General MM

The impact of COVID-19 on the management of patients with multiple myeloma

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The Multiple Myeloma (MM) Hub is pleased to share this article, prepared by Elena Zamagni, Paola Tacchetti, and Michele Cavo, "Seragnoli" Institute of Hematology, Bologna University School of Medicine, Bologna, IT, discussing impact of COVID-19 on the management of patients with MM. The MM Hub extends its gratitude to the authors for taking the time to prepare this guidance, based on their experiences in Bologna.

Introduction

COVID-19 suddenly fell on patients with MM, planting questions, fear and uncertainty, bringing a sense of loneliness and abandonment, increasing the need for reassurance and perspective. The virus also reached all the doctors and caregivers of the hematology departments, bringing stress, fatigue, new questions, and the need to re-organize their work priorities. It also raised uncertainties about the effectiveness of their work. Whilst patients with MM are afraid of the coronavirus, they are mainly afraid of not being able to proceed with their treatment and worry that any potential hold or modification of initial treatment plans will impair their outcome. Patients wish to stay safe and virus-free and are asking themselves if going to the hospital is dangerous, but at the same time they wish to speak to their doctors, to be able to tell them about the side effects of their treatment, to receive necessary drugs, and to speak about future plans. Mainly, supportive services, like psychological support and voluntary activities for patients are on hold and people are lacking the relational approach that is so important when you are weak, frail, and ill. At the same time, doctors and nurses need, and wish, to stay safe, and keep departments as free of SARS-CoV-2 as possible. In this regard, it must be highlighted that, probably, each hematology department will experience two phases with the spread of the infection:

1. The first one, when it's easy to trace the contacts of infected persons and isolate them, with a goal of not letting people who are positive for the virus circulate in the community
2. The second one is when the virus is already widely distributed, and consequently it's not easy to identify the contacts in real time. In this case, it's important to work safely, especially around patients who have tested positive, and to re-organize spaces and people, weekly or more often if needed, to reply to more urgent needs

Living this new, astonishing, and somehow surreal reality for one month now in Italy, we are able to share some thoughts, that are not formal recommendations, but the experience of our team in Bologna.

Outpatient unit

The outpatient unit is often the "first line" for patients. It is the unit with more people, in different disease phases, different severity and urgency, with more movement, and the highest grade of heterogeneity. Nowadays MM is mainly treated and managed within this setting. As previously said, there is the need for the safety of both patients and caregivers, to reduce the circulation of people and access to the hospital as much as possible, and to keep secure distances within our environments. At the same time, it is important to preserve compliance to treatments and ensure follow-up are safe.

These actions may help in the management of this new challenge:

- To change, where possible, all the planned visits to phone calls
    - This includes patients with monoclonal gammopathy of uncertain significance (MGUS) or smoldering MM (SMM), long-term follow-up of non-active MM, long-term maintenance patients, and patients receiving oral treatments in good/stable conditions
    - In this way, patients feel listened, reassured and followed; at the same time, doctors are able to check the blood tests (anticipated via web) and the status of the disease, to give the following appointment, and to preserve order, without postponing everything to a future that may turn out to be overbooked!
        - If a restriction on blood tests access exist, urgent execution of strictly necessary tests may be preferred (i.e. blood count or renal function)
    - Oral treatments may be provided to patients or their relatives, without passing through the hematology departments
- To dedicate some doctors, where possible splitting by disease speciality, to respond to the huge number of patients and relatives that will ask for news, help, reassurance, and change of schedule. In a few weeks, this will calm down the anxiety and restore a “new routine”
- To postpone non-urgent intravenous (IV) or subcutaneous (SC) treatments (i.e. maintenance therapies) to a future date to be assigned, whilst re-evaluating the situation from time to time
- To implement, as much as possible, domiciliary assistance, particularly for elderly/frail patients
- To retain the safest environment possible for patients on oral treatments that need in person visits, such as for new diagnoses requiring joint patient management or for patients receiving necessary IV or SC treatments within the hospital, we propose to:
    - conduct a “phone triage” (the day before the visit) and daily onsite triage, at the entrance of the unit, performed by doctors on a rotation scheme, in order to prevent access to the unit for symptomatic, potentially infectious patients
    - restrict the access to the unit to the patient alone, limiting the presence of relatives in the waiting and therapy rooms
    - ask the patients to wear protective masks within the hospital, as well as doctors visiting patients to wear the recommended protective equipment
    - dedicate one special room in the outpatient unit, which has external access, for sick and problematic patients who need help, but who are suspected to be carrying the virus
- To implement virtual team discussions, taking advantage of social networks and electronic devices, in particular for complex, multi-disciplinary cases, or new diagnoses, in order to maintain the quality of assistance to patients

Inpatient Unit

The inpatient unit must be kept totally, or as much as possible, COVID-free, both for the patients and the caregivers. This is of course linked to the need to proceed with the treatments that cannot be postponed, in order to not impair their outcome or to put patients at risk of relapse, while at the same time considering these patients have the highest infection risk. As far as MM is concerned, as previously said, most of the treatments are offered in an outpatient setting, apart from allogeneic transplantation (less and less present in the actual MM scenario), chimeric antigen receptor (CAR) T-cell programs, and in most, even though not all institutions, autologous stem cell transplantation (ASCT). The goal in this context is to respect

already-started, necessary programs, reducing as much as possible the risk of potential additional complications, while deferring or changing plans where possible, in order to keep beds free in the unit for other diseases, such as acute leukemias, which have a more strict and urgent treatment need. We believe that these actions might be appropriate:

- First of all, accept only patients who have a negative pharyngeal swab result for coronavirus. Access to the unit should be stopped for relatives, as well as the exit permissions for the patients, to reduce or abrogate the risk of infection during the stay
- Reduce as much as possible, re-discussing case by case, all salvage or second ASCTs, particularly in standard-risk patients
- Consider all patients that can be offered alternative, equally valid treatments other than high-dose chemotherapy and ASCT (i.e. patients aged > 65–70 years), weighing up the effectiveness of therapies, their on-time application, and the potential additional risks
- Hold new allogeneic stem cell transplants
- Stop commercial CAR-T programs, as has been done by most companies in Europe and will likely be done in the US. This measure allows intensive care units, full of patients with COVID-19, not to be put under further pressure

In such a difficult moment, is important that all the MM team stay united and calm, able to re-discuss previous choices in light of emerging new elements, re-allocate patients and care-givers to different tasks, and remain available to offer staff members to help the growing COVID-19 units in our hospitals. With the increased spread of the virus, the hospitals, and in particular the caregivers, are at higher risk of infection, despite sometimes being asymptomatic, and thus responsible for further transmissions. For this reason, it would be very important to ask to local administrations for serial pharyngeal swab on doctors and nurses; however, this is unfortunately at conflict with available resources in most countries.

Conclusion

In conclusion, we would like to acknowledge that, for most of us, this is the first time that we are facing such a complex scenario, with different and conflicting needs, with urgent and essential restrictions to be put in place, while keeping an eye to the “after” that will hopefully be behind the door. We really feel, in this moment more than ever, that caregivers and patients are fighting together to overcome this pandemic, but it is important to overcome fear, loneliness, and sense of abandonment, and to go back to hope.

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