

PERTINENT QUESTIONS Regarding the **CARE of PATIENTS WITH LUNG CANCER** in the **COVID-19 ENVIRONMENT**

*The following are neither guidelines nor recommendations of the IASLC but perspectives and guidance from our global and multidisciplinary membership. Thank you to: Drs. Chandra Belani, Paul Bunn, Harvey Pass, Suresh Ramalingam, Nasser Altorki, Benjamin Besse, Natasha Leighl, Tetsuya Mitsudomi, Pieter Postmus, Luis Raez, Tom Stinchcombe, Paul Van Schil, Yi-Long Wu and Murry Wynes, as well as Becky Bunn.

Q: How are you taking care of patients with lung cancer in this environment of COVID-19?

- A:** Patients who need a diagnostic procedure, staging, and infusion therapy are being seen in the hospital or outpatient setting. Patients on active therapy are being treated, but long-term follow-ups and survivors are being delayed. Telehealth for new consults (and clinic follow up as necessary) and those on targeted therapies is happening if feasible.
- A:** Patients on active therapy continue to come for infusions. Infusions are being spaced out—weekly to every 3 weeks and every 3 weeks to every 4-5 weeks. Consider a drug holiday for 1 cycle if patients are stable. Maintenance therapy and consolidation therapy are being held more often than not. Scans for those on TKIs are being delayed if the patients are being delayed to prevent COVID exposure.

Q: If a patient has suspected lung cancer, should that person proceed with diagnosis in the COVID-19 environment?

- A:** Patients are screened for symptoms prior to appointments via a phone call and at time of entry to outpatient area.
- A:** Generally, standard guidelines are being followed for CT-guided biopsies, provided that the patient does not have severe comorbidities that may complicate the procedure.
- A:** PPE, especially surgical masks and transparent plastic shields that are attached to a foam ring, are being used for EBUS and bronchoscopies. Elective procedures are being delayed for 2-4 weeks on a case-by case basis. These steps are being taken at specific institutions in preparation for a possible surge of COVID-19 symptomatic, PCR-positive patients.

Q: Should a diagnostic biopsy be performed in an elderly, vulnerable patient with suspected lung cancer?

- A:** Patients with suspected lung cancer should have diagnostic and staging procedures that are consistent with protocol from before the COVID-19 pandemic.
- A:** A transthoracic needle biopsy is preferred.
- A:** Consider a 2-4 week delay for bronchoscopic procedures on an individual basis.

Q: Should lung cancer surgery be performed in a patient with newly diagnosed lung cancer?

A: Yes, for those post-neoadjuvant cases or newly diagnosed solid cancers.

A: Obviously one of the more difficult questions, because one would stratify based on degree of solid component of the nodule, SUV on the PET-CT, size (of solid component overall), and disappearance ratio. A delay of 4 weeks could make sense, depending on the situation: for patients with low-risk early-stage disease, radiologic MIA, nodules with solid components less than 50% of the whole tumor and for sizes up to 3 cm. For patients with larger tumors, oncologists are pushing for liberalizing induction therapy (4 cm, N1 positivity, obviously N2 positivity) but this is in flux if elective delay is being considered.

Q: Should lung cancer surgery be performed in an elderly patient with multiple comorbidities and newly diagnosed lung cancer?

A: Probably not if effective local therapy (SBRT) can be administered closer to the patient's home and thus avoid the need for multiple trips to the institution

A: Surgeons are being much more restrictive regarding surgery for elderly/frail patients. Patients who are marginal candidates are either being referred for SBRT or to medical oncology. The situation is different for medical emergencies with lung cancer, however, such as those patients with bleeding not responsive to embolization and for life-saving situations.

A: Surgical decisions for those who are good candidates should not differ from those made before the COVID-19 pandemic.

Q: If a patient is resected and is a candidate for adjuvant chemotherapy, should it be administered? If yes, why? If no, why not?

A: Yes, it is (in the appropriate circumstances) life-saving treatment if it can be delivered in a COVID-19-safe environment. It could start 6-12 weeks post-resection, depending on infusion room staffing.

A: Avoid or delay adjuvant chemotherapy when the benefit/risk is marginal

A: Neoadjuvant and adjuvant therapy administration decisions should not differ from those made before the COVID-19 pandemic.

Q: If a patient is on chemotherapy/RT with locally advanced NSCLC, should the treatment be continued right now? If yes, why? If no, why not?

A: Chemotherapy/RT is generally given with curative intent and should be completed for patients with NSCLC or SCLC.

Q: If a newly diagnosed patient requires chemotherapy, should it be instituted immediately?

A: Yes, there is no reason to delay unless the patient has COVID-19.

Q: If a patient is currently on chemotherapy, should it be continued?

A: Yes.

Q: If a patient is stable on maintenance chemotherapy, would you continue treatment?

A: Yes. A drug holiday of 3-4 weeks or an increase duration between treatments could be considered.

Q: If a patient requires chemotherapy/IO for newly diagnosed lung cancer, what will you do?

A: For newly metastatic disease, standard therapies should be given to patients irrespective of the type of therapy because many patients are symptomatic and need to obtain disease control, maintain quality of life, and maintain or achieve good performance status.

Q: If a patient with lung cancer is currently receiving a targeted therapy, should it be continued? What complications have you seen/what are you considering?

A: Yes, the targeted therapy should be continued, but follow-ups can be extended out 6-12 weeks on an individual basis. Telehealth visits are an option.

Q: Should a patient be entered on a clinical trial in this COVID-19 environment? If a patient is currently on a clinical trial, should treatment be continued? What new steps are you taking/recommending?

A: Entry onto clinical trials will depend on institutional staffing and institutional requirements. It is likely that new enrollments will decline.

A: Patients on trials should continue on trial with as few modifications (avoidance of extra blood draws and face-to-face visits) as approved by the IRB and sponsors. Patients should be treated in a COVID-19 safe zone.

A: Patients on routine follow-up after therapy completion may be seen virtually if possible.

Q: If a patient is on long term follow-up, would you see them in the clinic, postpone the visit or conduct the visit via the phone or internet?

A: Patients come to outpatient radiology sites for CT scans, but then they are being called with results. For postoperative patients, where feasible follow up with the patient via phone every week for 4 weeks, with liberal use of photography to check wounds. Postoperative questions could include: degree of pain, ambulation, dyspnea and need for meds via phone prescription.

A: Conduct visits via phone or telehealth if possible.

Q: If a patient comes in with symptoms of COVID-19, should they be seen in the clinic?

A: Patients are prescreened before the appointment for symptoms and sent to testing place and turned away or admitted to the dedicated area if they meet the criteria.

Q: Should a patient with extensive-stage or recurrent SCLC (newly diagnosed) be treated now?

A: Just as before.

Q: Should a patient with a new diagnosis of limited-stage SCLC be treated with combined chemotherapy/RT?

A: Yes. Just as before.

Q: Anything else you'd like to share?

A: Everybody is adapting continuously.

A: Lung screening clinics have been shut down. Research staff should be on a schedule to avoid exposure. Outpatient services are functioning at 30%-50% level. Inpatient services are becoming difficult to manage, especially as providers are exposed and may need to be quarantined.

A: Lung cancer remains to be the leading cause of cancer death worldwide. We should remember that many countries manufacture cigarettes and that we should do everything in our power to stop that. We should remember that all countries could do more to reduce tobacco-smoking and now vaping to save many lives.



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