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COVID-19 Q&A
Accessing Lung Cancer Care
with
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University of Pennsylvania

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LUNGevity spoke with Charu Aggarwal, MD, MPH, who answered questions from the lung cancer community about accessing lung cancer care during the COVID-19 pandemic. It is important to note that the conversation took place on July 21, as issues around the COVID-19 pandemic continue to evolve.

Dr. Aggarwal is a thoracic medical oncologist and the Leslye M. Heisler Associate Professor for Lung Cancer Excellence at the Abramson Cancer Center at the University of Pennsylvania. She is a clinical researcher who is very involved in managing patients during the pandemic. She has been instrumental in writing guidelines to help the community take care of patients with lung cancer.

Below are the answers to the questions discussed in the accompanying video:

How can patients prepare to continue to take chemotherapy infusions during the pandemic?

I always stress to patients that getting chemotherapy does increase the risk for myelosuppression [decrease in bone marrow activity resulting in reduced production of blood cells]. More than ever before, I ask patients to be cautious. Washing hands and making sure that masking up whenever patients are out of the confines of their own house or outside their own family are extremely important. Reporting any kind of new symptoms that come up to their physician as well as the healthcare team is paramount.

I would say that most healthcare and infusion centers are taking more-than-adequate precautions. For example, at our infusion center, we are usually not allowing visitors to accompany patients, temperature checks are mandatory, and symptom screens have been in place for the last three-and-a-half months. Everyone is screened, including providers and healthcare workers. Patients shouldn't feel scared or anxious about coming in to the infusion centers because the hospitals and cancer centers are taking the necessary precautions.

In terms of clinical practice, what types of changes have you adopted in your practice to make sure that patients can continue to receive immunosuppressive treatments such as chemotherapy?

We've been looking at these practices since the very beginning of the pandemic. Our practices in mid-March were a little different than they are in mid-July. In mid-March, we were looking at a surge in the Northeast and the Philadelphia-New York area. At that time, our goal was to reduce the number of times that the patient had to come into the hospital so as to reduce interactions—to basically reduce exposure. At that time, we were thinking of using more growth-factor support, but perhaps giving slightly dose-intense regimens using a q-3 three-week regimen or a higher dose instead, but using it with growth factor support. I would say I've changed my practices a little bit since then. As our practices have evolved, we have become much more accustomed to and good at minimizing exposure and making sure that we are maintaining physical distancing, hand washing, and universal masking. I have now started to go back to my usual practices and have not really been doing a lot of dose reductions. I do, again, stress

the importance of early reporting of symptoms and really keeping your physician team and your healthcare team in the loop with any symptoms that come up.

Do patients need to take any special precautions with immunotherapy?

Over the last three months, we've seen a lot of data come out in terms of risk factors for patients, including risk factors for lung cancer patients. What we've seen is that immunotherapy does not necessarily increase the risk for COVID-19-related mortality or the risk of severity with the COVID-19 disease. I certainly have been able to deliver immunotherapy safely. There have been situations in which we've had some toxicities from immunotherapy that can manifest as inflammation of the lung or immunotherapy-related pneumonitis that can sometimes be mistaken for signs and symptoms of COVID-19. These symptoms may vary from fevers to shortness of breath or a cough. I think getting a multidisciplinary team to review those findings, getting a radiologist on board, and having a pulmonologist weigh in have been extremely helpful. We've been able to manage these situations as they have come up without any major issues.

In itself, receiving immunotherapy infusions and administering immunotherapy has not been a major challenge.

Would you have different suggestions for a patient who's getting the chemo-immuno combination therapy?

Adding chemotherapy does increase the risk slightly because of its myelosuppressive nature. In most instances, we're able to mitigate that either by using growth-factor support or, if it's a regimen that's not going to cause that much myelosuppression, we are able to get by with good education as well as early reporting of symptoms. I think those are the key things that I tell my patients. Call me, or call my team with anything that comes up, and we are here for you.

Do you think of targeted therapies differently from the infusion-related treatments?

Early on in the pandemic, we were drawing up plans in terms of which patients definitely needed to come in and which patients could be seen through a telehealth or remote visit. In my practice, the patients who had been on targeted therapies and had good outcomes were the ones whom we chose to move out to our remote or telehealth visits. These were the patients who weren't necessarily at high risk or higher risk from COVID-19-related side effects or severity, but we thought that this was a group for whom we could avoid exposure.

We have certainly continued to do this for a subset of our patients who are on targeted therapies; these get scans locally at a facility in a physically distanced way. I obtain the reports and the images, the patients get labs locally, and then we conduct a televisit. However, we are just starting to move more and more to have these patients come in as well because oftentimes these are the patients who need bone support, for example, for bone metastases. They need to come in to get their shots anyway or their infusion anyway once every three months or once every few weeks, so we are beginning now to bring these patients safely into our environment.

Do you have any additional mechanisms in place to help patients out during the COVID-19 pandemic if they're experiencing dramatic side effects from their treatment? How has that changed during the pandemic?

We've become more cautious. We've become more mindful of reacting to these symptom calls early, if we get reports from patients that they're experiencing even a fever, for example. We have a very low threshold to order testing or order a scan. Before, we would probably have taken a slightly different approach.

What happens if a patient is diagnosed with COVID-19 in the middle of their treatment? What has your approach been, and what are your suggestions?

This is actually a very difficult question. Our approach has evolved over the course of the last few months. If there's a patient who tests positive for COVID-19, we do not administer the chemotherapy and immunotherapy during the week when they were tested. Of course, we have a two-week mandatory period during which no treatment will be administered. We are also requiring two negative COVID-19 tests that are 24 hours apart and a lack of symptoms to be able to resume therapy.

I have had patients who have had COVID-19 positivity, either with symptoms or without. I'm happy to say that we've been able to resume treatments and that this is not something that's an all or none. This is something that physician teams are learning to manage. I've certainly been able to administer treatment safely after a patient has had two COVID-19 tests that have been negative. I want everyone to be assured that if this happens, it should be treated like a roadblock, not like a complete stop sign.

You discussed some of the precautions your own clinic and infusions centers are taking to make sure that patients can be safe while they come in for the in-person appointments. What about the CT scanners and the blood-draw clinics? What types of precautions are they putting in place to make sure that patients continue to be safe?

Patient safety is the number-one priority for us at both the cancer center and the hospital. With in-person appointments, we are continuing to screen 24 hours and 48 hours before appointments with our symptom questionnaire. As soon as patients get off the elevator, there is a temperature scanner; there's a whole team that scan patients. If an elevated temperature is detected, that patient or the caregiver is asked questions and appropriately triaged. When they check in, they're asked the questions again. Our patients do get tired of the questions, but it’s important to ask because it's for everyone's safety.

We are not asking that people come in with caregivers. We are issuing companion passes to ensure that we are limiting the number of people who are coming in. Our appointments are staggered, so that there is enough time for the rooms to be turned over between patients. Our clinics have been mandated to allow only a certain number of patient visits. The same thing applies for our radiology as well as our phlebotomies sections. The CAT-scan appointments are staggered, so that physical distancing is able to be maintained in the waiting rooms. It's important to be able to minimize the number of patients waiting for scans and for blood draws. These are decisions that have not been taken lightly, and so far they have yielded very good results.

What advice do you give patients? When they go back home, what are the top two or three things that you tell them to stick to to make sure they are safe during the pandemic?

I always encourage patients to make sure that they have a family member listening in on the conversation because, as you know, we are limiting the number of patient caregivers who are coming in for the appointments. I have been asking my patients to get their spouse or other family members on FaceTime. If the patient is sitting in the room with me, I usually have their family member on FaceTime. We've actually been really lucky that with telemedicine, we are able to get in members from other times zones to join in. I've been encouraging that because the pandemic is a very hard time to undergo lung cancer treatment.

As many eyes and ears that patients can have in the room with them to take notes and ask all the relevant questions, I think is the most important piece of advice. I've been asking patients to report symptoms back to me as soon as possible. Being unified as a team to be able to deliver good care to patients has been important. Patient safety is of the utmost importance, so I do offer patients a lot of safety guidelines when I talk to them, and I really encourage them to follow them.

For most cancer patients, having a caregiver at appointments in person is very helpful, especially when they have finished an infusion and have to drive back home. Under what circumstances would your clinic issue a companion pass?

We do have certain set of guidelines for offering companion passes. Again, patient safety is most important. We want to limit the foot traffic, but we also want to make sure that patients are being taken care of. If there are patients who have physical disabilities that prevent them from coming in to the center themselves, we are certainly issuing companion passes. I've had patients who are starting first-time infusions, and we don't know how they're going to do. We are issuing companion passes if it's the first time that a patient is getting chemotherapy. How can we just ask our patients to come in and be by themselves? We are looking at this on a case-by-case basis. I would say that the physician team, including the physician and the nurse practitioner, as well as the triage nurses, at least at my center, have a lot of say in terms of which patients receive companion passes because we know the patients well. Patients talk to us, and they talk to us about their anxieties and about their fears. We are listening, and we are making sure that we're making those adjustments on a case-by-case basis.