Management of Prostate Cancer During the COVID-19 Pandemic

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Introduction:

During the COVID-19 global pandemic, cancer patients and physicians must carefully weigh the potential benefit of routine cancer care versus the high morbidity and mortality of COVID-19, especially in patients of older age, patients with comorbidities, and those with cancer.(1) Staff and resources may also be redistributed to care for COVID-19 patients, and thus judicious use of resources is critical during this time. There are continuously evolving policies and guidelines on a global, national, state, institutional, and departmental level; thus, these guiding principles are intended to provide a framework to think about how to manage prostate cancer patients.

For recommendations on prostate cancer early detection during the COVID-19 pandemic, please refer to: https://www.nccn.org/covid-19/pdf/Prostate_Early_Detection.pdf.

General Principles:

1. The benefit of routine localized prostate cancer care should not be overestimated.(2, 3) In most instances, minimal harm is expected with delays in care or treatment of 3–6 months, especially when weighed against the risk of mortality of COVID-19.
2. ***Remote visits*:**
    a. Telehealth (phone or video) visits should be used, with rare exceptions, in place of in-person visits.
    b. If necessary given reallocation of staff/providers, telehealth visits can usually be safely deferred for patients with localized disease.

3. *Avoid, defer, and shorten/reduce routine care, staging, and treatment when possible*:

a. **Avoid**:

i. Patients with very low, low, and favorable intermediate risk (IR) disease should not undergo further staging, active surveillance, confirmatory testing/monitoring, and treatment until deemed safe.

ii. In general, prophylactic whole pelvic radiation therapy (WPRT) should be avoided during this time due to the increased risk of grade IV lymphopenia (Unpublished data, RTOG 9413).

iii. For patients with non-metastatic disease, avoid initiating androgen deprivation therapy (ADT) for patients with a prostate-specific antigen (PSA) doubling time of >9 months. Once ADT is initiated or intermittent ADT is started, consider remote telehealth visits and PSA/testosterone and other laboratory monitoring to avoid clinic exposures.

b. **Defer**:

i. Patients with asymptomatic unfavorable intermediate risk (UIR), high risk, and very high risk (HR) prostate cancer can defer further staging and radical treatment until deemed safe.

ii. Neoadjuvant ADT should be considered in asymptomatic UIR and HR patients planning to receive definitive radiation therapy (RT). This may safely be given for up to 4–6 months as necessary.(4-6)

iii. Data from Johns Hopkins suggest delaying surgical treatment for UIR and HR patients upwards of 6 months from biopsy diagnosis will not negatively impact their outcome.(7)

iv. Individuals who have received definitive treatment for their cancer with either radiation or surgery could defer initial post-treatment monitoring (PSA-based testing and digital rectal exam [DRE]) until deemed safe. Alternatively, telehealth visits with discussions of PSA and testosterone could be considered.

c. **Shorten/reduce**:

i. Consideration to use 3-, 4-, or 6-month formulations of ADT should be preferred over 1-month injections.

ii. If it is deemed safe for patients to receive RT, the shortest safe external beam RT (EBRT) regimen should be used. This can consist of 5 to 7 fractions, consistent with current NCCN Guidelines.

iii. For symptomatic patients (eg, obstruction, bleeding), conservative measures should be prioritized (eg, medical therapy, ADT, clean intermittent catheterization). If necessary, surgical intervention or RT may be considered.

4. Encourage and consider:

a. Encourage communication with patients' primary care providers to coordinate care, reduce overall health risks, and clarify advanced planning.

b. Address and document goals of care and advanced directives *early* if frail, and/or limited life expectancy to avoid unwanted emergency department (ED) visits and hospitalizations.

c. Discuss and document Durable Power of Attorney (DPOA) and emergency contact information.

d. Encourage patients to have an adequate supply of oral cancer medications and supportive care medications on hand (and/or have delivered by mail).

e. Consider deferring repeat imaging over time if PSA is declining and absence of symptoms until risk of COVID-19 has resolved.

f. Educate patients receiving chronic steroids (eg, prednisone, methylprednisolone) and their caregivers that if they become sick, they may need stress-dose steroids.

g. For patients with advanced disease:

i. Consider non-myelosuppressive regimens when alternatives exist to minimize risk of immunosuppression and infectious complications.

ii. When cytotoxics are used consider growth factor support with administration of same-day growth factor injections or pegfilgrastim to minimize visits.

iii. Consider deferring sipuleucel-T until COVID-19 risk has resolved, given risks of exposure during associated protracted and cumulative times spent in pheresis and infusion centers.

h. Consider telehealth genetic counseling options if available, or deferring in-person visits until COVID-19 risk has passed to minimize exposure.

Please consult your institutional, state, and federal policies. The following are useful resources:

- AMA: https://www.ama-assn.org/delivering-care/public-health/covid-19-2019-novel-coronavirus-resource-center-physicians
- ASCO: https://www.asco.org/asco-coronavirus-information
- ASTRO: https://www.astro.org/Daily-Practice/COVID-19-Recommendations-and-Information
- AUA: https://www.auanet.org/covid-19-info-center

- CDC: https://www.cdc.gov/
- CMS: https://www.ama-assn.org/delivering-care/public-health/cms-payment-policies-regulatory-flexibilities-during-covid-19
- WHO: https://www.who.int/health-topics/coronavirus#tab=tab_1
- *Prostate cancer radiotherapy guidelines: https://www.astro.org/ASTRO/media/ASTRO/Daily%20Practice/PDFs/COVID-Zaorsky-et-al(ADRO).pdf
- CMS Adult Elective Surgery and Procedures Recommendations: https://www.cms.gov/files/document/31820-cms-adult-elective-surgery-and-procedures-recommendations.pdf

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7. Gupta N, Bivalacqua TJ, Han M, et al. Evaluating the impact of length of time from diagnosis to surgery in patients with unfavourable intermediate-risk to very-high-risk clinically localised prostate cancer. BJU Int 2019;124(2):268-274.