



# Cancer en tiempos de COVID-19

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19 de Octubre 2020

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# Coronavirus disease 2019 (COVID-19): Cancer screening, diagnosis, treatment, and posttreatment surveillance in uninfected patients during the pandemic

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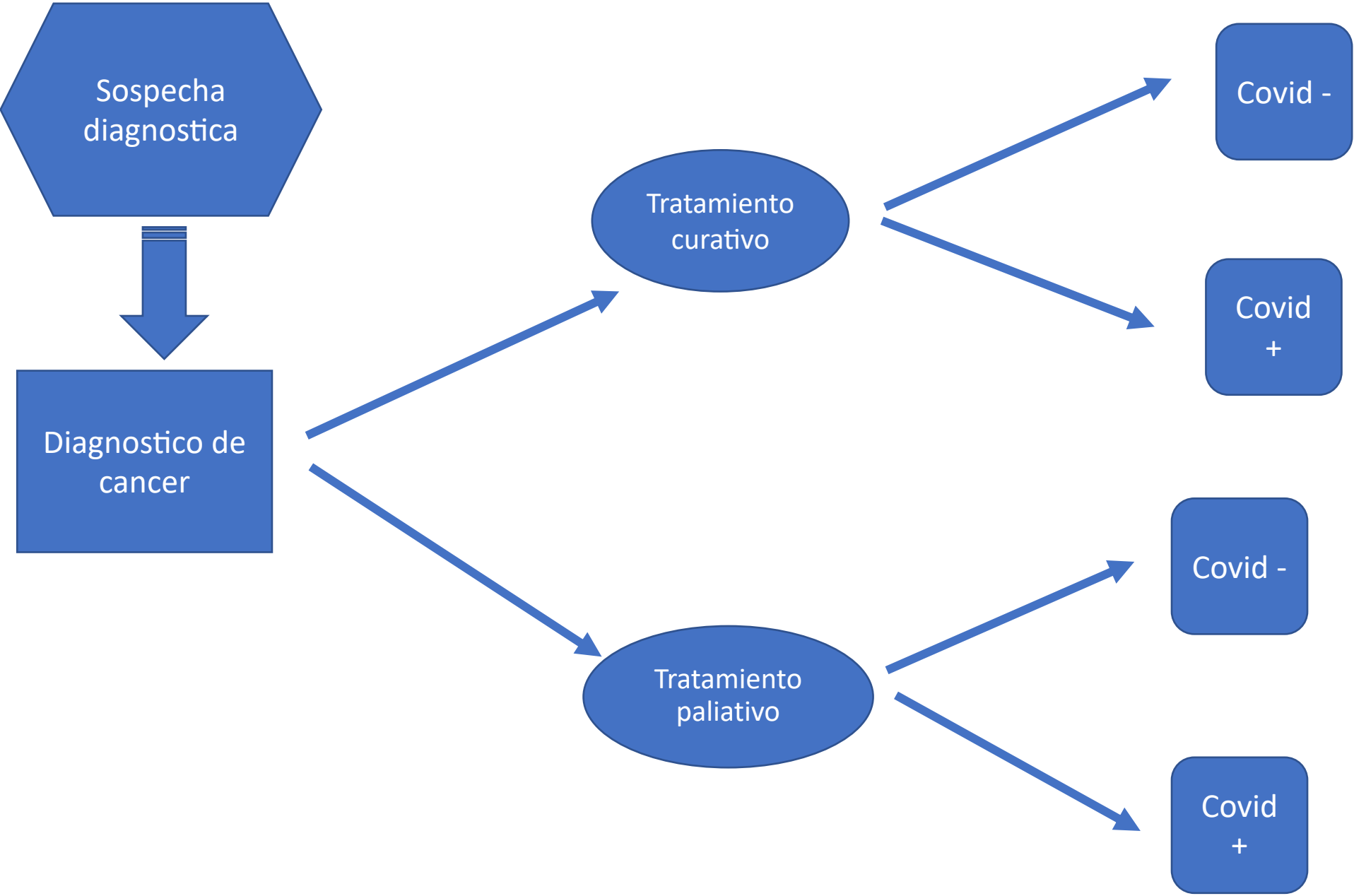
All topics are updated as new evidence becomes available and our [peer review process](#) is complete.

Literature review current through: **Sep 2020**. | This topic last updated: **Oct 09, 2020**.

- Durante la pandemia COVID se tienen restricciones para acceso a los servicios de salud.
- Para evitar los contagios, fue necesario cuarentena domiciliar, que limito, asistencia a centros de salud.
- Tomemos en cuenta que los pacientes con diagnostico de cancer que ya se encuentran en tratamiento pueden adquirir la infeccion de COVID 19.

- Consideremos que tenemos dos escenarios: pacientes diagnosticados con cancer infectados con COVID 19 y pacientes diagnosticados con cancer no infectados por COVID 19.
- Existe un tercer escenario que tambien es importante; pacientes con sospecha de cancer, los cuales se encuentran en estudios de diagnostico, que de igual forma pueden estar con o sin infeccion por COVID 19.





# Pilares de tratamiento contra el cancer

1. Cirugia
2. Medico
3. Radioterapia
4. Paliacion
5. Otros: Nutricion, Fisioterapia, Psicologia.

La OMS ha  
indicado tres  
prioridades  
para los  
países

1. Proteger a los trabajadores de salud
2. Involucrar a las comunidades para proteger a las personas con mayor riesgo de enfermedad grave (p. Ej., Adultos mayores y personas con comorbilidades médicas)
3. Apoyar a los países vulnerables a contener la infección.

Organización Mundial de la Salud. Comentarios del Director General en la sesión informativa para los medios sobre 2019-nCoV el 11 de febrero de 2020.

<https://www.who.int/dg/speeches/detail/who-director-general-s-remarks-at-the-media-briefing-on-2019-ncov-on-11-february-2020> (Consultado el 12 de febrero de 2020).

## Symptoms associated with coronavirus disease 2019 (COVID-19) <sup>[1]</sup>

Symptoms that may be seen in patients with COVID-19
■ Fever
■ Cough
■ Dyspnea (new or worsening over baseline)
■ Anosmia or other smell abnormalities
■ Ageusia or other taste abnormalities
■ Sore throat
■ Myalgias
■ Chills/rigors
■ Headache
■ Rhinorrhea and/or nasal congestion
■ Nausea/vomiting
■ Diarrhea
■ Fatigue
■ Confusion
■ Chest pain or pressure

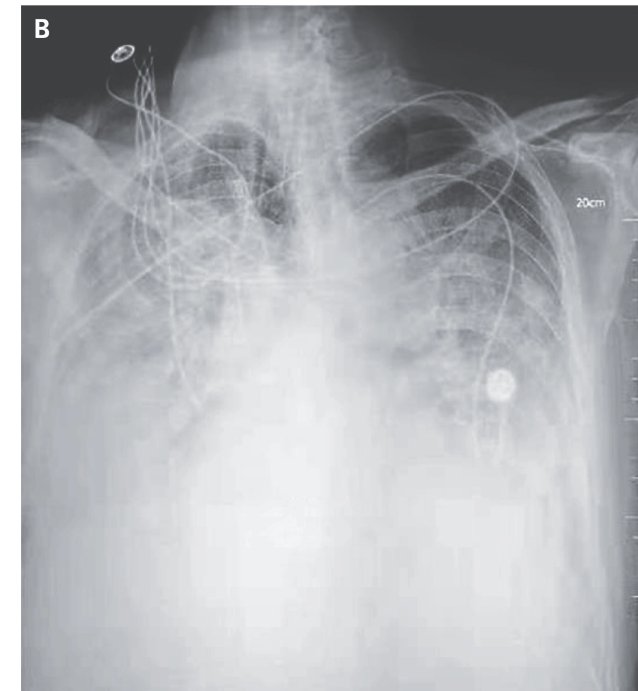
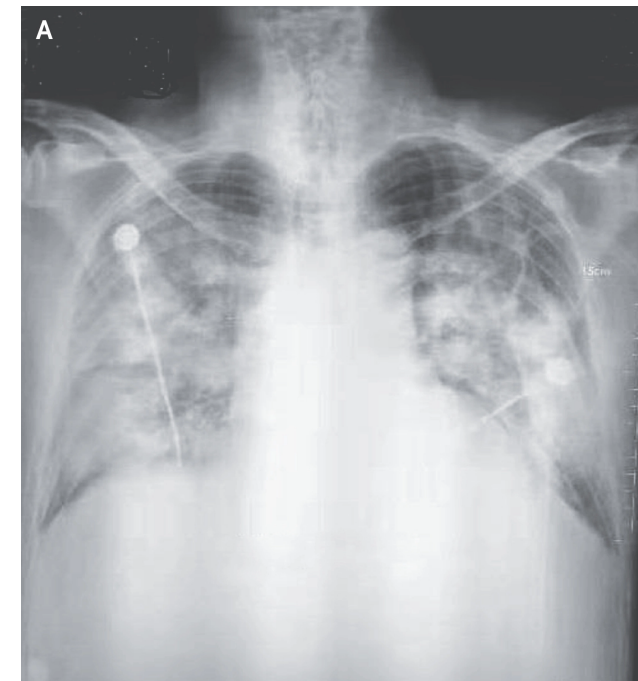
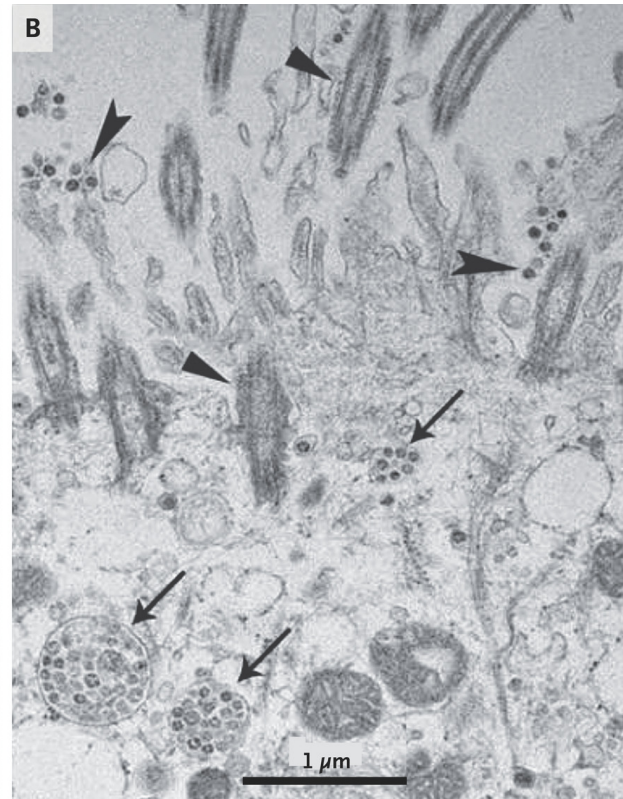
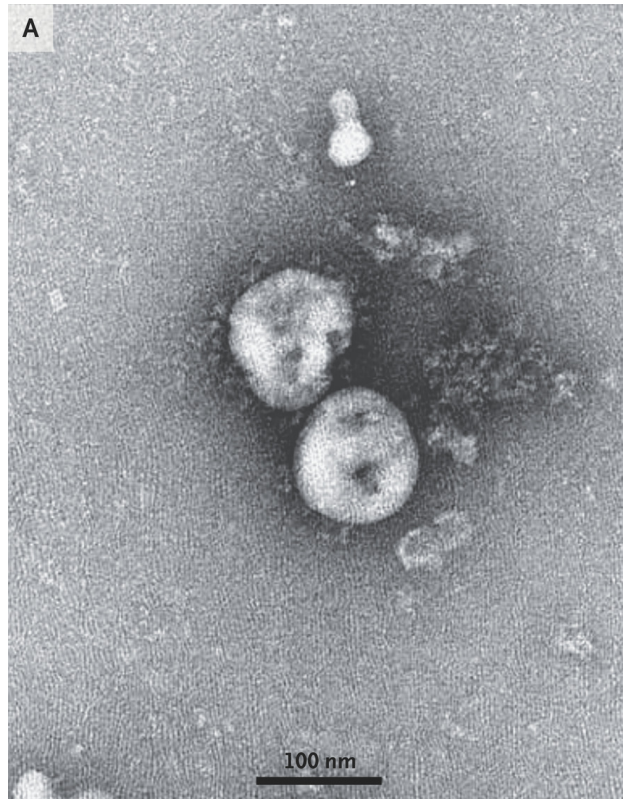
Most patients with confirmed COVID-19 have fever and/or symptoms of acute respiratory illness. However, various other symptoms have been associated with COVID-19; this list is not inclusive of all reported symptoms. These symptoms are also not specific for COVID-19, and the predictive value of a single symptom in the diagnosis of COVID-19 is uncertain.

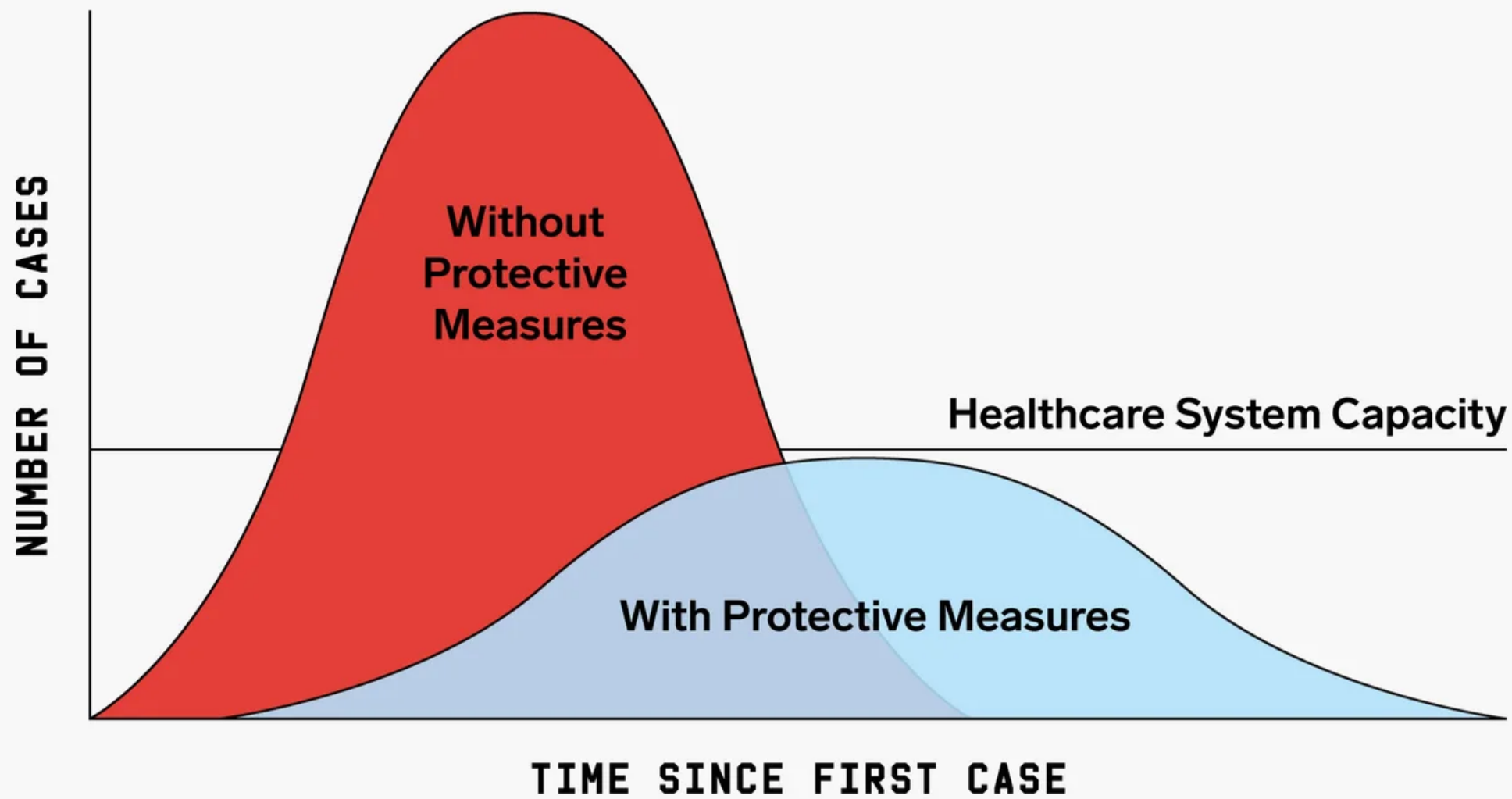
COVID-19: coronavirus disease 2019.

# A Novel Coronavirus from Patients with Pneumonia in China, 2019

Na Zhu, Ph.D., Dingyu Zhang, M.D., Wenling Wang, Ph.D., Xingwang Li, M.D., Bo Yang, M.S., Jingdong Song, Ph.D., Xiang Zhao, Ph.D., Baoying Huang, Ph.D., Weifeng Shi, Ph.D., Roujian Lu, M.D., Peihua Niu, Ph.D., Faxian Zhan, Ph.D., et al., for the China Novel Coronavirus Investigating and Research Team

February 20, 2020 - N Engl J Med 2020; 382:727-733 - DOI: 10.1056/NEJMoa2001017

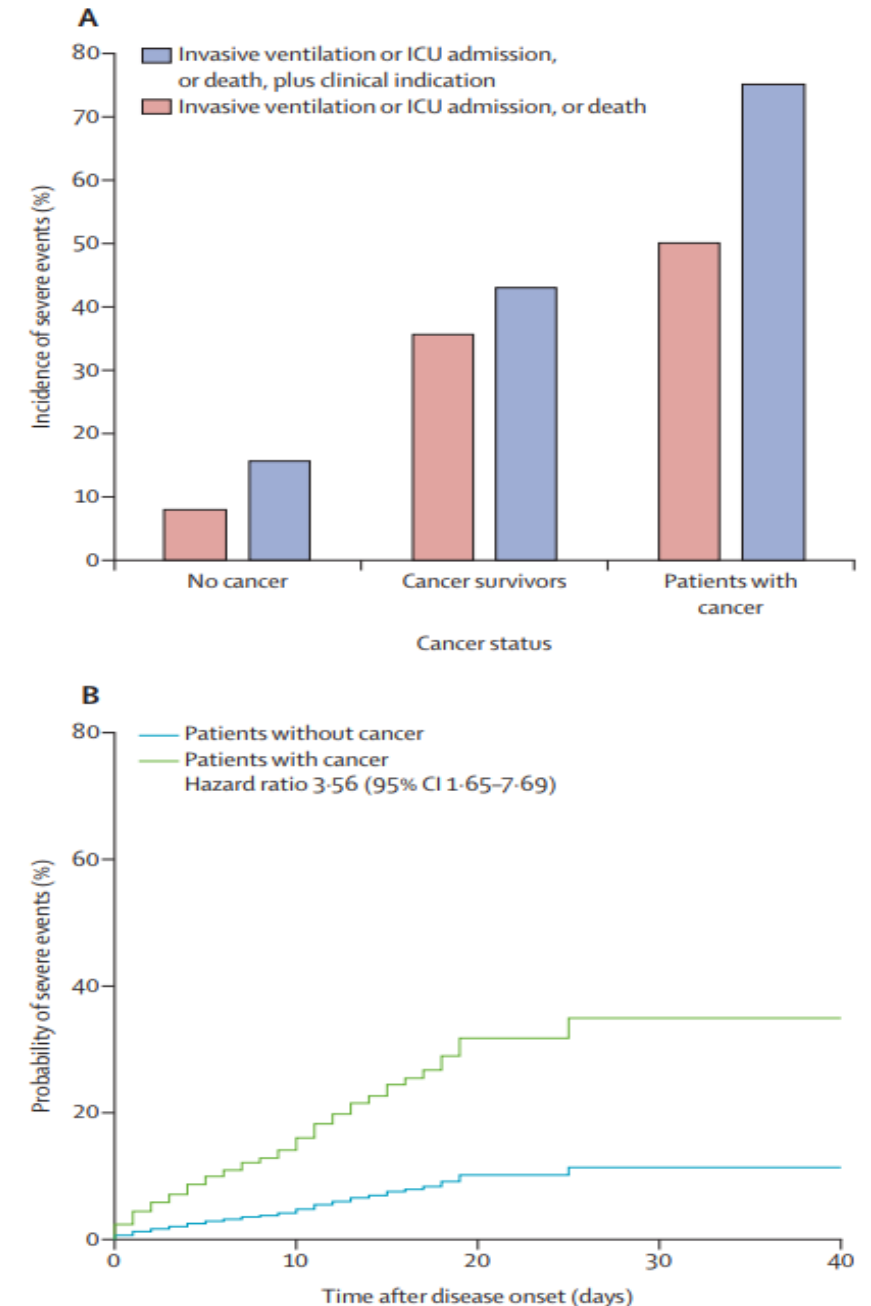




## Cancer patients in SARS-CoV-2 infection: a nationwide analysis in China

Most importantly, patients with cancer were observed to have a **higher risk of severe events** (a composite endpoint defined as the percentage of patients being **admitted to the intensive care unit requiring invasive ventilation, or death**) compared with patients without cancer (seven [39%] of 18 patients vs 124 [8%] of 1572 patients; Fisher's exact  $p=0.0003$ ).

[www.thelancet.com/oncology](http://www.thelancet.com/oncology) Vol 21 March 2020







## ASCO's COVID-19 Resources [Click for details](#)



# ASCO 2020 is Going Virtual

Social distancing is vital to the health and wellbeing of our communities, but it doesn't mean we still can't connect with one another when we need it most.

[Read the Announcement](#) →





# COVID-19 Provider & Practice Information



ASCO invited its members to submit questions about issues and challenges they see emerging while caring for patients with cancer during the coronavirus pandemic. Currently, limited clinical cancer-specific data are available and information is evolving. The following information is based on evidence gathered through PubMed searches of the medical literature, a search of relevant websites with information on infectious diseases (CDC, WHO, IDSA, etc.), and input from clinical oncologists and infectious disease experts. ASCO will update this information as new questions emerge and evidence develops.

## CLINIC/CENTER PREPAREDNESS: How should my practice prepare for a local outbreak of COVID-19?

The following guidance is for all cancer practices to consider, with or without reports of local transmission of COVID-19.

### ***Staff Preparedness:***

- Provide clinic staff with additional training on symptom recognition, screening procedures, and use of **Standard Precautions** and personal protective equipment (PPE).
- Additional PPE may need to be obtained/sourced, as staff that do not usually use it may be required to perform tasks where it is appropriate.
- Provide clinic staff with training on how to obtain SARS-COV2 testing for patients according to current testing guidelines.
- Identify telephone-based mental health services in your community if available and be prepared to refer patients and their families, and staff when appropriate.

### ***Clinic Preparedness:***

- Limit access to the facility through one point of entry, if possible.
- Facility access should exclude vendors, minimal ancillary services, limitations on most or all visitors, and no one under 18 years of age. Consider remote or virtual support services.
- Establish triage stations outside the facility, clinic, or office with social distancing of six feet apart to screen patients and visitors for COVID-19 symptoms and fever before they enter.
- Install barriers or social distancing mechanisms at front desks if screening is not conducted outside of the facility.
- Convert waiting area to allow for distancing of at least six feet. This may require reduction in visits or an increased interval between visits to allow for a reduced or eliminated waiting area.
- Convert through a simple re-design, any current open infusion suite to semi-private space with at least six feet distance between patients and/or use available curtains as a barrier between patients.
- Suspend or move to a virtual platform, all on-site group and patient activities (yoga, education seminars, support groups, etc.).

### ***Patient Scheduling:***

- Postpone routine follow-up visits of patients not on active cancer treatment. This includes 6-month and 12-month survivorship visits.
- In place of routine follow-up visits, brief remote check-ins should be initiated to ensure that patients on maintenance therapies have sufficient drug supplies and provide instructions on when they should call their provider.
- For survivorship care, remote check-ins will become more important the longer the pandemic restrictions exist. A timeline over the next months should be identified to institute direct tele-communication for survivorship check-ins.
- Provide patient communication and education via direct tele-communication, websites, and patient portals regarding COVID-19 virus and rationale for changes in visit schedules will be essential.
- Home collection of routine lab samples may be considered instead of patient visits into the clinic. Evaluation of laboratory test results can be performed by the health care team and communicated via telecommunication.
- For areas not yet impacted by widespread, local transmission, the postponement of non-urgent visits should be used to enable more immediate scheduling of urgent visits.

The CDC has published [guidance](#) on steps you may take to prepare for and to respond to an outbreak of COVID-19 in your community.

## TELEMEDICINE: Should our clinic move to telemedicine for routine follow-up?

Along with postponing certain non-urgent visits, we recommend adoption of telemedicine for patients not requiring a physical exam, treatment or in-office diagnostics. Specifically:

- Explore alternatives for face-to-face triage and visits.
- Conduct appointments via telemedicine.
- Identify staff to conduct telephonic and telehealth interactions with patients. Develop protocols for staff to triage and assess patients quickly.
- Instruct patients to use available telephone triage, patient portals, on-line assessment tools, or call and speak to an office/clinic staff member.
- Conduct remote check-ins for symptom monitoring of high-risk patients.

The American College of Physicians has created a [tutorial](#) for deploying telemedicine services.

## INFECTION PREVENTION AND CONTROL: What screening and infection prevention and control practices should my clinic undertake?

Cancer centers are recommended to limit access to the facility to one point of entry and screen all patients and visitors outside the facility, clinic, or office for COVID-19 symptoms and fever. Further recommendations include:

- When scheduling appointments, instruct the patient to call ahead and discuss the need to reschedule their appointment if they develop symptoms of a respiratory infection (e.g. cough, sore throat, fever) on the day they are scheduled to be seen.
- Contact the patient the day prior to appointment for screening of symptoms of cough, sore throat, fever, or other flu-like symptoms. Patient should be rescheduled if symptoms are present.
- Allow access to visitors only if essential to the visit. If visitors are required, limit to one visitor for all provider visits and deny entry of visitors in any communal treatment area – ask visitors to wait in vehicles or return after treatment. Deny entry to any visitor displaying symptoms of a respiratory or other infection.
- Upon access to the facility, screen all patients and visitors:
  - Provide screening staff PPE (including masks), waste bins, access to cleaning/disinfecting agents.
  - Question patients and visitors as to symptoms of cough, sore throat, fever, recently out of the country in the past 14 days, exposure to anyone with respiratory symptoms or known COVID-19. If available, use an infrared thermometer to take temperatures during screening.
  - Include signage with COVID-19 screening questions and visualization of symptoms for all patient/visitors, as well as patient education materials and illustrations of proper hygiene for infection prevention and symptoms to report.
- Provide a facemask to and rapidly isolate patients with suspected infection until more thorough screening or testing can be conducted. Isolation should take place in an exam room or other private area with the door closed.
- All staff entering the room of a patient with known or suspected COVID-19 should adhere to Standard Precautions and use a N95 respirator or facemask, gown, gloves, and eye protection.
- Establish a plan of action for patients that present with respiratory symptoms (e.g. resource for testing, schedule patient with primary care or local/health department).

The CDC has published [guidance](#) for infection control and prevention in health care settings in the context of COVID-19. (Accessed March 18, 2020)

# ESMO management and treatment adapted recommendations in the COVID-19 era: Breast cancer

## Contributors

For contributor details please visit:

<https://www.esmo.org/guidelines/cancer-patient-management-during-the-covid-19-pandemic>



## Cancer Patient Management During COVID-19 Pandemic

### Priorities for Breast Cancer Patients

#### Cancer Patient Prioritisation

The tiered approach of ESMO in delivering a guidance for cancer patients during the COVID-19 pandemic is designed across three levels of priorities, namely: tier 1 (high priority intervention), 2 (medium priority) and 3 (low priority) – defined according to the criteria of the Cancer Care Ontario, Huntsman Cancer Institute and ESMO-Magnitude of Clinical Benefit Scale (ESMO-MCBS), incorporating the information on the value-based prioritisation and clinical cogency of the interventions.

##### High Priority

- Patient's condition is immediately life threatening, clinically unstable and/or the magnitude of benefit qualifies the intervention as high priority (e.g. significant overall survival [OS] gain and/or substantial improvement in quality of life [QoL])

##### Medium Priority

- Patient's situation is non-critical but delay beyond 6 weeks could potentially impact overall outcome and/or the magnitude of benefit qualifies for intermediate priority

##### Low Priority

- Patient's condition is stable enough that services can be delayed for the duration of the COVID-19 pandemic and/or the intervention is non-priority based on the magnitude of benefit (e.g. no survival gain with no change nor reduced QoL)

## Cancer Patient Management During COVID-19 Pandemic

### Priorities for Breast Cancer Patients

#### Outpatient Visit Priorities

##### High Priority

- Post-operative unstable clinical scenario (e.g. haematoma, infection)
- Breast cancer diagnosis during pregnancy

##### High/Medium Priority

- New diagnosis of invasive breast cancer (for multidisciplinary tumour board discussion: biology and stage will drive priority)
- On-treatment patients with new symptoms or side effects (depending on severity of symptoms/side effects, burden of progression, etc.). *Convert as many visits as possible to telemedicine visits. Intensify safety monitoring for those patients on oral chemotherapy or endocrine therapy plus biological agents*

##### Medium Priority

- New diagnosis of non-invasive cancer. *Convert as many visits as possible to telemedicine visits*
- Post-operative visits in patients with no complications

##### Low Priority

- Established patients with no new issues: *refer to telemedicine*
- Survivorship follow-up: *refer to telemedicine*
- Follow-up for patients at high risk of breast cancer (BRCA carriers, etc...) or patients at high risk of relapse
- Psychological support visits (*convert to telemedicine*)



## Cancer Patient Management During COVID-19 Pandemic

### Priorities for Breast Cancer Patients

#### Priorities for Breast Disease: Diagnostics and Imaging

##### High Priority

- Self-diagnosis of breast lump or other symptoms suggestive of malignancy
- Clinical evidence of locoregional relapse with surgical radical approach feasible (according to stage, histology and biological features of the disease)
- Pathology assessment (histopathology or cytopathology) for abnormal mammograms or breast symptoms or a symptomatic metastatic relapse
- Further diagnostic imaging for BIRADS 5 screening mammogram in asymptomatic subjects

##### Medium Priority

- Further diagnostic imaging for BIRADS 4 screening mammogram in asymptomatic subjects
- Image-guided or clinically guided biopsy to ascertain a suspicion of metastatic relapse
- Initial metastatic work-up (according to stage and biological features) in patients with early stage invasive breast cancer
- Echocardiograms in patients with early stage invasive breast cancer requiring indication to anthracycline-based or anti-HER2 treatment

##### Low Priority

- Mammography-based population screening and risk-adapted breast screening programmes for asymptomatic subjects (e.g. MRI or US)
- Patients with abnormal findings at screening mammograms who can go to 6-month interval imaging (BIRADS 3)
- In patients with early stage breast cancer, follow-up imaging, restaging studies, echocardiograms, ECGs and bone density scans can be delayed if clinically asymptomatic
- In patients with metastatic breast cancer, we recommend symptom-oriented follow-up. Imaging, restaging studies, echocardiograms and ECGs can be delayed or done at lengthened intervals. *Implement telemedicine follow-up*

## Cancer Patient Management During COVID-19 Pandemic

### Priorities for Breast Cancer Patients

#### Priorities for Breast Disease: Surgical Oncology

##### High Priority

- Breast cancer surgery complication with bleeding or indication to incision and drainage of a breast abscess and/or haematoma
- Complications of reconstructing surgery (e.g. ischaemia)
- Surgery in patients who have completed neoadjuvant chemotherapy-based treatment (or, in exceptional cases, with progression of disease during neoadjuvant treatment)
- Surgery in patients with invasive cancer for whom a multidisciplinary tumour board may decide, case by case, to proceed with upfront surgery
- Breast cancer surgery during pregnancy (multidisciplinary treatment should be individualised according to stage and biology)

##### High/Medium Priority

- Excision of malignant recurrence (depending on phenotype and extent)

##### Medium Priority

- Clinically low-risk primary breast cancer (e.g. stage I/II ER-positive/PR-positive/HER2-negative, low grade/low proliferative index tumours). *After multidisciplinary tumour board discussion consider starting neoadjuvant/preoperative endocrine therapy according to menopausal status and delay surgery*
- Discordant biopsies likely to be malignant

##### Low Priority

- Excision of benign lesions and duct excision (fibroadenomas, atypia, papillomas)
- Surgery of non-invasive breast cancer (*in situ*) except for extended high-grade DCIS
- Discordant biopsies likely to be benign
- Breast reconstruction with autologous tissue and/or implants
- Prophylactic surgery for asymptomatic high-risk patients

## Cancer Patient Management During COVID-19 Pandemic

### Priorities for Breast Cancer Patients

#### Priorities for Breast Cancer: Radiation Oncology

##### High Priority

- Palliative treatment of bleeding/painful inoperable breast mass, when control of symptoms cannot be achieved pharmacologically
- Patients already on radiation treatment
- Acute spinal cord compression, symptomatic brain metastases or any urgent palliative radiotherapy
- Adjuvant post-operative radiotherapy for high-risk breast cancer patients (inflammatory disease at diagnosis, node-positive disease, TNBC or HER2-positive breast cancer, residual disease at surgery post neoadjuvant therapy, young age (<40))

##### Medium Priority

- Adjuvant post-operative radiotherapy for low-/intermediate-risk breast cancer patients (age <65y and stage I/II luminal cancer, ER-positive regardless of nodal status or positive margins). *Use of hypofractionated regimens should be considered to reduce hospital visits. Endocrine therapy can be started during the waiting interval*

##### Low Priority

- Elderly patients with low-risk breast cancer (age >70y, with low-risk stage I ER-positive/HER2-negative breast cancer): *Starting adjuvant endocrine therapy is recommended while postponing radiotherapy*
- Carcinoma *in situ*



## Cancer Patient Management During COVID-19 Pandemic

### Priorities for Breast Cancer Patients

#### Priorities for Breast Cancer: Medical Oncology – Early Breast Cancer

##### High Priority

- Neoadjuvant and adjuvant chemotherapy for TNBC patients
- Neoadjuvant and adjuvant chemotherapy in combination with targeted therapy for HER2-positive breast cancer patients
- Neoadjuvant and adjuvant endocrine therapy +/- chemotherapy for high-risk ER-positive/HER2-negative breast cancer as defined by current guidelines
- Completion of neoadjuvant chemotherapy (with or without anti-HER2 therapy) that has already been initiated
- Continuation of adjuvant capecitabine treatment in high-risk TNBC patients, and T-DM1 in high-risk HER2-positive breast cancer patients (in the post-neoadjuvant setting)
- Continuation of treatment in the context of a clinical trial, provided patient benefits outweigh risks, with possible adaptation of procedures without affecting patient safety and study conduct. *Regulatory agencies and sponsors may provide guidance on rules on study conduct during pandemics*

##### Medium Priority

- For postmenopausal women with stage I cancers, with low-intermediate-grade tumours, lobular breast cancers, endocrine therapy may be started first while surgery can be delayed
- For patients with low-risk genomic signatures/score, prefer endocrine therapy alone
- Ongoing adjuvant trastuzumab alone may be postponed by 6-8 weeks in patients at high risk of complicated COVID-19 infection

##### Low Priority

- Follow-up imaging, restaging studies, echocardiograms, ECGs and bone density scans can be delayed if patient clinically asymptomatic or clinical signs of response in the neoadjuvant setting

## Cancer Patient Management During COVID-19 Pandemic

### Priorities for Breast Cancer Patients

#### Priorities for Breast Cancer: Medical Oncology – Early Breast Cancer

##### Specific Recommendations

- Continuation of standard adjuvant endocrine therapy in pre and postmenopausal setting:  
*Use telemedicine to manage potential toxicity reported by patients*
- Neoadjuvant endocrine therapy is an option for patients with ER-positive/HER2-negative breast cancer to enable deferral of surgery by 6 to 12 months in clinical stage I or II breast cancers
- For selected HER2-positive breast cancer, low-risk or elderly patients with cardiovascular or other comorbidities, adjuvant anti-HER2 therapy may reasonably be discontinued after 6 months instead of 12 months of treatment according to data from prospective randomised trials
- If chemotherapy is considered for a patient with ER-positive/HER2-negative breast cancer, then it can be administered in the neoadjuvant setting
- Chemotherapy schedules may be modified to reduce accesses to hospital (for instance, using 2- or 3-weekly dosing instead of weekly dosing for selected agents when appropriate). Patients should receive G-CSF growth factor and, eventually, antibiotics support to minimise neutropaenia, while dexamethasone use should be limited, as appropriate, to reduce immunosuppression
- Following a case-by-case discussion according to the logistics of the patient, LHRH analogue may be given with long acting, every 3 months dosing, to reduce patient visits or alternatively, home administration of LHRH analogue by the patient or visiting nurse may be considered. Monthly home administration of LHRH analogue by the patient or visiting nurse is the preferred recommendation
- If possible, schedule imaging exams and blood tests near home
- Implement telemedicine safety monitoring whenever possible



## Cancer Patient Management During COVID-19 Pandemic

### Priorities for Breast Cancer Patients

#### Priorities for Breast Cancer: Medical Oncology – Metastatic Breast Cancer

##### High Priority

- Early-line chemotherapy, endocrine therapy, targeted agents or immune-checkpoint inhibitors likely to improve outcomes in metastatic disease (high priority to pertuzumab/trastuzumab plus chemotherapy in HER2-positive breast cancer). Consider also discussing case by case in a multidisciplinary tumour board, endocrine therapy with CDK 4-6 inhibitors in ER-positive/HER2-negative breast cancer, chemotherapy plus atezolizumab in PD-L1-positive TNBC
- Visceral crisis
- Continuation of treatment in the context of a clinical trial, provided patient benefits outweigh risks, with possible adaptation of procedures without affecting patient safety and study conduct. *Regulatory agencies and sponsors may provide guidance on rules on study conduct during the pandemics*

##### Medium Priority

- Second-, third-, beyond third-line treatment when therapy may provide clinical benefit and impact on outcome
- Consider avoiding or delaying the addition of mTOR or PIK3CA inhibitors (still not approved in European Union) to endocrine therapy, particularly in elderly patients with comorbidities
- Consider, discussing case by case, inclusion in a clinical trial, provided patient benefits outweigh risks, with possible adaptation of procedures without affecting patient safety and study conduct

##### Low Priority

- Bone agent therapy (zoledronic acid, denosumab) not urgently needed for hypercalcaemia, or not needed for pain control and in patients who are otherwise not in need of coming to the hospital (i.e. receiving oral chemotherapy or endocrine therapy). Bone agents can be administered every 3 months
- If clinically asymptomatic, follow-up imaging, restaging studies, echocardiograms and ECGs can be delayed or done at lengthened intervals

## Cancer Patient Management During COVID-19 Pandemic

### Priorities for Breast Cancer Patients

#### Priorities for Breast Cancer: Medical Oncology – Metastatic Breast Cancer

##### Specific Recommendations

- When chemotherapy is recommended, prefer oral treatments in order to reduce access to hospital
- Chemotherapy schedules may be modified to reduce clinical visits (for instance, using 3-weekly dosing instead of weekly dosing for selected agents when appropriate). Patients should receive G-CSF growth factor support to minimise neutropaenia, while dexamethasone use should be limited, as appropriate, to reduce immunosuppression
- LHRH analogue may be given with long acting, every 3 months dosing, to reduce patient visits or alternatively, home administration of LHRH analogue by the patient or visiting nurse may be considered. Monthly home administration of LHRH analogue by the patient or visiting nurse is the preferred recommendation
- Endocrine therapies: oral agents used widely in adjuvant or metastatic setting (e.g. tamoxifen, aromatase inhibitors) should have no effect on immune function and can be safely continued. Fulvestrant should have no effect on immune function but requires monthly i.m. administration
- Implement telemedicine safety monitoring whenever possible
- All patients must be assured with the best home-based supportive care and enhanced symptoms control via telemedicine
- Bone agents for patients with bone metastases should be delivered at minimal hospital access
- The incorporation of CDK4/6 inhibitors to endocrine treatments should align with ongoing recommendations, the local practice and resource availability. The risk associated with neutropaenia has not been clearly defined and demands research implementation - close monitoring for symptoms of infection is recommended, to promptly withdraw the treatment and possibly refer to COVID-19 diagnostic pathway

Gracias por su atencion