756&bid=40056182

https://www.thelancet.com/journals/lanonc/article/PIIS1470-2045(20)30096-6/fulltext

https://ascopubs.org/doi/full/10.1200/JOP.2016.010843

www.nice.org.uk/guidance/ng161