



WEBSITE DISCUSSIONS Part 2

The Battle Against Coronavirus and the Implications in Cancer Treatment

How Has the Coronavirus Pandemic Changed Cancer Management in Patient Care?

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- Dr. Jack West: Hi, I'm Dr. Jack West, and I'm an associate clinical professor in medical oncology at the City of Hope Comprehensive Cancer Center. And I'm also the founder and president of GRACE, Global Resource for Advancing Cancer Education. And I'm very happy to be joined today by two of my colleagues who are also on the board of directors for GRACE and have long been committed to patient education. And so I'd like to introduce and have them give details on their own positions. First, Dr. Jared Weiss, if you can say a bit about yourself.
- Dr. Jared Weiss: Sure. I'm Jared Weiss. I'm associate professor of medicine at University of North Carolina's Lineberger Comprehensive Cancer Center, where it's a privilege to take care of patients and run trials in lung cancer.
- Dr. Jack West: And also Dr. Ben Levy.
- Dr. Ben Levy: I am an associate professor at Johns Hopkins School of Medicine and the clinical director for the Johns Hopkins Sidney Kimmel Cancer Center at Sibley Memorial Hospital in Washington, DC, and like Jared it's pleasure to take care of lung cancer patients and deliver hopefully great care and great science to these patients.
- Dr. Jack West: Excellent. We're here today to give an update on where we are in the battle against Coronavirus and also the implications of Coronavirus in our own treatment of lung cancer and potentially other cancers. So we had an initial discussion, now a couple of months ago as we were in the thick of that first wave. And we were coping with that. We talked a bit about telemedicine, and also increasing the intervals between our treatments and many of the interventions we initiated included kind of kicking the can, and holding off on some interventions with the thought that our situation might be fundamentally different in several weeks to months. We are now at that point. And I would say that unfortunately, it's not remarkably different.



It's not that we've come out the other side and it's business as usual in many States, including, I would say all of the States that we are in, we are seeing some escalation in cases, if not a full fledged surge, and growing concern and potentially need to clamp down further. Can you give sense? We're all in different Parts of the country and I'll speak to California where particularly in Southern California, the number of new cases has been going up quite a bit. And there's as of the very beginning of July, a sense that we may have a lockdown again, just as we were in March. What about how things are where you are both in terms of the rules of the game and the general sentiment, because I'd also say that in California, part of the problem we've had is that there's varying commitment in a lot of ways, not that much commitment, and especially among younger folks, a great interest in going to the beaches, going to the restaurants, even bars, and this may be feeding, fueling the escalation in cases over time, Jared what are things like where you are?

Dr. Jared Weiss:

So we did a pretty decent job of flattening the curve in North Carolina, of course, flattening the curve, doesn't change the area under the curve or in plainer English. Our peak is coming later than most States. We haven't hit it yet. For us, the first wave is not over. We are still in the escalating phase of the first wave. The current projections are for us to continue exponential increase in case numbers until at least late September. The good news here in North Carolina is that until some of the recent openings, every time the models were revised, our peak case load kept coming down. Now, of course, human behavior has a heavy influence here. This is something that people have a lot of control over. And unfortunately in North Carolina, and I think the rest of the country, not everyone is doing what we should do, both for ourselves, but also our families and the rest of society, which is to say that with reopening's and gatherings that shouldn't be happening, and failures of mask wearing, for the first time that I'm aware of our projections actually started bumping upwards.

Dr. Jack West:

And Ben, how are things in the DC Baltimore area?

Dr. Ben Levy:

Yeah, it's a little different. You know, DC currently is in phase two of reopening things and it's been a cautionary tale similar to what Jared was saying. I think we have to be careful as we begin to open slowly, our numbers continue to track down, DCs at it's lowest numbers since the surge happened. And, and, and almost back to where we were at the beginning of this, however if we look at the modeling from Hopkins my own, my own institution, it looks like we are heading for another surge come September or October. And we're preparing for that. In terms of, are people behaving or not, I will tell you, at least in the DC Baltimore area you know a lot of the majority of the is behaving, I think, where the challenge has come in is in the younger audience that we're still having challenges with mask wearing in the twenties and thirties, young thirties getting these people to consistently wear masks. So, and there's, there's, there's been a lot of push, a



lot of public awareness through emails and through signs on local restaurants and public places as a reminder to wear masks. But currently as it stands now, and in July, 2020, this area is at its lowest point a long time. And that's not to say that things may not change dramatically. I think what we've learned is that as much as we know about this virus, oftentimes, the virus determines its own timeline, irrespective of what the modeling is showing. So we're preparing and trying to make every preparation possible for the second potential uptick in cases.

Dr. Jack West: Now, when we first connected to talk about COVID and Coronavirus, COVID being the name for the full blown syndrome, and Coronavirus the virus itself, it was still relatively early days, and maybe this'll be something we're dealing with for long enough that we still look back at this as early days, but we have been learning some over time. Including getting some data that the people with lung cancer who develop Coronavirus have a disturbingly high risk of complications and in some series of deaths as well. How is this changing management in any practical ways at your institution? And I would say both for lung cancer and more broadly for cancer in general, kind of now, and potentially in place for the coming weeks and months. And Ben, maybe I could start with you.

Dr. Ben Levy: Yeah. I think we talked a lot about this, the last go around, and clearly we were trying to come up with policies and procedures that made sense, not necessarily rooted in the data because we didn't have a lot of data at that time, but what made intuitive sense and scientific sense to do. And clearly a couple of things we did, one was for better, for worse surgeries were delayed for curative intent patients. And we moved as much as we are of a neoadjuvant institution, a large percentage of our patients that were lung cancer, early stage back in April and May who would have gotten surgery. Many of these patients were unfortunately delayed, and this did give us an opportunity to deliver chemotherapy. Now you can make.

Dr. Jack West: Just to clarify, neoadjuvant being treatment, some systemic body therapy before pursuing the curative intent surgery or potential treatments. Yeah, you were saying.

Dr. Ben Levy: Sorry, for that.

Dr. Jack West: No, it's all good.

Dr. Ben Levy: Yeah. And so the, you know, this did give us an opportunity to give chemotherapy first where we usually give it after surgery, but at the same time, you know, that in itself may pose challenges by further immunosuppressing patients and maybe theoretically increasing their risk of complications from the virus. So that's one thing that we're changing now. And we're starting to give back to some of these elective surgeries. I think the other thing that we were doing in addition to all the social distancing measures



that we were taking for patients to come in, but in general cancer management, we were moving out the interval of treatment. So where their treatment may have been every three weeks, we moved it to every four weeks or even every six weeks based on some new approvals, and that was again, to limit the amount of patient flow into the hospital. Those were the two big things that we were doing in terms of treatment. I would say that surgeries were delayed, unfortunately, and we often gave treatment beforehand. And then those patients that were on treatment existing treatment, we were increasing the interval and things have changed. We can certainly talk about how that's changed in a bit, but we're still doing some of that. And trying to do any sort of change in an iterative way that's a little bit longer acting than just doing, you know, cutting it off saying, okay, it's time to move back to everyone moving back to the same schedule they were before.

Dr. Jack West:

Well, one of the other things, my sense was that a good amount of our, let's just give six weeks or two months of chemo or some other systemic therapy. And then we'll do surgery at that point was based on a premise that we just have to get through this initial surge of activity. And hopefully in two or three months, it'll all be behind us and that's not happening in my senses. So you move ahead two, three months and you still have the same challenges that you did when you started that there may not be some point in the immediate future when surgery is a much less concerning enterprise. So Jared, what are things like at UNC particularly, maybe in lung cancer, but maybe more broadly? I know you treat other tumor types, especially head and neck where interestingly a lot of those patients are treated quite aggressively and they're kind of getting beaten with the treatments themselves to the point that it's pretty challenging. And that was before Coronavirus.

Dr. Jared Weiss:

Right. So I think, you know, when last we spoke, there was a lot that we did not know. There's still a lot, we don't know, but there are some things that we know much better than that. More specifically, when we first spoke, we really didn't know what the risk was for a patient coming into one of our facilities. And I think all three of us were definitely afraid of people coming into our facilities, we were doing everything in our power to keep patients out and I'll stand by that based on what we knew at the time that that was the right thing to do. My facility, and I suspect yours, have done something rather similar has very strict policies before you can walk in the door. You're asked a series of questions to screen you, about how you're feeling, about your contacts, your temperature is checked. And it is mandatory that your hands are sterilized in front of a healthcare worker. And that if you're not already wearing a mask, you put one on before you walk through the doors. It's made clear to you, you were obliged to wear that mask in the entirety of your time in the facility.



And if you are not, you will be escorted out by security. There are other precautions as well, but the gist is very strict precautions. And what I know now that I didn't know when we first spoke is that these sorts of precautions actually work. We've had a fair number of cases. So we have a denominator and our in-hospital transmission rate remains zero. And I'm aware of many other hospitals that have rigorously looked and also have rates of zero. And that influences my thinking a lot. I'm a lot less scared about my patients coming in than I was when we first spoke. And so that has influenced me heavily as well, when we first spoke, I would say I was in my honeymoon period with virtual care. And I would say, I now have some concerns about my marriage.

Dr. Jack West: You're just talking telemedicine.

Dr. Jared Weiss: Oh yeah, my actual medicines, my actual marriage is rather happy. But for telemedicine, I still stand by what I said when we first spoke that for some patients, it can be better care. If you have an EGFR mutated patient on Osimertinib, who's been doing well, six months feels great. There's no reason you can't get local labs and scans do a quick video appointment. And that's probably better care for that patient, even outside of COVID-19 because you're demedicalizing their life. And I still stand by the idea that remote care will forever be a greater part of my practice than it was pre COVID-19. However and this may be in some ways unique particular to the environment I'm in. For some patients, I have come to a very harsh feeling that it is dramatically inferior care. The face to face connection is not the same. The ability to judge sick versus not sick as the same, physical exam, now that I don't have it I realized that it was more useful perhaps than I might have joked the first time we spoke. And then the final point is that many of our patients don't have the resources to do an appropriate telemedicine or video visit. So, you know, when we spoke last time, we spoke a little bit about internet bandwidth, but I'm noting on my video visits that I'm having a lot of visits where I'm struggling to hear every other word. And then to take that a step further, I'm in an environment where some of my patients from very rural environments, they're even people who have landlines that I can't understand them on a landline telephone. And so I'm seeing some heterogeneity for which situations in which patients virtual care is appropriate for it. And I've shifted back to doing more of my care in person.