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Management of Indian Haematology Patients during COVID19 Crisis

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Introduction :- In current COVID19 situation, we have tried to formulate a practical approach for managing haematology patients, which we have been following for the last four months at our centre. Cancer can kill; COVID also can kill. The aim is to be alive till the end of pandemic - both patients and doctors. Some general points for consideration:

Due to lockdown and general panic, the stocks in Blood Banks are in an all-time low. So transfusions and donor arrangements have to be dealt judiciously. [6,7]

Telemedicine was encouraged to reduce hospital visits in all chronic follow up patients who are stable with safe blood counts. Our Haematology Management Protocol - COVID19 Acute Myeloid Leukaemia

For Acute Promyelocytic Leukaemia cases it was the same as before.

Acute Myeloid Leukaemia - NON-M3

We admitted all these patients with one attendee for few hours in COVID suspect ward and did COVID19 test before starting treatment. We were worried about intense 7+3 induction regimen. Hypomethylating agent (Subcutaneous Azacitidine or five-day protocol Decitabine) + Venetoclax or Midostaurin was preferred than a 7+3 nightmare.

For consolidation, we continued either hypomethylating agents or preferred 1.5gm cytarabine BD on Day 1,2,3. This protocol had a minimal blood product requirement and lessened the chance of febrile neutropenia. Acute Lymphoblastic Leukemia

We did a 50% dose reduction of induction drugs and used minimal steroids In elderly patients, Vincristine + steroids were considered and few received 50% dose adjusted R-HYPER-CVAD / MAC
For Consolidation we gave home-based Subcutaneous Cytarabine or switched to oral 6-MP/Methotrexate maintenance. We tried to keep WBC counts >2,000/microL in maintenance patients. Myelodysplastic Syndromes

Higher-risk MDS (IPSS-R score of >3.5): We gave Hypomethylating agents (without reducing doses). We made Transfusion cut-off as Hb < 7gm and Platelet < 10,000/microL or clinical bleeding.

Myelo- proliferative Neoplasms the protocol was the same like before. Myeloma

For Newly Diagnosed cases if <65 years -VRd x 4 cycles, followed by autograft & Lenalidomide maintenance protocol were continued. We converted Bortezomib to no more than weekly injections. We continued myeloma autograft with 140mg/m² Melphalan. For Maintenance, we continued single-agent iMID. For Relapse - we tried weekly Carfilzomib with Pomalidomide. Hodgkin Lymphoma

We gave ABVD every two weeks with Peg GCSF or mid-cycle home GCSF. This avoided severe neutropenia. We used liberal prophylactic antibiotics. In relapsed cases, Gemcitabine based or three-day admission DHAP salvage were given. We did dose adjusted BEAM autografts. Non- Hodgkin Lymphoma Indolent NHL:

In asymptomatic patients, Wait & Watch policy with monthly monitoring was done. We gave R-CVP. Oral Ibrutinib home therapy for Marginal zone, Mantle cell, Small cell lymphoma, and Waldenstrom Macroglobulinemia. Relapsed /Refractory cases, we used Lenalidomide, Ibrutinib with or without Rituximab.

High-grade Non-Hodgkin Lymphoma

If fit - R-CHOP 14/21 was given with GCSF support. For Frail patients, we preferred R-CVP. Suspected CNS lymphoma, we gave R-CHOP with IT Methotrexate than HDMTx. In few patients, we considered Lenalidomide / Ibrutinib maintenance. Dose adjusted BEAM autografts were done. Bone marrow transplant

We did a detailed discussion about the pros and cons with patient and attendee. We admitted them in a separate block and got both tested for COVID19. The donor was made to stay as attendee for the patient. We shifted them inside transplant unit and observed for a week to rule out COVID symptoms. For autograft, we did around 30% dose reduction but for allograft, no drug dose modification was done. Once engrafted, they were discharged early and kept on follow-up. From first lockdown to mid June 2020, we completed twelve bone marrow transplants in our centre which included five AML haplo-identical transplants. Conclusion
As we wait for the situation to better, the normal functioning of hospitals may take some more time even months. These above are the methods we are following in our MIOT hospital at Chennai, India the city which has got around 30,000 COVID19 cases during submission. Our advice is where ever feasible, we should try to stick to time tested conventional protocols. The above protocols may be useful temporarily till the COVID crisis is over.

Disclosures
No relevant conflicts of interest to declare.

Author notes
* Asterisk with author names denotes non-ASH members.