Welcome

• Session Outline
  • Case Presentation
  • Didactic Presentation
  • Question & Answer
    • We will review questions submitted through registration
    • Questions or discussion topics may be submitted through the Q&A feature

• ECHO etiquette
  • Panelists will be the only ones able to speak during the session
  • Attendee microphones are muted

• Recording will be available on the IGCS website
Case Presenter

Navya Nair
Assistant Professor
Division of Gynecologic Oncology
Department of Obstetrics & Gynecology
LSU Health Sciences Center, New Orleans
United States of America

Didactic Lecturer

Jalid Sehouli
Director of Department of Gynecology with Center for Oncological Surgery
Deputy Director of the Charité Comprehensive Cancer Center (CCCC)
Germany
Panelist Introduction

Hennie Botha
Associate Professor
Stellenbosch University and
Tygerberg Hospital
South Africa

Ane Gerda Zahl Eriksson
Department of Gynecologic Oncology
Division of Cancer Medicine
The Norwegian Radium Hospital
Oslo University Hospital
Norway

Thomas Samuel Ram
Radiation Oncology
Professor & Associate Director
Ida B Scudder Cancer Center,
Christian Medical College
India
PLEASE NOTE that Project ECHO® case consultations do not create or otherwise establish a provider-patient relationship between any International Gynecologic Cancer Society (IGCS) volunteer clinician and any patient whose case is being presented in a Project ECHO® setting. Responsibility for the patient remains with the Medical Team who cares for the Patient at the Presenting Institution.
Case Presentation

- 74yo female presented to Emergency Department with inability to void.
- Evaluation revealed large pelvic mass causing the patient’s symptoms.
Contributing history

• Past Medical History: none
• Family History: unremarkable
• Social History:
  • patient travels frequently to/from New Orleans for work
Physical Examination

• BMI 19

• Exam under anesthesia, cystoscopy:
  • 6cm firm mass extending to the introitus with complete obliteration of vagina.
  • Mass is fixed extending to bilateral side walls.
  • Cystoscopy: posterior bladder base with friable nodules.

• Imaging revealed right hydroureteronephrosis.
• Right nephrostomy tube and foley catheter placed.
Pathology

Poorly differentiated squamous cell carcinoma

p16+
Imaging

• PET CT:
  • Numerous ground glass opacities with hypermetabolic activity involving bilateral lungs (SUV 3-4).
  • Irregular cervical mass with hypermetabolic activity, SUV 10.6.
  • No lymphadenopathy noted.
  • **DDx:** metastatic disease vs infectious vs inflammatory process.
  • Consider chest CT and/or biopsy for further evaluation.
Imaging

[Image of chest CT scan with arrows indicating lesions]

[Image of PET scan with arrows indicating areas of increased activity]

IGCS INTERNATIONAL
GYNECOLOGIC CANCER SOCIETY
Imaging
Treatment

• Imaging reviewed by clinicians, felt unlikely to be due to metastatic disease.

• Given significant symptoms, patient started treatment with definitive chemoradiation while chest findings being worked up concurrently.
Treatment

- Prior to chest CT and lung biopsies, COVID-19 entered into differential diagnosis.
- Additional testing was cancelled.
- Rapid COVID-19 testing approved by hospital CMO.
- Patient tested **POSITIVE FOR COVID-19**.
- Patient remains asymptomatic.
Options

1. Hold all treatment x 2 weeks.
2. Hold weekly chemotherapy only x 2 weeks and continue daily radiation with appropriate PPE.
3. Continue treatment as scheduled with appropriate PPE.
Case Discussion
COVID-19 (Coronavirus SARS-CoV-2) and the Management in Gynecological Oncology

J. Sehouli

Charité Campus Virchow Klinikum und Campus Benjamin Franklin Charité Comprehensive Cancer Center
ESGO OVARIAN CANCER CENTER OF EXCELLENCE
University Medicine Berlin, Germany, Europe, one World!
Conflict of Interest

I have no relevant conflicts of interest to declare
COVID-19 in Italy

146,321 cases of COVID-19
15,891 health-care workers
18,366 associated deaths

Median age of cases: 62 years

Integrated surveillance of COVID-19 in Italy

12 April 2020 UPDATE

Note: more recent data (grey squares) should be interpreted with caution due to the possible reporting delay of more recently diagnosed cases, and to the possibility that cases with date of onset within the reporting period have not yet been diagnosed.

99% of the clinical samples processed were confirmed by the National Reference Laboratory at the Istituto Superiore di Sanità.

Data available for 52,845 cases

Total number of COVID-19 cases diagnosed by the Italian Regional Reference Laboratories

By Region / Autonomous Province of diagnosis

By province of residence

*The case definition considers as a confirmed case any person with laboratory confirmation of virus causing COVID-19 infection, irrespective of clinical signs and symptoms. (https://www.covi.isp.s.r.t/)
How does mortality differ across countries Apr. 16, 2020?

<table>
<thead>
<tr>
<th>Country</th>
<th>Observed case-fatality ratio</th>
<th>Deaths per 100,000 population</th>
<th>Mortality: 13.2%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Italy</td>
<td></td>
<td></td>
<td>13.1%</td>
</tr>
<tr>
<td>United Kingdom</td>
<td></td>
<td></td>
<td>13.0%</td>
</tr>
<tr>
<td>France</td>
<td></td>
<td></td>
<td>12.8%</td>
</tr>
<tr>
<td>Netherlands</td>
<td></td>
<td></td>
<td>11.1%</td>
</tr>
<tr>
<td>Spain</td>
<td></td>
<td></td>
<td>10.5%</td>
</tr>
<tr>
<td>Iran</td>
<td></td>
<td></td>
<td>6.3%</td>
</tr>
<tr>
<td>US</td>
<td></td>
<td></td>
<td>4.5%</td>
</tr>
<tr>
<td>China</td>
<td></td>
<td></td>
<td>4.0%</td>
</tr>
<tr>
<td>Germany</td>
<td>2.8%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mortality: Observed case-fatality ratio
Daily confirmed new cases (5-day moving average)

Outbreak evolution for the current 10 most affected countries
Clinical characteristics of COVID-19-infected cancer patients: A retrospective case study in three hospitals within Wuhan, China

• Retrospective cohort study
• 28 cancer patients with laboratory confirmed COVID-19 from three designated hospitals in Wuhan
• If the last anti-tumor treatment was within 14 days, it significantly increased the risk of developing severe events (HR=4.079, P=0.037).
• Patchy consolidation on CT on admission was associated with a higher risk for developing severe events (HR=5.438, P=0.010).
• COVID-19-infected cancer patients presented poor outcomes with high occurrence of clinical severe event and mortality.
• Anti-tumour treatment within 14 days of COVID-19 diagnosis increased the risk of developing severe events.
Which is her risk to have a worse outcome in case of COVID-19 infection?

The COVID-19 Task force of the Department of Infectious Diseases and the IT Service
Istituto Superiore di Sanità

Table 1. Most common comorbidities observed in COVID-19 positive deceased

<table>
<thead>
<tr>
<th>Diseases</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ischemic heart disease</td>
<td>363</td>
<td>28.1</td>
</tr>
<tr>
<td>Atrial Fibrillation</td>
<td>290</td>
<td>22.5</td>
</tr>
<tr>
<td>Heart failure</td>
<td>207</td>
<td>16.0</td>
</tr>
<tr>
<td>Stroke</td>
<td>144</td>
<td>11.2</td>
</tr>
<tr>
<td>Hypertension</td>
<td>911</td>
<td>70.6</td>
</tr>
<tr>
<td>Type 2-Diabetes</td>
<td>409</td>
<td>31.7</td>
</tr>
<tr>
<td>Dementia</td>
<td>203</td>
<td>15.7</td>
</tr>
<tr>
<td>COPD</td>
<td>224</td>
<td>18.1</td>
</tr>
<tr>
<td>Active cancer in the past 5 years</td>
<td>217</td>
<td>16.8</td>
</tr>
<tr>
<td>Chronic liver disease</td>
<td>40</td>
<td>3.8</td>
</tr>
<tr>
<td>Chronic renal failure</td>
<td>298</td>
<td>23.1</td>
</tr>
<tr>
<td>HIV</td>
<td>1</td>
<td>0.1</td>
</tr>
<tr>
<td>Autoimmune diseases</td>
<td>40</td>
<td>3.1</td>
</tr>
<tr>
<td>Obesity</td>
<td>129</td>
<td>10.0</td>
</tr>
</tbody>
</table>

Number of comorbidities in COVID-19 deceased pts

Active cancer in the past 5 years is highlighted.
Cancer therapy within COVID-19 Pandemia

• The benefit of an effective cancer therapy is higher than the estimated risk for an infection by the corona virus
• Priorization of cancer therapy in case of survival benefit but do not ignore effects on PFS and QoL
• Do not automatically postpone or reduce cancer therapies
Cancer COVID-19 Pandemia

Facts

• In general, the benefit of cancer therapies is superior to the risk of infection with Covid-19
• The goal should be always in the cancer management to offer the best and personalized approach.
• Based on the individual resources and infection rates diagnostics and treatments may have to be adapted.
• Patients with controlled co-morbidities seem to have lower risk for severe infections.
• Treatment postponing or dose reduction should not be routine.
• All SOP’s and guidelines should be re-reviewed and of necessary adapted to new situations and environments.
Cancer COVID-19 Pandemia

Facts

• Adaption of cancer center structure (eg Tumor boards via videoconference for medical staff and patients and relatives)¹
• Before consultation telephone call in advance (medical history)³
• Reduce all contacts for patients and medical staff

¹ Onkopedia 07.04.2020; 2) ASCO Stand 03.04.2020; 3) ESMO Status 25.03.2020; 4) DGHO Webinar - SARS-CoV-2 in der Hämatologie/Onkologie 03.04.2020
Structures/Organization/Processes: Personal/Räume/Prozesse

- Establishment of 6 COVID-19 unclear diagnosis wards + 2 pediatric wards
- Establishment of 6 COVID-19 von 5 COVID-19 stations
- Establishment of 6 COVID-19 5 COVID-19 Intensive unit cares
- Establishment of 6 COVID-19 9 Intensiv unit cares with unclear status
- Establishment of 6 COVID-19 POST-ACUT Stations (incl. palliative station)

- Increase in 350 ICU beds to 500 intensive ICU beds at Charité
COVID-19 era: Challenges in field of Gynecological Oncology

- Diagnostics
- Surgical Therapy
- Medications
- Maintenance therapies
- Cancer Care
How to react for gynecological cancer patients within the COVID-19 pandemic?

Influence of pandemic on diagnostic and therapeutical infrastructure:
- What can I do? What should I do?

Patient’s condition:
- Is my patient fit enough, can I improve the health status of my patient?
- Do I have to treat immediately?
- How I can protect my patient, how I can protect my medical staff and me?
Potential reasons for limitation of surgical procedures within the COVID-19 era

Saving Measures
- Protecting clothes
- Medical staff

Saving resources for COVID-19 patients
- Beds
- Exclusion stations, COVID stations, post COVID (palliative) stations
- Intensive care units/ventilation places/post-COVID places

Personalschutz
- Risk situation: In- and Extubation
- Reduction of personal contact to protect medical staff
- Medical staff COVID-19 infection
What are the implications for gynecological surgeries within this crisis?

The patient’s perspective:
- Fear and concern due unplanned surgeries
- Will this compromise my prognosis?
- Can a postponed cancer therapy still help?

The physician’s perspective:
- How to communicate with my patients and their relatives?
- Can I perform a complex cancer therapy in this "fragile" situation?
- Feeling of powerlessness
### Modified Elective Surgery Acuity Scale

<table>
<thead>
<tr>
<th>Tiers/Description</th>
<th>Definition</th>
<th>Locations</th>
<th>Examples</th>
<th>Action</th>
</tr>
</thead>
</table>
| Tier 1a*          | Low acuity surgery/healthy patient  
Outpatient surgery  
Not life threatening illness | Ambulatory surgical center (ASC)  
Hospital with low/no COVID-19 census | Surgery for benign-appearing ovarian cysts  
Hysterectomy for menorrhagia without anemia | Postpone surgery or perform at ASC |
| Tier 1b*          | Low acuity surgery/unhealthy patient | ASC  
Hospital with low/no COVID-19 census |  | Postpone surgery or perform at ASC |
| Tier 2a*          | Intermediate acuity surgery/healthy patient  
Not life threatening but potential for future morbidity and mortality.  
May require in-hospital stay | ASC in select cases  
Hospital with low/no COVID-19 census | Hysterectomy for pre-cancerous conditions or low risk endometrial cancer | Postpone surgery or consider ASC |
| Tier 2b*          | Intermediate acuity surgery/unhealthy patient | ASC  
Hospital with low/no COVID-19 census |  | Postpone surgery if possible or consider ASC |
| Tier 3a*          | High acuity surgery/healthy patient  
Potentially life threatening or patient is highly symptomatic  
Requires in-hospital stay | Hospital | Surgery for most cancers  
Resection of masses resulting in significant end-organ damage or quality of life impairment | Do not postpone |
| Tier 3b           | High acuity surgery/unhealthy patient | Hospital |  | Do not postpone |

*If high COVID-19 census for any tier, case prioritization may change.
SGO COVID-19 Guidelines

• Oncology patients at highest risk for severe events:
  • Patients ≥ 65 years old
  • Patients at any age with significant co-morbidity or ECOG status ≥ 2
  • Patients receiving cytotoxic chemotherapy

• General considerations:
  • Pre-screen clinic patients via telephone.
  • Reschedule or use telehealth for routine visits. Minimize testing.
  • Prioritize newly diagnosed and recurrent cancer patients with symptoms.
  • Restrict visitors and encourage physical distancing; minimize personnel interactions.

• Management of disease:
  • Neoadjuvant chemotherapy may be effective in delaying surgery and inpatient hospitalization.
  • Consider treatment that minimizes risk of hospitalization or allows use of telemedicine.
  • Consider alternative strategies that minimize exposure to the health care setting.
  • Delay therapy in low risk cases.
Surgery in the first 2 weeks after diagnosis of endometrial cancer was associated with worsened survival associated with elevated perioperative mortality and treatment in low-volume hospitals. Delay in surgical treatment was a risk factor for mortality in low-risk cancers only and was likely associated with poor access to specialty care. We suggest that the target interval between diagnosis and treatment of endometrial cancers be ≤8 weeks; however, referral to an experienced surgeon and adequate preoperative optimization should be prioritized over expedited surgery.

Survival implications of time to surgical treatment of endometrial cancers
Endometrial Cancer

Systematic Review:
Benchmark for the optimal surgical schedule: 2-8 weeks after diagnosis

<table>
<thead>
<tr>
<th>Year; author</th>
<th>NOS</th>
<th>Patient n (% α)</th>
<th>Stage</th>
<th>Wait time limit</th>
<th>Median wait time</th>
<th>Hazard ratio</th>
<th>Tumor recurrence</th>
<th>OS (median)</th>
<th>5-year OS</th>
<th>Other OS</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019; AlHilli</td>
<td>7</td>
<td>284,499 (-)</td>
<td>I-IV</td>
<td>6 weeks</td>
<td>27 (10–41) vs 26 (13–40)</td>
<td>+</td>
<td>–</td>
<td>+</td>
<td>+</td>
<td>2-year</td>
</tr>
<tr>
<td>2016; Shalowitz</td>
<td>7</td>
<td>208,438 (37 ***)</td>
<td>I-IV</td>
<td>Stratified +</td>
<td>–</td>
<td>+</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>2016; Strohl</td>
<td>6</td>
<td>112,041 (71.5)</td>
<td>I-IV</td>
<td>6 weeks</td>
<td>–</td>
<td>+</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>2015; Matsuo</td>
<td>7</td>
<td>435 (-)</td>
<td>I</td>
<td>Stratified +</td>
<td>–</td>
<td>+</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>+</td>
</tr>
<tr>
<td>2015; Sabourin</td>
<td>--</td>
<td>1,687 (40.3)</td>
<td>I</td>
<td>Stratified +</td>
<td>49 (2–490)</td>
<td>+</td>
<td>–</td>
<td>+</td>
<td>+</td>
<td>–</td>
</tr>
<tr>
<td>2014; Elit</td>
<td>6</td>
<td>9,417 (44)</td>
<td>N/A</td>
<td>Stratified +</td>
<td>–</td>
<td>+</td>
<td>–</td>
<td>–</td>
<td>+</td>
<td>3-year and 7-year β</td>
</tr>
<tr>
<td>2013; O’Leary</td>
<td>--</td>
<td>9,330 (45)</td>
<td>N/A</td>
<td>6 weeks</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

Endometrial Cancer

a. Low-risk patients: Patients with grade 1 disease can be considered for conservative management with non-surgical options, including systemic hormonal therapy or intrauterine devices.

b. High-risk patients: Patients with higher-risk disease (grade 2 or 3 or high-risk histology) should be considered for simple hysterectomy and bilateral salpingo-oophorectomy alone ± sentinel lymph nodes, if available and feasible, and/or postoperative management based on uterine risk factors. Risk of laparoscopic surgery concerning pneumoperitoneum in the setting of COVID-19 must be weighed against risk of laparotomy.

c. Advanced disease: Patients with advanced disease should be considered for tissue biopsy to confirm diagnosis and proceeding with systemic therapy.
Cervical and Vulvar Cancer...only very marginal evidence

-> no significant inferior outcome after delay!

<table>
<thead>
<tr>
<th></th>
<th>Pregnant n = 28</th>
<th>Nonpregnant n = 52</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Obstetric data</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GA at diagnosis, wk Mean (SD; range)</td>
<td>17.4 (7.4; 5–32.3)</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>GA at delivery, wk Mean (SD)</td>
<td>36.1 (5.3)</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>Termination N (%)</td>
<td>7 (25)</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>Planned vaginal delivery N (%)</td>
<td>3 (14.3)</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td>Birthweight, g Mean (SD)</td>
<td>2820 (592)</td>
<td>–</td>
<td></td>
</tr>
<tr>
<td><strong>Onologic data</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radical hysterectomy N (%)</td>
<td>14/28 (50.0)</td>
<td>39/52 (57.7)</td>
<td>.51</td>
</tr>
<tr>
<td>EBL, ml Mean (95% CI)</td>
<td>1108 (336–1284)</td>
<td>714 (225–850)</td>
<td>.32</td>
</tr>
<tr>
<td>Operative time, min Mean (95% CI)</td>
<td>268 (188–294)</td>
<td>259 (181–260)</td>
<td>.54</td>
</tr>
<tr>
<td>Transfusion N (%)</td>
<td>6/24 (25)</td>
<td>5/50 (10)</td>
<td>.09</td>
</tr>
<tr>
<td>Delay from diagnosis to treatment, wk Mean (95% CI)</td>
<td>20.8 (2.9–53.9)</td>
<td>7.9 (0.4–20.1)</td>
<td>.0014</td>
</tr>
<tr>
<td>Still living N (%)</td>
<td>25 (89.3)</td>
<td>51 (98.1)</td>
<td>.09</td>
</tr>
</tbody>
</table>

CI, confidence interval; EBL, estimated blood loss; GA, gestational age. 

Advanced Ovarian Cancer

- EORTC + CHORUS
- NACT is non-inferior (OS und PFS)

Vergote et al, Lancet Oncology Volume 19, Issue 12, December 2018, Pages 1680-1687
Era of Maintenance therapies in the management of ovarian cancer

The 3-Columns-Model

<table>
<thead>
<tr>
<th>Number of tumor cells</th>
<th>Surgery</th>
<th>Targeted therapies</th>
<th>Chemotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>10^8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10^7</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10^6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10^5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10^4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10^3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10^2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10^1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

time
How long can we safely delay post-operative chemotherapy?

  - decreased OS (HR 1.087, 95% CI 1.005-1.176) in patients with no residual tumor after surgery and delayed TTC

- Analysis of a prospective database of 668 patients in 3 National Cancer Institute-designated Comprehensive Cancer Center (Jan 2004 to Feb 2012)
  - No relationship between OS and TTC > 42 days

- A meta-analysis of 15 studies and 59,569 patients (until May 2017)
  - HR was 1.18 (95% CI: 1.06–1.32) for OS
  - Relative OS decreases by 4% (HR 1.04) for each week in the delay of initiating adjuvant chemotherapy for stage III-IV

Do we add G-CSF as a preventive maneuver to all patients receiving paclitaxel and carboplatin?

• Prophylactic growth factors as would be used in high-risk chemotherapy regimens, as well as prophylactic antibiotics, may be of potential value in maintaining the overall health of the patient and make them less vulnerable to potential COVID-19 complications. (COVID-19 Patient Care Information. www.asco.org March 30, 2020)

• The rate of febrile neutropenia in elderly and fragile patients included in EWOC/ENGOT-Ov23 trial was 7.5% (Falandry et al. Journal of Clinical Oncology 37, no. 15_suppl (May 20, 2019) 5508-5508)

• Consider G-CSF support in elderly patients and those with comorbidities.
Are there any contraindication for maintenance therapies within this COVID-19 era?

• No!

…but as for every therapies: take care n the comorbidities of your patients, minimalize ald diagnostic tool and use all channels of communication (eg. video, TC) to ensure patients safety!
Before surgery

- Evaluation of PCR-testing
- Extend staging to CT-Thorax
- Optimize comorbidities
- Use the instrument of pre-rehabilitation (online-tutorial)
- Select the best surgical team in the best environment
Potential Ethical conflicts in the SARS-Cov2-Pandemia

- Distribution of resources (e.g. testing, moutggouard mask)
- Protection and risk-assesment for patients, relatives, medical staff (solidarity conflict)
- Allocation ethics (triage-situation)
- Preservation and protection of health care system vs. economic, political and social effects due lock down procedure
- Solidarity conflict (solidarity vs self-harm vs life planning)
- Loss of autonomy (restriction of freedom): physical, social, culture, mental, philosophic
Minimally and Open Surgery within the COVID-19 Pandemia

• There is no evidence that one surgical approach is superior to another
• Minimize the number of the surgical and anesthetically team
• Do your best to minimize surgery time
• Minimize the production of plume aerosol
• Use a closed smoke evacuation/filtration system with Ultra Low Particulate Air Filtration (ULPA) capability
• Use laparoscopic and open suction to remove surgical plume and fluids
• Avoid rapid desufflation or loss of pneumoperitoneum
  • During instrument exchange or specimen extraction (off insufflation)
  • Do not vent into the theatre room, use filter
• Minimize blood/fluid droplet spray or spread
• Minimize leakage of CO2 from any trocars (check seals or use disposable trocars)
Cancer therapy: How we can improve safety without compromising the prognosis? The Charité-Approach

- Focus on best individualized treatment protocol
- 2-meter distance rule for all patients, relatives and medical staff
- Mouth guard for medical staff and patients
- Use growth factors in case of chemotherapy
- Define the best schedule
- Delegate and define minimal blood controls and diagnostics (hospital vs. practice)
- Use pre-rehabilitation
- Use video-consultation
- Use psychological support for patients and medical staff
- GYN-Activ Online-Lounge for relatives
- Check participation within trials
What chemotherapy should be recommended?

Clinical trials

**ENGOT RECOMMENDATIONS ON CONDUCT CLINICAL TRIALS DURING THE COVID-19 PANDEMIC**

Version 1.1

March 23th, 2020

- Inclusion of patients in clinical trials may be challenged by many factors, with the restriction of access to regular health care as the most relevant.

- However, we recommend that the site may continue to include patients in ongoing trials with open recruitment if they can guarantee the standard health care of the patient in case of any complication related to the disease, the IMP or the COVID-19 infection, as well as the compliance with the protocol.
WHO Operational Planning Guidelines

Goals: Balance demands of COVID-19, maintain essential health service delivery and mitigate the risk of system collapse

1) Establish simplified purpose-designed governance and coordination mechanisms to complement response protocols
2) Identify context relevant essential services
3) Optimize service delivery settings and platforms
4) Establish effective patient flow at all levels
5) Rapidly redistribute health workforce capacity
Clinical implication within the COVID-19 era

- Detailed medical history (fever, cough)
- Indication for testing
- CT-thorax-diagnostics (staging, atypical pneumonia)
- Identify and protect fragile patients (resources, prerehabilitation, optimize comorbidities)
- Define the best surgical and medical protocol
- Define postoperative care and use other (local) resources
- Digitalize all your meetings (eg. tumor conferences) and offer them also to your patients and their relatives (eg. video consultation)
- Reduce all patients ways and transit traffic for patients & medical staff
Further information (see updates)
Discussion
Closing Notes

• Series continued
  • Saturday, April 25

• COVID-19 Discussion Forum

• Recording on IGCS website within 24 hours

• COVID-19 Resources
  • www.igcs.org/covid-19
Thank You

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