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Bone Marrow Transplant Society of Australia and New Zealand COVID-19 consensus position statement

In the context of a viral pandemic, utilisation of health care resources may exceed standard capacity. The impact of potential resource limitation on the needs of a stem cell transplant and bone marrow service needs to be carefully considered. Challenges are likely to include reduced availability of highly specialised health care staff due to illness or allocation to other areas, as well as compromised infrastructure and acute care bed capacity.

Representatives of all adult and paediatric allogeneic stem cell transplant centres in Australia and New Zealand have been in regular communication and have reached a consensus regarding several issues relating to the COVID-19 pandemic. This document will be updated regularly as the situation changes and published at bmtsanz.org.au. Here, we report the first edition of this consensus:

1 Centres will identify backup donor options for patients undergoing allogeneic transplant from interstate and overseas unrelated donors, including haploidentical related donors and cord blood donors. Travel restrictions and illness are likely to reduce the unrelated donor pool.

2 Centres will cryopreserve all international and possibly interstate unrelated donor products before starting conditioning. Cryopreservation by the collecting centre will be requested as a preference for international donors.

3 Donors who have developed COVID-19 will be excluded for at least 3 months. Refer to updated international guidelines for the management of donors with contact or geographical risk of SARS-CoV-2 exposure.[1–3]

4 The Australian Bone Marrow Donor Registry (ABMDR) will update donor questionnaires to include questions specific to risk factors for COVID-19.

5 Donors and recipients should be screened for symptoms of COVID-19 prior to commencement of donor mobilisation and recipient conditioning. Routine donor screening is recommended if feasible, although the sensitivity of screening in asymptomatic donors, and optimal timing of this testing, remains uncertain.

6 Centres should attempt to triage transplants. Triage will depend on patient, donor and disease factors. This should include consideration of risks of disease progression or relapse and estimated transplant related mortality. It is not possible to develop a strict triage protocol that would take into account all eventualities or how the COVID-19 pandemic will evolve. Nevertheless, general suggestions for disease-based triage are as follows:

- High priority: Adverse outcomes are expected if transplant is delayed for any reason other than patient factors.
  - Allogeneic transplantation
    - Acute leukaemia with considerations for the disease risk index (DRI) and Haematopoietic Cell Transplant Comorbidity Index (HCTCI)
    - High-risk myelodysplastic syndrome not responding to bridging therapy
    - Aplastic anaemia
    - Severe combined immune deficiency in children
  - Autologous transplantation
    - Relapsed/refractory aggressive lymphoma or Hodgkin lymphoma
    - Central nervous system (CNS) lymphoma in first remission based on individual patient considerations
    - Multiple myeloma failing induction therapy
- Intermediate priority: Patients can be delayed with bridging therapies used where possible to stabilise disease while awaiting transplant.
  - Allogeneic transplantation
    - Stable myelodysplastic syndrome
    - Stable myelofibrosis
  - Autologous transplantation
    - Multiple myeloma with consideration of collection of autologous cells based on local resources
    - Relapsed indolent lymphoma
    - Mantle cell lymphoma (MCL) in first remission
    - High-grade lymphoma in first remission
- Low priority: Patients can be delayed with low risk of adverse outcome
  - Allogeneic transplantation
    - Chronic myeloid leukemia (CML) in chronic phase
    - Low grade lymphoproliferative disorders including Chronic lymphocytic leukemia (CLL) and indolent lymphoma
    - Sickle cell disease
    - Immunodeficiency
  - Autologous transplantation
    - Autoimmune diseases (multiple sclerosis, myasthenia gravis, systemic sclerosis)
    - Amyloidosis
    - Clinical trials: unless the clinical trial provides standard of care transplantation that patients would otherwise receive.

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Primary objective of Concord Haematology Clinical Research Unit is to contribute independently to quality clinical research

The Haematology Clinical Research Unit (CRU) at Concord Repatriation General Hospital, the subject of 'A retrospective pharmaceutical financial benefits and cost avoidance analysis of clinical trial participation in the Australian haematology setting' by Truong *et al.*,[1] seeks to reassure readers of the *Internal Medicine Journal* that the primary objective of the CRU is to contribute independently to quality clinical research.

In the accompanying editorial 'Pre-marketing is a type of marketing', Laking[2] has made an incorrect assumption that the financial analysis conducted is limited solely to commercial trials. Forty-one of 114 (36.0%) clinical trials in the study period were sponsored by the Australasian Leukaemia Lymphoma Group, supported not just by industry funding but also by the National Health and Medical Research Council and the Medical Research Future Fund grants, along with local fundraising efforts.

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