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Guidelines Update

Management of digestive cancers during the COVID-19 second wave: A French intergroup point of view (SNFGE, FFCD, GERCOR, UNICANCER, SFCD, SFED, SFRO, ACHBT, SFR)



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ABSTRACT

Introduction: The COVID-19 pandemic has major impact of healthcare systems, including cancer care pathways. The aim of this work is to discuss in a multidisciplinary approach the therapeutic and/or strategies adaptations for patients treated for a digestive cancer during the European second wave of COVID-19 pandemic.

Methods: A collaborative work was performed by several French societies to answer how to preserve digestive cancer care with no loss of chance during the second wave of COVID-19. In this context, all recommendations are graded as expert's agreement according to level evidence found in literature until October 2020 and the experience of the first wave of the COVID-19 pandemic.

Results: As far as possible, no therapeutic modification should be carried out. If necessary, therapeutic adjustments may be considered if they do not constitute a loss of chance for patients. Considering the level of evidence all therapeutic modifications need to be discussed in multidisciplinary tumor board meeting and with patient consent. By contrast to first wave cancer prevention, cancer screening, supportive care and clinical trials should be continued.

Conclusion: Recommendations proposed could limit cancer excess mortality due to the COVID-19 pandemic but should be adapted according to the situation in each hospital.

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The European second wave of the COrona Vlrus Disease 2019 (COVID-19) pandemic requires us to think again our practice of digestive oncology. These proposals are based on a recent literature review, the first national digestive oncology guidelines group (TNCD) recommendations [1] and the experience of the first wave of the COVID-19 pandemic.

The risk of death from COVID-19 in patients treated for cancer was overestimated in the first studies [1]. In large European cohorts and a recent meta-analysis, death and severity of COVID-19 were mostly due to patients' characteristics with low impact of cancer treatments [2–4]. In the French GCO-002 CACOVID-19 cohort ($n=1289$), independent factors associated with death, in multivariate analysis, were male gender, ECOG performance status ≥ 2 and the updated Charlson comorbidity index (ICCa) [2].

The impact of the reorganization of healthcare systems during the first wave of the COVID-19 pandemic was major on cancer care pathways [5–8]. The French ONCOCARE-COV study confirmed a reduction in terms of colon cancer screening (–86%), histopathological (–48%) and biomolecular (somatic and germinal) (–69%) analyses, oncology announcement consultations (–54%), oncogeriatric evaluations (–86%) and new patients files discussed in multidisciplinary tumor board meeting (MTBM) (–39%) [5]. The decrease in cancer treatment was also significant concerning surgery (–30%) and to a lesser extent for radiotherapy (–16%) and chemotherapy (–9%); all clinical research trials were stopped for 3 months [5]. The prognostic impact of delay in diagnosis and treatment is not yet known, but population-based modeling analyses are worrying [9].

Thus, due to the second wave of the COVID-19 pandemic, it seems essential to maintain cancer diagnosis and treatments if possible while preserving access to specialized tertiary cancer care and, when necessary, access to intensive care units to ensure continuity of care.

All recommendations were proposed by the steering committee (COPIL) of the TNCD on November 3rd, 2020 and based on an expert agreement in the absence of sufficient data from the literature. These proposals must be interpreted according to the intensity of the epidemic and its impact on the organization of healthcare structures. The present letter is a summary of the French intergroup guidelines available on the TNCD website (www.tncd.org).

1. Patients care

- Cancer screening and diagnostic procedures (imaging and endoscopy) should be continued since the cumulative diagnostic and therapeutic delays could have major consequences.
- Patients, as well as the whole population, must be reminded of the need not to forego care, screening and prevention actions when these are offered by health professionals and care establishments.
- It is necessary to preserve, as much as possible, the diagnosis announcement procedure with the oncology nurses. They ensure a good understanding of the treatments and their potential side effects, the follow-up, the effectiveness of the surveillance, the continuity of home care, and the good management/compliance of oral drugs. They can also contribute to reschedule postponed medical cares.
- Supportive and palliative cares should be preserved (pain management, diet counseling, psychological support, adapted physical activity, etc.).
- It is recommended to vaccinate patients against Influenza and *Streptococcus pneumoniae*.

- Except before surgery, there is no indication to screen for COVID-19 in asymptomatic patients (especially before chemotherapy courses or consultations).

2. Proposed adaptations of medical treatments

- As far as possible, no therapeutic modification that could lead to a loss of chance (unplanned therapeutic reduction) and/or an increased toxicity (replacement of 5FU to unplanned oral capecitabine) should be carried out.
- If therapeutic delays are necessary, they should only concern the patients at risk of a severe form of COVID-19: older patients and/or with poor general condition and/or with co-morbidities (heart disease, diabetes, chronic pulmonary disease, chronic renal failure, cirrhosis and/or body mass index $> 40 \text{ kg/m}^2$).
- If necessary, therapeutic adjustments may be considered if they do not constitute a loss of chance for patients according to the recommendations of the first COVID-19 TNCD [1].
- Therapeutic adjustments must be recorded and/or discussed during a MTBM.
- In case of COVID-19 infection, wait at least 14 days, and 48 h without cough and fever, and if possible 3 weeks, before resuming treatment with chemotherapy, tyrosine kinase inhibitors or immunotherapy (7 days is enough for asymptomatic form).

3. Proposed adaptations of surgical treatments

- Surgical units and non-COVID-19 postoperative critical cares should be preserved.
- If possible, no oncologic surgery should be postponed.
- If necessary, a postponement of surgery can only be considered if it is for a short duration and using a validated neoadjuvant treatment recorded and/or discussed during a MTBM and according to the recommendations of the first COVID-19 TNCD [1].
- If postponement of surgery is not possible but necessary due to the local situation, a transfer to another regional hospital should be discussed.

4. Proposed adaptations of interventional radiology and radiotherapy

- If possible, no interventional radiology or radiotherapy should be postponed.
- For the neoadjuvant treatment of rectal cancers, if the local context does not allow standard chemoradiotherapy, short course radiotherapy (5×5 Grays) followed by chemotherapy (9 courses of FOLFOX) is a new alternative validated by the RAPIDO trial [10].
- Radiation therapy should not be interrupted in case of COVID-19 infection except for patients with a severe form.

5. Proposed adaptations for follow-up

- If possible, oncology announcement consultations should be done face-to-face, given the potential loss of chance for patients to perform these consultations by phone or video consultation.
- Follow-up consultations can be carried out by phone or video consultation if possible.
- Postponement of imaging examinations and follow-up consultations can only be considered for patients at low risk of recurrence.

6. Proposed adaptation of cancer research

- If possible, patient inclusions in clinical trials should be continued, as well as monitoring of patients in clinical trials.

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- Cancer research must also be continued.

In conclusion, France's second wave of COVID-19 could be worse than the first. Adaptation of strategies in cancer care is necessary but postponement of cancer screening, diagnosis and treatment with late diagnostic and therapeutic delay have major consequences. Indeed, it seems important to ensure continuity of cancer care as much as possible. Present updated recommendations were based on a multidisciplinary overview and experts' agreement and should be adapted according to the situation in each hospital.

Conflict of interest

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