To the Editors:

We thank Dr Leong for her timely article about the possibility of a lung cancer pandemic once the coronavirus disease 2019 (COVID-19) one is better controlled.1 We have been actively contributing to the TERAVolt study2 described and agree that concurrent COVID-19 infection with any form of lung cancer carries a poor prognosis. Locally, we run a large pleural unit with high rates of lung cancer and mesothelioma and provide a regional interventional service.3 As per known literature, we have noticed a dramatic drop in referrals. New patient referrals to pleural clinic for any cause in 2020 were only 43% compared to 2019 numbers (unpublished local data) (clinics were kept open during the pandemic as multi-site working is possible locally) and we also noted a drop in interventions performed (57 in 2020 vs 97 in 2019, even allowing for 6 weeks where no elective theatre lists ran). However, there has been substantial work locally and nationally to mitigate the impact of COVID-19, and we believe Dr Leong’s article will be greatly enhanced by pointing out some of this. ‘COVID light’ or ‘free’ pathways with regular COVID-19 swabs have enabled re-starting elective interventional services and provide chemotherapy in a safer fashion.4 The United Kingdom Lung Cancer Coalition have listed a number of points to support lung cancer care, namely to restart screening programmes, revise visiting restrictions, establish diagnostic hubs, enable virtual discussions and straight to computed tomography (CT) referrals amongst others.4 A campaign has also been recently launched by the Lung Cancer Clinical Expert Group (CEG) and the Roy Castle Foundation, ‘Differentiate between the C’s’, which provides a template to differentiate between lung cancer and COVID-19 for healthcare professionals (Fig. 1).5 An appraisal of the various discussion points and proformas produced by the CEG is beyond the scope of this article, and not unique. Various other oncological societies have also provided such guidance, and perhaps a further commissioned article would complement this letter. It would be also important for all centres to collate data on the outcomes of patients presenting late with lung cancer, what symptoms they have and how long they had those for and why they did not present earlier. However, such qualitative and quantitative data will be very difficult to collate prospectively, and might be an option for large-scale audits such as the

Figure 1 How to differentiate lung cancer from COVID-19. An infographic for healthcare professionals by Lung Cancer Clinical Expert Group (CEG) and secretariat Roy Castle Lung Foundation (RCLCF); freephone number (0333 323 7200) within the UK and the website address (www.roycastle.org) for use overseas.

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REFERENCES

1 Leong TL. Delayed access to lung cancer screening and treatment during the COVID-19 pandemic: are we headed for a lung cancer pandemic? Respirology 2021; 26: 145–6.
2 Garassino MC, Whisenant JG, Huang LC, Trama A, Torri V, Agostoni F, Baena I, Banna G, Berardi R, Bettini AC et al. COVID-19 in patients with thoracic malignancies (TERAVOLT): first results of an international, registry-based, cohort study. Lancet Oncol. 2020; 21: 914–22.
3 Aujayeb A, Jackson K. A review of the outcomes of rigid medical thoracoscopy in a large UK district general hospital. Pleura Periton 2020; 5: 20200131.
4 Grange M, Peake M, Rintoul R. Assessing the impact of COVID-19 on lung cancer services. [Accessed 23 Jan 2021.] Available from URL: https://www.uklcc.org.uk/assessing-the-impact-of-covid-19-on-lung-cancer-services/
5 Grange M, Peake M, Rintoul R. Assessing the impact of COVID-19 on lung cancer services. [Accessed 23 Jan 2021.] Available from URL: https://www.uklcc.org.uk/assessing-the-impact-of-covid-19-on-lung-cancer-services/

Reply

From the Author:

I thank Dr Aujayeb et al. and Dr McCarthy et al. for their interest regarding our article discussing the effects of the coronavirus disease 2019 (COVID-19) pandemic on lung cancer diagnosis and management. As they affirm, COVID-19 has had a significant negative impact on referral and procedural rates for suspected lung cancer. Correspondence from Dr Aujayeb outlines a number of approaches to mitigate these effects, and communication from Dr McCarthy describes their institution’s bronchoscopy response to the pandemic.

The COVID-19 pandemic is characterized by global heterogeneity in terms of prevalence, mortality, healthcare capacity, testing and vaccination programmes. As such, strategies adopted by lung cancer clinicians depend not only on patient factors including age, comorbidities, performance status, risk of infection and cancer phenotype, but are also determined by the local COVID-19 context. In Australia, where the pandemic is largely under control, the risk of community-acquired infection is low. As such, the practice of routinely testing patients for COVID-19 prior to tissue sampling procedures for lung cancer diagnosis was curtailed in late 2020. With resumption of full capacity elective procedures, waiting times for definitive diagnosis and management have returned to pre-pandemic levels. However, in countries such as the UK and USA, new cases continue to rise and the trajectory of the disease remains unpredictable, especially with the emergence of highly transmissible mutant strains. As such, patient-specific measures that balance the risk of infection and the benefits of lung cancer care are needed.

In a comprehensive document, the European Society of Medical Oncology (ESMO), along with other leading professional bodies released recommendations to guide prioritization of patients at each step of the lung cancer diagnostic and management pathway. The overarching principles are that decisions associated with clear survival benefit should be maintained and that regimens should be adjusted to minimize hospital visitation where possible. Proposed approaches to achieve the latter include conversion to telemedicine consultations, postponement of low-dose computed tomography (CT) screening and modification of drug and/or radiation scheduling to reduce the frequency of cycles and/or fractions. Recommendations regarding bronchoscopic procedures warrant specific attention, given their aerosol-generating nature. In a recent report, the CHEST/American Association for Bronchology and Interventional Pulmonology released statements to guide performance of bronchoscopy while maximizing protection of patients and healthcare workers. In particular, in cases where the indication is diagnosis and/or staging of lung cancer, the guidelines recommend that bronchoscopy be performed in a timely and safe manner. This is contingent upon local resources to pre-procedurally screen for COVID-19 and to provide appropriate lung cancer follow-up. Of note, the detection rate of nasopharyngeal swab reverse transcriptase-polymerase chain reaction (RT-PCR) testing for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) has been reported as 59–71% among symptomatic patients, and may be lower in asymptomatic individuals. Furthermore, the utility in pre-bronchoscopy screening has not been evaluated, and therefore, measures including use of negative-pressure procedure rooms and personal protective equipment are essential.

One certainty in the midst of the uncertainties posed by the pandemic is that healthcare services, including those for lung cancer, need to evolve to function in an effective, safe and timely manner to establish a new ‘COVID-normal’ system.

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Respirology (2021) 26, 511–512
doi: 10.1111/resp.14033 © 2021 Asian Pacific Society of Respirology