

**Cell Therapy Transplant Canada**

**Position Statement on COVID-19**

**Latest Revision: March 26, 2019**

CTTC is monitoring closely the rapidly evolving situation and is committed to engaging and supporting our membership. We have scheduled a series of virtual town halls, have dedicated a web page to collate and aggregate position statements from other societies, and have an online forum for community discussion (CTTCanada.ca).

Based on the consensus of program directors we recommend the following:

1. Centres should identify backup donor options for patients undergoing allogeneic transplant from unrelated donors (haploidentical related donors, cord blood donors). The logistics of hematopoietic stem cell transplant (HSCT) are likely to become more challenging as time goes on.
2. Centres should cryopreserve all allogeneic donor products coming from donation centres outside Canada before the start of the preparative regimen. We do not believe the evidence supports a waiting period between the arrival and cryopreservation of an HSC cell product and the start of a preparative regimen, as there has been no demonstrated blood-borne transmission of SARS-CoV-2 and given that the risk of relapse with a delay is very real. The preparative regimen can begin as soon as cryopreserved stem cells are secured in house.
3. If transportation issues are challenging from collection sites outside or inside Canada, consideration may be given to cryopreservation by the collection centre and transported to the centre in a similar manner to cryopreserved cord blood units.
4. As SARS-CoV-2 has become prevalent in the community, Canadian donors and family/related donors should also be collected and cryopreserved prior to starting the recipient starting preparative regimen due to a risk of the development of the infection after the start of the donor preparative regimen.
5. For donors who have developed COVID-19, Health Canada requires a 28 day deferral. Use of that donor earlier would require exceptional release.
6. Donor questionnaires should be updated to include questions specific to risk factors for COVID-19. Sample questionnaires are available on our website.

7. When COVID is endemic, it is strongly recommended that, prior to the start of the preparative regimen, all recipients should be screened clinically for signs and symptoms of COVID-19; with transplant deferred until it is clear there is not an active respiratory viral infection.
8. In areas with high prevalence of SARS-CoV-2, centres should strongly consider diagnostic testing of asymptomatic patients. While the sensitivity of this test in this scenario is unknown, a positive test would change management. Patients with a positive test are at risk for development of symptoms later in their disease course. In addition, they are at risk of passing this infection off to health care workers and other transplant patients on isolation wards.
9. It is possible that access to diagnostic imaging, consulting medical services, and intensive care units will become strained in the coming weeks. Health care workforces are also likely to be challenged, and the blood supply is already under pressure. Drug shortages are possible. Given that, it is prudent to delay elective or non-urgent transplants, to minimize the risk to these patients until there is stabilization of these issues.
10. We recommend delaying all elective transplants (for example, transplants for hemoglobinopathies, combined immunodeficiencies (non-SCIDS)).
11. Centres should consider delaying transplants for malignant diseases that could safely be delayed for 3 months with a low risk of disease progression in that interval (low risk myelodysplastic syndrome, low risk myeloproliferative diseases). Similarly, centres should consider delay of autologous transplant for multiple myeloma based on centre capacity.
12. We suggest proceeding with autologous stem cell transplants done with curative intent for high risk diseases (Diffuse Large B-Cell Lymphoma, Hodgkin Lymphoma), and allogeneic stem cell transplant for acute leukemia.
13. Given the rapidly evolving clinical situation, we suggest that this be evaluated on a regular basis, evaluating the ability of the local health system to have resources to support patients through transplant.
14. Access to out-of-country CAR-T therapy is likely to be challenging, and capacity within Canada cannot meet current usage. Centres should ensure they have appropriate supply of tocilizumab sequestered for specific CAR-T patients prior to infusion of cells, as

given the widespread off label use of this medication in COVID-19 patients, shortages are likely.