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 man[1] (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.

Bridget F. Koontz, MD
Department of Radiation Oncology, Duke Cancer Institute, Durham, North Carolina

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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.

Thus, I would have treated the patient in early March with stereotactic body radiation therapy and androgen deprivation therapy (ADT) because of the known survival benefits of ADT, the potential protective effect of ADT on COVID-19–specific mortality, and because the patient is estimated to live >10 years. Now that his treatment has been delayed, I would treat him with shorter-term ADT based on the DART 01/05 randomized trial, which demonstrated that long-term ADT increased cardiovascular events by 2.1-fold and the dominant mode of death in high-risk prostate cancer is other-cause mortality.[2] I would continue to offer stereotactic body radiation therapy to reduce hospital exposure to COVID-19 if it is in the peak of a second wave (estimated 7% increased risk of contracting COVID-19 from 5- vs 20-fraction radiation therapy from increased cumulative hospital exposure). I would not give nodal radiation therapy based multiple negative randomized trials, while we await the results of RTOG 0924.[3]

Daniel E. Spratt, MD
Department of Radiation Oncology
University of Michigan
Ann Arbor, Michigan

Disclosures: D.E.S. served on advisory boards for Janssen, AstraZeneca, and Blue Earth.

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https://doi.org/10.1016/j.ijrobp.2020.07.008

Less Is More During COVID 19

For this patient with moderate-volume unfavorable intermediate-risk disease,[1] we would generally treat with 6 months of androgen deprivation therapy (ADT). Studies of dose-escalated therapy (GETUG-14, EORTC 22991) thus far have not found that dose escalation can substitute for ADT. His cardiac history is not severe enough to make us concerned that the survival benefit of ADT would be lost. While waiting for the COVID-19 peak in Massachusetts to pass, we delayed radiation initiations by giving 5 to 6 months of the ADT course neoadjuvantly, per TROG 96.01.[2] Traditionally, we have used 44 fractions of 1.8 Gy, but during the pandemic we have more frequently treated with moderate hypofractionation (60 Gy in 20 fractions).

For high-risk disease, we would offer ADT for 2 years and 28 fractions of intensity modulated radiation therapy plus a brachytherapy boost per ASCENDE-RT.[3] If procedures were being limited due to a COVID-19 surge we would use 60 Gy in 20 fractions. We do not typically treat the pelvic lymph nodes prophylactically for localized high-risk disease except for young patients at the highest end of the risk spectrum, and we await the results of RTOG 09-24. We would not offer stereotactic body radiation therapy for high-risk disease off trial, but a future NRG trial may be testing stereotactic body radiation therapy for high risk.

Without symptoms or potential exposures, we would not routinely test for SARS-CoV-2, but we would screen daily and test as needed. The pandemic has led us toward more use of moderate hypofractionation, but we continue to favor combination therapy per ASCENDE-RT for high-risk or higher volume unfavorable intermediate-risk patients.

Jonathan E. Leeman, MD
Paul L. Nguyen, MD
Dana-Farber/Brigham and Women's Cancer Center
Department of Radiation Oncology, Harvard Medical School
Boston, Massachusetts

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