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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Letter to the Editor

Adaptation of multidisciplinary meeting decisions in a medical oncology department during the COVID epidemic in a less affected region of France: a prospective analysis from Bordeaux University Hospital

Luc Heraudet [a], Charlotte Domblides [a,b], Amaury Daste [a], Marine Gross-Goupil [a], Alain Ravaud [a,b,*]

[a] *Department of Medical Oncology, Hôpital Saint-André, Bordeaux University Hospital, Bordeaux, France*
[b] *Bordeaux University, France*

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A multidisciplinary meeting (MDM) is mandatory in France for decision-making as regards to patients with cancer. A weekly MDM is held in the medical oncology department of Bordeaux University Hospital (Bx CHU) to decide the indications for medical treatment.

Owing to the coronavirus disease (COVID) epidemic in France, recommendations have been published [1]. Quarantine started on March 17th, 2020. The Nouvelle-Aquitaine region which includes Bx CHU is less affected than other regions of France. To minimize the loss of chance for patients with cancer, we have organized our MDMs in accordance with the French guidelines. To assess the impact of decisions, we prospectively looked at three successive weekly MDMs held since March 19th. Our main fields of expertise are genitourinary, lung, head/neck, brain and breast/gynaecological tumours.

Ninety-eight successive medical files were discussed at three MDMs. The majority of patients (98%) were within our areas of expertise and there was a palliative intent (89·8%). Discussion was based on criteria proposed as guidelines for France [1]. Finally, the position of the patients was considered in the context of the COVID epidemic. The proposal for treatment was recorded in real-time during the MDM, and if any, as having been impacted by the COVID epidemic.

From discussions regarding curative treatment for ten patients (Table 1a), the proposals were: standard treatment for five patients, an option considered not affecting survival for 1 patient, a delay in surveillance considered as not affecting survival for one patient. The decision was considered as potentially impacting tumour growth or symptoms but having a limited impact, if any, on overall survival for three patients: one patient – 76-years-old with a laryngeal carcinoma was planned for radiotherapy excluding cetuximab; one patient – 62-years-old with an urothelial upper tract carcinoma refused adjuvant chemotherapy due to COVID and one patient – 61-years-old with an isolated peritoneal ovarian carcinoma was postponed for radical surgery. Therefore, the decision for 50% of patients to have curative treatment was modified by the COVID epidemic.

* *Corresponding author*: Department of Medical Oncology, Hôpital Saint-André, 1 rue Jean Burguet, Bordeaux, 33075 cedex, France.
E-mail address: alain.ravaud@chu-bordeaux.fr (A. Ravaud).

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Table 1a
Patients given treatment with curative intent.

Tumour type	Number of patients	Age		Life expectancy		Standard oncological treatment or standard surveillance	COVID option treatment with no loss of chance	Delay or pause in treatment or surveillance without major impact
		<60 years	>60 years	<5 years	>5 years			
Testicular germ cell cancer	6	6	0	0	6	4	1[a]1[b]	
Laryngeal carcinoma	1	0	1	1	0	0	0	1
Breast cancer	1	0	1	0	1	1	0	0
Upper tract urothelial cancer	1	0	1	0	1	0	0	1
Ovarian cancer	1	0	1	1	0	0	0	1
Total	10	6	4	2	8	5	2	3

COVID, coronavirus disease.
[a] 46-year-old man presented a seminoma with metastatic retroperitoneal lymph nodes; standard chemotherapy protocol is normally BEP, switched in the context for VIP owing to the potential pulmonary toxicity of bleomycin and to avoid the d8 and d15 of bleomycin, minimizing hospital admissions.
[b] First follow-up scan after chemotherapy delayed.

From MDM discussions for 88 patients at a palliative state (Table 1b), proposals were: standard treatment for 38 patients (43·2%), an option considered not affecting survival for 13 patients (14·7%), a delay, a pause in treatment or a delay in surveillance considered as not affecting survival for 14 patients (15·9%). The decision was considered as potentially impacting tumour growth or symptoms by delaying treatment for at least 2–3 months or stopping specific treatment, not symptomatic treatment, but having a limited impact, if any, on overall survival for eight patients (9·1%). In addition, a decision for unspecific palliative treatment only was proposed for 15 patients (17%) but not affected by the COVID epidemic. Therefore, the decision regarding palliative treatment for 39·8% of those patients was modified by the COVID epidemic.

Patients in first-line metastatic treatment had more chance of receiving a standard treatment or an option of

Table 1b
Patients given treatment with a palliative intent.

Tumour type	Total number of patients /1st line	Standard oncological treatment or standard surveillance or investigation pts/1st line	COVID treatment option with no loss of chance pts/1st line	Delay or pause in treatment or surveillance without major impact pts/1st line	Treatment or abstention with possible impact on tumour growth or symptoms but limited impact on duration of survival pts/1st line	Palliative care approach without impact of COVID pts/ 1st line
Urological cancer	39/25	21/15	5/3	6/4	2/2	5/1
Non prostate GU tumour	30	17/13	2/0	5/4	2/2	4/1
Prostate cancer	9	4/2	3/3	1/0	–	1/0
Brain primary tumours	17/4	3/2	–	3/0	4/0	7/2
Glioblastoma/high grade glioma	14	3/2	–	1/0	4/0	6/2
Non glioblastoma/high grade gliomas	3	–	–	2/0	–	1/0
Head and neck carcinoma	12/7	6/2	5/4	1/1	–	–
Lung cancer	5/3	2/1	–	–	1/0	2/2
Breast cancer	6/3	2/1	2/1	2/1	–	–
Gynaecological cancer	4/2	–	1/0	2/2	1/0	–
Gastrointestinal cancer	2/1	2/1	–	–	–	–
Cancer of unknown primary site	3/3	2/2	–	–	–	1/1
TOTAL	88/48	38/24	13/8	14/8	8/2	15/6

COVID, coronavirus disease.

the standard (62·7%) than patients in later lines (45·4%). Patients with aggressive brain tumours or lung carcinoma could nevertheless be affected in first-line for palliative treatment only.

During MDMs, the main discussions concerning proposals were based on comorbidities, therapeutic balance rather than age, as the pressure for access to beds or ICUs was lower than in other regions.

No patient with COVID + has been hospitalized in our department, considered to be protected, since the outbreak of the epidemic in our region.

Our study is the first to be published regarding the impact on decision-making after the COVID epidemic. Our department is unique in two ways – it has patients with different tumour types for whom medical files are discussed during the same MDM as for medical treatment. This offers an equity in decision-making between patients – type of population, comorbidities, expected therapeutic balance and/or anticipated survival which differs when compared with MDMs dealing with a specific tumour type only; – being part of a large University Hospital dealing with all diseases, forced to anticipate the impact of our decision to start treatment or to expose patients to side effects that could impair processes in our institution (access to beds, units, ICU, medical or nursing staff availability).

In addition, our study provides information for departments which anticipate a risk of being overwhelmed in a few weeks compared with more difficult decisions that have been taken in regions where the COVID epidemic has been widely spread [1–3].

Depending on the increase in the COVID epidemic in Nouvelle-Aquitaine, guidelines will be adapted in accordance with the prospective study.

In conclusion, even in less affected region, decision during MDM owing to the COVIC epidemic were impacted up to 40–50%, mainly by modifying the standard with expected limited impact on specific survival.

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References

[1] You B, Ravaud A, Canivet A, Ganem G, Giraud P, Guimbaud R, et al. The official French guidelines to protect patients with cancer against SARS-CoV-2 infection. Lancet Oncol 2020 May;21(5):619–21. pii: S1470-2045(20)30204-30207.

[2] Liang W, Guan W, Chen R, Wang W, Li J, Xu K, et al. Cancer patients in SARS-CoV-2 infection: a nationwide analysis in China. Lancet Oncol 2020 Mar 21;21(3):335–7.

[3] Zhang L, Zhu F, Xie L, Wang C, Wang J, Chen R, et al. Clinical characteristics of COVID-19-infected cancer patients. A retrospective case study in three hospitals with Wuhan, China. Ann Oncol 2020 Mar 26. pii: S0923-7534(20)36383-3.