

COVID-19 Q&A
with
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LUNGevity spoke with Jessica Donington, MD, MSCR, who answered several questions about COVID-19 and lung cancer surgery from her perspective as a thoracic surgeon at the University of Chicago. It is important to note that the conversation took place on April 5, as issues around the COVID-19 pandemic can change rapidly.

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

As a thoracic surgeon, what are the top five things you would tell our lung cancer community about COVID-19?

The top thing I would start with is that you need to do everything that the public health officials are telling us that we all need to do to be protected, including self-isolating.

Second, I would remind you that you are the people for whom some of these precautions are put in place because people with lung cancer do have increased risk for morbidity and mortality related to these infections. All of this social isolation and distancing is about keeping people like you safe—and you guys are really important to us!

The third thing is that we know that interactions with the healthcare community are essential for you, but we're doing our best to limit those as much as possible. We are trying to be agile. We are trying to deliver you care without putting you at increased risk. That does mean that some of our policies, some of the things that used to be standard of care, are very different now. That's because, again, that risk of coming to see us may not be worth the treatment we're delivering each day.

Fourth is to recognize that we're all working on treatment plans, which may not be what they were before. That's because, again, that risk of coming to see us may not be worth the treatment we're delivering each day. Very importantly, our field is moving forward.

Fifth is for some of my early-stage patients. Although we think of lung cancer as being an incredibly deadly disease, we do think that some of our patients with very early tumors with ground-glass opacities might fall into the group for which we suddenly are saying that it's safer to watch and wait then to move forward. But we are not ignoring you! We can stay very engaged, and we will resume treatments and bring you in for appropriate biopsies when we think the risk/benefit ratio makes sense.

Should patients who are scheduled for lung surgery delay it?

There are many factors that go into how we decide which surgeries can and should be delayed. First of all, if your city is in phase 3, which means that the whole healthcare system has been utilized to its max, then nobody's getting surgery right now for lung cancer unless it is an immediately life-threatening

problem. If you're in a phase 1 or 2 city where you live, we've been given criteria from the American College of Surgeons and from many other organizations about what kind of patients should be getting surgery or not. Most patients with stage I tumors, less than 1.5 centimeters or that are mixed ground-glass, are being told that they can defer surgery at this point. We do not feel that a delay of two, six, or maybe even 12 weeks, will significantly impact your survival.

Those are the recommendations now. Carcinoid tumors also fit into this group. For the patients with stage II and stage III disease, these questions are much more challenging. Each institution is making up their own priority of what kind of surgeries they are moving forward with. Most elective surgery in the United States is on hold right now, but cancer surgery doesn't really fit as elective. The definition of what should move forward is unique for each institution. Within my institution, we have created a priority scale called an MNTS scale: medically necessary time-sensitive surgery. Who should proceed and how, and it not only takes into account your disease, but also the individual patient and also the resource utilization of the hospital. Does this patient need an ICU bed after surgery? Does this patient require 10 people on the healthcare team to make the operation work? All of that goes into the decision. And then hospital-wide, we just go through that scale every day. We take the top patients, and we say, "We would like to do your surgery today. Could you come?" And, really, it has forced us and our patients to make this a day-by-day decision.

The last group is stage III patients. We have made decisions to take people we had once thought were operative stage III and told them that we think non-operative therapy may be better right now. That's because of the huge inpatient resources required for operating on a patient with stage III disease. It also gets paired with the new benefit we've found in non-operative therapy with the addition of some immunotherapies after chemo and radiation.

You've used the phrase "elective surgery," and that's something we've been hearing a lot. Can you tell us what elective surgery means?

We don't know what elective surgery means anymore. I guess we think of classic completely electives surgery to be, say, plastic surgery procedures that people decide to have. That's why we really like the term medically necessary time-sensitive. Cancer surgery has never in the United States been considered elective. We have always recognized that this is one of the major ways we cure cancer and that it is by no means elective, but it doesn't mean that it all needs to be done today.

That's why it's been a little challenging. I would say that the two fields that have been the most challenged by what's elective and what's not are cancer surgery and cardiovascular surgery. It's very clear, for example, if you have a bowel obstruction, that you need surgery today. For us, it's much, much harder. That's why a lot of institutions have these scales and these new categories of what needs to go this week and what we can put off until the pandemic might be over.

I do think it's important for our patients to know that our tumor boards still take place. Every institution I know that had a tumor board still has a tumor board, and we do this virtually. For patients with stage I cancer, we go through this very good conversation about what's the benefit of surgery versus SBRT in terms of risk, resources, survival, everything. The conversations have changed, but it's not as if they don't happen.

Should patients who have already undergone surgery and are supposed to go on adjuvant chemotherapy wait before going to an infusion center?

The same way we have a new discussion with patients about the risk of undergoing surgery, we also have a new discussion with our patients about the risk of starting chemotherapy. All of our infusion centers are being asked to prioritize resources the same way we are prioritizing surgery and to only be treating those patients with the greatest need first. Again, depending upon where you are in the pandemic, there will be different recommendations about starting chemotherapy or not starting chemotherapy. I think that this is a discussion that you have to be having with your oncologist about the resources available, the protection that's been put in place, and such. That's a very clear new discussion to have, and the outcome may depend upon the stage of your resectable cancer; IB versus IIIA is again a very different discussion.

Should patients who have already undergone surgery and are supposed to get radiation therapy wait before having it?

Again, this is very much a resource-related thing. Radiation has the same issues. They have had to try and take patients' treatments and spread them out during days so that patients are not running into each other in waiting rooms and the staff can be spread apart. Again, it may depend upon the indication for your radiation. If your radiation is being done for positive margins or known residual disease, then there is a greater need than not, but it is a very clear discussion for you to have with your radiation oncologist about whether it is safe to wait or is not safe to wait.

Do you have any advice for our lung cancer community on how to manage stress and anxiety?

It is hard, and I don't know that getting online and reading everything that's out there is particularly helpful. We have really used a lot of our technology in terms of the ability to be face to face on our computers with our community as a really important way to manage stress. I don't know whether my patients want to hear this or not, but I will tell you that talking to my patients is how I relieve my stress about having all these meetings about how we're going to manage this disease and COVID-this and COVID-that. The thing that helps me the most is to spend those minutes at the end of the day getting on the phone with my patients and saying, "Hey, how are you?"

I think that you just need to continue to reach out. All of your providers are very anxious about the fact that they can't see you every day either, the way we are used to. I don't think you have to feel bad at all about calling your practitioners, your surgeons, and your staff. They want to hear from you, and if that helps, I feel like we want that, too. Our institutions are a little bit slow about getting all the virtual visits and all of the technology in place for those, but we are all working very quickly toward that so that hopefully some of that stress can be relieved by discussing it with those who care about you.

What is your message of hope for the lung cancer community in these times of COVID-19?

My message of hope is that you guys are important to us. We totally get that you guys are in this group that is particularly put under stress. It's so stressful to have lung cancer. It is so stressful to be living through a pandemic, and to be at the crux between the two is really, really hard. We as a treatment community are doing everything we can to make sure that your care stays a priority. Most of our



medical centers have lung cancer way up there and people who are working through ways to make sure we can deliver care in a safe and novel environment, and it's moving forward.