



Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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GRAY ZONE EXPERT OPINIONS

Through COVID-Colored Glasses: New Perspectives on Same Data



Before COVID-19, my recommendation for this man¹ (at his first diagnosis) would have been moderately hypofractionated radiation therapy (RT) (70 Gy in 28 fractions) and short-term androgen deprivation therapy (ADT). With re-biopsy, I agree with the treatment option of RT and long-term ADT. I will admit to being a slow adopter of prostate stereotactic body radiation therapy for intermediate-risk disease, although with the HYPO-RT-PC trial's publication,² I have been offering it more frequently. I will also say that in my practice at a community hospital within an academic enterprise, serving a varied socioeconomic base including the surrounding rural counties, the patient tolerance for toxicity and novel treatments is low.

COVID-19 and the significant concern about exposure felt by my patients with cancer has changed my practice. First, I offer a longer delay between start of ADT and RT. Second, although I have generally been a proponent of elective nodal irradiation, I have foregone that coverage in all but a few select patients, and only after discussion with them about potential risks/benefits. Third, I have found patients more willing to try stereotactic body radiation therapy for the reduced number of visits, although I would not offer it for high-risk patients (underrepresented in HYPO-RT-PC, significant variability within the traditional National Cancer Comprehensive Network high-risk cohort such that I do not know yet which men can be treated with tight fields).

Our institutional policy has been to not test asymptomatic radiation therapy patients for SARS-CoV-2 unless they have a known exposure or high-risk living situation. That may have changed between this writing and publication owing to community spread or other updates.

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Reference

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Cancer Treatment Decision-Making During the COVID-19 Pandemic: Data Over Opinion



The fundamental question is how will a delay in treatment affect outcomes. Treatment delays may lower the risk of contracting and dying of COVID-19 by allowing the peak of the pandemic to pass, but they have the potential to increase cancer-specific mortality (CSM). Our team has created an integrated model to provide quantitative estimates of the net impact of treatment delay on overall mortality (<http://onccovid.med.umich.edu/>).

Using the following assumptions, if the patient has 1 additional comorbid condition and lives in San Mateo, California, and assuming a COVID-19 replication rate (R_0) of 2,¹ we would estimate the patient's

1. 5-year CSM pre-COVID-19 to be 3.2%.
2. 5-year overall mortality pre-COVID-19 to be 16.7% (CSM + other-cause of mortality).
3. age- and comorbidity-adjusted COVID-19-specific mortality to be 13.9%.
4. hazard ratio for treatment delay on CSM to be 1.0 (multiple data sets confirm this).

The integrated impact of a 3-month delay would result in an improvement in his restricted mean survival time of only 9 days over a 5-year period, something incredibly small.

What would you do? Continue the discussion on Twitter at #gyzone, and take the poll at www.redjournal.org/poll.