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Impact of the COVID-19 pandemic on diagnosing and treatment referrals of lung cancer patients: A single-centre experience

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Background: Due to the global pandemic of COVID-19 in 2020, a substantial drop in the rate of cancer diagnosis, treatment and prognosis is anticipated owing to limited health resources dealing with cancer. Here, we present single-centre data of University Clinic Golnik, which addresses more than 40% of all cases of diagnosis and treatment of lung cancer in Slovenia, but was also one of the main COVID-19 treatment centres in the country during the last year.

Methods: Data for lung cancer diagnosis and treatment referrals through multidisciplinary tumour board (MDT) were prospectively collected through the clinical hospital registry and analysed in comparison with the year before. Descriptive statistical analysis was performed.

Results: There were 583 patients diagnosed with lung cancer in year 2019 and 614 in 2020. There was no major difference in symptom duration prior to diagnosis: no symptoms in 17% vs 22%, symptoms lasting less than 1 month in 12% vs 5%, 1-3 months in 43% vs 39% and more than 3 months in 25% vs 24% for years 2019 and 2020, respectively. The time of diagnosis of patients did not presen in worse ECOG performance status (PS): 90% vs. 89% had PS 0-2 and 10% vs. 8% had PS 3-4 in 2019 and 2020, respectively. Limited stage of disease was diagnosed in 31% and 37% of patients, loco-regionally advanced in 10% and 8% of patients and metastatic disease in 57% and 53% comparing the years 2019 and 2020. Referrals to the first oncological treatment by the MDT in years 2019 and 2020 were as follows: 31% and 37% proceeded to surgery, 9% and 9% to chemo-radiotherapy, 15% and 16% to palliative radiotherapy, 33% and 28% to systemic therapy and 11% and 10% to best supportive care alone. No major differences in any of these parameters was found comparing the two years.

Conclusions: In our small single-centre experience, there seems to be no decline in newly diagnosed lung cancer cases, neither increase in later-stage diagnosis. Later analysis will show if this might be attributable to increased radiological investigations performed due to respiratory symptoms and fear of COVID-19 and surely due to timely performed diagnostic procedures and excellent organisation despite the pandemic.

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Sustained cancer clinical trial activity during the COVID-19 pandemic

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Background: The COVID-19 pandemic deeply threatens the rigorous conduct of clinical trials, notably by delaying site initiation visits, patient enrolment, treatment administration, trial-associated procedures, and data monitoring. Unlike most other medical specialties, clinical trials are integral part of patient care in oncology. Limiting access to clinical trials therefore results in a loss of chance for patients.

Methods: In this retrospective single-center study, we collected clinical trial-specific items (including patient-related or trial management-related items) during the first pandemic wave (March–June 2020) and lockdown (March 17th–May 11th) at Gustave Roussy, and compared them to those of the same period in 2019.

Results: In March 2020, 84 phase I (P1) and 210 phase II/III (P2/3) trials were open. During the first pandemic wave, 21 (25%) P1 and 20 (9%) P2/3 trials were temporarily halted; following a unilateral sponsor decision in virtually all cases; all but one were industry-sponsored. Despite this, all important metrics of the P1/2 trial activity remained similar to those of 2019, including the number of patients referred for inclusion (599 vs 620), inclusion consultations (215 vs 247), patients starting treatment (130 vs 130), Internal Review Board (IRB) submissions (14 vs 16), and site initiation visits (11 vs 15), all in 2020 vs 2019, respectively. The impact of the first lockdown was more marked on P2/3, with 152 patient inclusions (vs 346 in 2019), 125 randomizations (vs 278), 43 IRB submissions (vs 50) and 34 site initiation visits (vs 40). However, in parallel, 475 patients were included in three “COVID and cancer” trials. Among the 443 P1 and 2851 P2/3 patients, 198 and 628 COVID-19 PCR were performed internally, and five and 15 (2.5%) were positive, respectively. One patient with a community-based COVID-19 died after transfer in intensive care.

Conclusions: Cancer clinical trials can, and must be maintained despite challenges brought by COVID-19. Sharing experiences and retrospectively evaluating the impact on patients’ safety and cancer-related outcomes will be critical to duly manage the clinical trials conduct and to anticipate at best challenges brought by future similar crises.

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Worsening of breast and cervical cancer stage at diagnosis due to COVID-19 pandemic

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Background: The COVID-19 pandemic affected health services by overloading hospitals’ capacity, impacting cancer screening and treatment. Unfortunately, a late cancer diagnosis has a detrimental effect in prognosis. We aimed to assess the staging management, no differences emerged in terms of interval between symptom onset and radiological diagnosis (median 19 days in 2020 vs 28 days in 2019, p = 0.88), symptom onset and cytosthotological diagnosis (25 vs 36 days, p = 0.27), symptom onset and treatment start (median 86 vs 100 days, p = 0.79). However, less CRC were discussed in multidisciplinary tumor meetings during the 2020 (45% vs 54%, p = 0.07).

Conclusions: While COVID-19 related limitations will be likely felt for decades to come, our data suggest an alarming drop in early-stage CRC diagnosis during the first pandemic wave. Vice versa, our study draws the attention on the efforts made to ensure diagnostic-therapeutic pathways proper operation.

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of breast cancer (BC) and cervical cancer (CC) patients (pts) during their first consultation, comparing the periods during and prior to the pandemic.

Methods: Data were collected from pts who started follow-up and treatment in a cancer hospital in Brazil from Sep/20-Jan/21 and from Sep/19-Jan/20. These periods were selected considering the beginning and duration of the COVID-19 pandemic in Brazil, which started on Feb/20 and is still ongoing. We considered the period (Sep/20-Jan/21) to be representative of the pandemic impact on cancer diagnosis. The primary endpoint was BC and CC stages at diagnosis. CC staging was defined according to 2018 FIGO staging. Clinical or pathological (for those with upfront surgery) BC stage was defined according to the TNM anatomic stage from AJCC 8th edition. The comparison of cancer stages between the two periods was performed using Chi-square test.

Results: 268 BC pts and 44 CC pts had their first consult from Sep/20-Jan/21; 457 and 60, respectively, occurred from Sep/19-Jan/20. Pts who attended their first consult during the pandemic period presented with higher BC (P < 0.001) and CC (P = 0.328) stages than those prior to the pandemic, although the difference was not statistically significant for cervical cancer. The proportion of CC pts diagnosed with locally advanced disease (stages II-IV) was 56.8% (N = 25) in Sep/20-Jan/21 compared to 43.3% (N = 26) in Sep/19-Jan/20. Similarly, 37.3% (N = 100) of BC pts had stage III disease in Sep/20-Jan/21 compared to 23.2% (N = 106) in Sep/19-Jan/20. Fewer pts were diagnosed with stage I BC during the pandemic (9.3% vs 20.6%). Additionally, fewer BC pts were diagnosed due to screening tests during the pandemic (13.7%; N = 36) than before it (25.5%; N = 113) (P < 0.001).

Conclusions: BC and CC pts presented with a higher stage in their first consultation at a cancer center during the period of the COVID-19 pandemic compared to a similar period prior to the pandemic, confirming the long-term negative impact of the pandemic on oncologic pts. Thus, efforts should be made not to compromise essential cancer services.

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Transition to a virtual cancer multidisciplinary team meeting during the COVID-19 pandemic: Experience from a regional Irish Cancer Centre

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Background: The COVID-19 pandemic has dramatically changed how healthcare services are provided. In order to comply with public health recommendations, the multidisciplinary team (MDT) network of the South East Cancer Centre at University Hospital Waterford made a transition to a virtual MDT meeting format. This created a network of eight individual cancer MDTs with three satellite hospitals. Following adaptation to virtual format, remote participants now join by videoconference, telephone call, or by phone application.

Methods: A 30-part questionnaire was developed in electronic format and distributed to consultants who comprise the senior membership of the cancer MDTs. The objectives were to investigate experience of the virtual meetings post-implementation, and assess preference regarding the future of the meetings.

Results: Among 36 respondents, surgeons accounted for 38.9%, medical oncologists (22.2%), pathologists (13.9%), radiologists (11.1%), haematologists (5.6%) and radiation oncology, palliative care and physicians for 2.8% each. The most common means of joining the meeting included videoconference (61.1%), physical attendance at MDT room (19.4%), telephone (11.4%) and by phone application (8.3%). 67% experienced difficulties using the technology including issues connecting (67%) and screen-sharing (50%). 78% agreed that the virtual format did not affect their attendance at MDTs with 11% reporting increased attendance. 56% thought the case discussion at the virtual MDT was not as in-depth as the conventional MDTs, but a majority (81%) believe that decisions made are not impacted by the virtual format. 71% believe it has negatively impacted on education. Most respondents (40%) preferred the traditional face-to-face format, with 37% preferring a combination of virtual and face-to-face. The majority of consultants determine that virtual MDTs should continue past social distancing guidelines.

Conclusions: The results of this study suggest that virtual MDT meetings can be implemented into routine MDT practice. Although challenges are encountered, transition to a virtual format enables continuation of MDT meetings in uncertain times and may become a lasting legacy of COVID-19.

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