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no staff exposures occurred. No caregivers screened positive, and no children presented for treatment without the designated parent.

Conclusion: With careful multidisciplinary planning to mitigate COVID-19 risk, pediatric RT with GA was carried out for a large pt volume without widespread infection, and without increased toxicities from either GA or RT. Frequent pt COVID testing and attention to PPE limited staff exposures.

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Telemedicine Perspectives in Radiation Oncology

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Purpose/Objective(s): Given the changes to Radiation Oncology clinic workflow inspired by the COVID-19 pandemic, this study sought to determine the attitudes and perceptions of radiation oncologists towards the integration of telemedicine in the clinical setting.

Materials/Methods: An online survey was sent nationwide to radiation oncologists, accompanied by a \$10 gift card incentive for completing the survey. Of 117 complete responses received, the majority of respondents reported practicing in an academic setting (92%) and in an urban area (95%). 42% of respondents were still in training, while the rest had graduated from residency 0-5 years (16%), 6-10 years (8%), 11-20 years (15%), and 21+ years (19%) ago.

Results: Of all respondents, 79% worked at institutions that had implemented a work-from-home policy. Satisfaction was reported to be 87% regarding work-from-home flexibility, 84% regarding decreased commute to work, 40% regarding interaction with patients, 46% regarding impact on workflow, and 76% regarding overall impression. Before COVID-19, 99% of all visits were completed in-person whereas after COVID-19, telephone and telemedicine video visits comprised approximately 35% of new patient consults, 12% of on-treatment visits (OTVs), and 51% of follow-up visits. The primary factors in determining whether a patient was seen via telemedicine were patient preference (46%), physician preference (32%), and department policy (22%). Overall, in-person visits were felt to be better than telemedicine encounters in obtaining information during consultation (55%), establishing a personal connection with the patient/family (89%), answering questions about radiation treatment (45%), assessing for toxicity while on-treatment (87%), and assessing for toxicity/recurrence during follow-up (70%). 70% of respondents were in favor of more telemedicine utilization even after the COVID-19 pandemic, while 22% were in favor of telemedicine use only during the pandemic, and 8% were against the use of telemedicine unless absolutely necessary. Telemedicine visits for OTV encounters were deemed somewhat appropriate or extremely appropriate by 86% of respondents for patients confirmed to be COVID-positive, 79% for patients with mild symptoms who had not been tested, 65% for asymptomatic patients living with an at-risk person, 57% for asymptomatic patients who had recently traveled to a high-risk zone within the last 14 days, 92% for physician with mild symptoms who had not been tested, and 89% for asymptomatic physician living with an at-risk person.

Conclusion: Telemedicine has become quickly integrated into the Radiation Oncology clinical workflow allowing for convenience, flexibility, and minimization of infection transmission. These encounters are likely to play a role in conjunction with – not in place of – in-person visits, which allow physicians the ability to obtain crucial information during consultation, establish a personal connection with patients, and assess for toxicity/recurrence.

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Feasibility of Implementing Thoracic Radiation Therapy for COVID-19 Pneumonia

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Purpose/Objective(s): The value of low dose whole thoracic radiation therapy (LD-WTRT) for SARS-CoV-2 (COVID-19) pneumonia is unknown. Should ongoing clinical trials demonstrate LD-WTRT proves effective for COVID-19 pneumonia recovery, widespread rapid implementation will be helpful globally. Our aim was to outline a pragmatic process that could be implemented successfully in a community hospital.

Materials/Methods: To identify appropriate patients admitted to the hospital with COVID-19 pneumonia, we worked with Nursing Informatics to screen all currently admitted COVID+ patients requiring oxygen supplementation. For patients meeting criteria of the PreVent protocol per chart review, radiation oncologists contacted the hospitalist physician for telehealth consultation with the patient to discuss single dose LD-WTRT. After a patient had confirmed interest in treatment, at time of physical exam, we obtained consent and digitally transferred the signed consent form via secure text to avoid contaminated forms. Chest radiographs were used to estimate AP/PA field size and separation at the carina; diagnostic chest CT data was imported into the treatment planning system for field size and MU calculation before patient arrival, without using the department's CT simulator. Inpatient Nursing transported patients for treatment after clinic hours on a route pre-approved by Infection Control. The treating radiation oncologist and one 'hot' radiation therapist assisted with patient set-up supine or prone on the linear accelerator couch. After decontamination, the physician and a 'cold' therapist confirmed field size and MU calculations to prepare for treatment delivery. Nursing monitored patient O₂ saturation and stayed gowned with the 'hot' therapist. After patient departure, Radiation Oncology contacted Facilities for decontamination of the vault before treating cancer patients the following day.

Results: For the first treated patient, telehealth consultation lasted 40 minutes. In-person exam, evaluation and consent took 60 minutes, of which 30 were for the protocol-required consent form. With the diagnostic CT scan, field design and MU calculations took 20 minutes. Patient arrival to departure took 40 minutes. Once the patient was positioned on the couch, localization, MU confirmation and entry and treatment delivery took 16 minutes.

Conclusion: We have developed a process to efficiently provide LD-WTRT for patients with COVID pneumonia that minimizes staff exposure, departmental equipment, and room contamination. Should clinical trials indicate that LD-WTRT helps treat COVID pneumonia patients, this process can work in most hospital-based radiation oncology departments to provide LD-WTRT efficiently and safely. Staff and cancer patient vaccination will further lower the risks of implementing LD-WTRT but is not necessary with careful planning and consultation with infection control.

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