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► **To cite this version:**

Luana Calabrò, Solange Peters, Jean-Charles Soria, Anna Maria Di Giacomo, Fabrice Barlesi, et al.. Challenges in lung cancer therapy during the COVID-19 pandemic. *The Lancet Respiratory Medicine*, 2020, 10.1016/S2213-2600(20)30170-3 . inserm-02546052

HAL Id: inserm-02546052

<https://inserm.hal.science/inserm-02546052>

Submitted on 17 Apr 2020

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Challenges in lung cancer therapy during the COVID-19 pandemic



Coronavirus disease 2019 (COVID-19), caused by the newly identified strain of the coronavirus family severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), has rapidly evolved into a worldwide pandemic and caused a public health emergency of major international concern.^{1,2} As a result, a profound reorganisation of hospital wards and clinical activities is happening worldwide to deal with the increasing number of COVID-19-positive patients who require hospitalisation and intensive care support.³ This comprehensive reallocation of health resources is of particular concern in patients such as those with underlying chronic diseases, including cancer.

The prioritisation of health support towards patients with COVID-19 is raising apprehension within the medical oncology community, in which physicians are increasingly being forced to select which patients should receive anticancer therapy on the basis of who is most likely to have a positive outcome.⁴ In this context, the threat of COVID-19 infection might also factor into decision making—a role which could possibly be lessened by knowledge of the COVID-19 status of patients suitable for anticancer therapy.⁴ This already dismal scenario seems to be even more severe for patients with lung cancer because of the high risk of interference of COVID-19 with their effective diagnostic and therapeutic management by treating physicians.

Clinical manifestations of COVID-19 range from asymptomatic, to mild symptoms (such as cold, fever, cough, or other non-specific signs), to severe pneumonia leading to acute respiratory distress syndrome, which occurs in 17–29% of infected individuals.² Mortality due to COVID-19 has been reported in about 3% of COVID-19-positive patients in the Chinese population,⁵ while higher mortality rates are being reported in Italy,⁶ which is, after the USA, currently the country with the second highest number of confirmed COVID-19 cases worldwide.⁷

In the early phase of COVID-19-induced pneumonia, the main CT findings include multifocal peripheral and basal ground-glass opacities, crazy paving patterns, traction bronchiectasis, and air bronchogram signs. A progressive transition to consolidation, together

with pleural effusion, extensive small lung nodules, irregular interlobular or septal thickening, and adenopathies, characterise the more advanced phase of the disease.^{8,9} These radiological manifestations can overlap with CT findings that are often found in patients with lung cancer upon disease progression or onset of concomitant pneumonia due to overlapping opportunistic infections. Regarding clinical manifestations, the worsening of pulmonary symptoms during lung cancer progression can be similar to that typical of COVID-19, adding further complexity to the thorough assessment of the course of disease in lung cancer patients. Together, these similarities can pose a major challenge to clinicians in distinguishing lung cancer evolution from a potential COVID-19 super-infection on the basis of radiological and clinical evidence, and, importantly, these specific conditions require very different therapeutic approaches.

Adding further complexity to this scenario, pneumonitis can also be induced by immune checkpoint inhibitor therapy, an effective and widely used standard-of-care treatment for lung cancer in various treatment lines and settings.¹⁰ Immune checkpoint inhibitor-related pneumonitis has been reported in about 2% of cancer patients,¹¹ with a seemingly higher incidence in patients with lung cancer.¹² Similar to COVID-19 infection, the clinical symptoms of immune checkpoint inhibitor-induced pneumonitis are often not specific, consisting mainly of cough (or its worsening), chest



DJP Marazzi/SPL

Lancet Respir Med 2020

Published Online

April 9, 2020

[https://doi.org/10.1016/S2213-2600\(20\)30170-3](https://doi.org/10.1016/S2213-2600(20)30170-3)

S2213-2600(20)30170-3

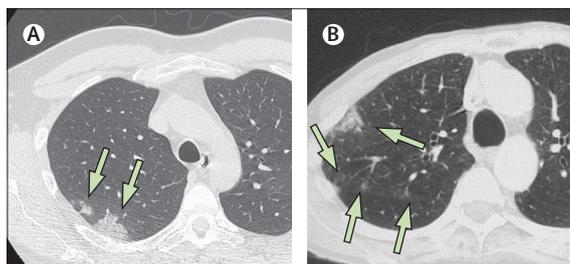


Figure: CT scans of pneumonia due to COVID-19 and immune checkpoint inhibitor therapy

(A) Axial lung image (without intravenous contrast) of 49-year-old man with COVID-19, showing two sub-solid areas in the upper right lobe (arrows).

(B) Axial lung image (without intravenous contrast) of an immune checkpoint inhibitor-treated 76-year-old man with metastatic melanoma, showing a sub-solid area and ground-glass opacities with a rounded morphology in the upper right lobe (arrows). COVID-19=coronavirus disease 2019.

pain, dyspnoea, and fever. Additionally, CT assessment of immune checkpoint inhibitor-related pneumonitis shows radiological findings similar to those typical of COVID-19-induced pneumonia (figure), thus hindering discrimination between the two clinical entities. Similarly, tyrosine kinase inhibitors can induce radiological patterns of interstitial-like pneumonitis, which develops in 4% of patients with epidermal growth factor receptor-mutant lung cancer treated with osimertinib.¹³

In this scenario, standard chemotherapy does not seem to represent a suitable or potentially safer alternative to immune checkpoint inhibitor therapy—neither for treating physicians who want to avoid the overlapping immune checkpoint inhibitor-related and COVID-19-related radiological and clinical changes, or for patients who are unsuitable for immune checkpoint inhibitor therapy. First, combinations of chemotherapies and immunotherapies have shown the best efficacy and represent the standard of care in a large group of patients without oncogene-driven lung cancer and without high PD-L1 expression in tumour cells. Second, the development of chemotherapy-associated pneumonitis is known to occur in up to 16% of treated patients,¹⁴ and cytotoxic chemotherapy has immunosuppressive activity.¹⁵ Notably, administration of chemotherapy within the month preceding COVID-19 diagnosis has been shown to be associated with a higher risk of severe infection-related complications.¹⁶

The clinical and biological aggressiveness of lung malignancies clearly does not allow for anticancer therapy to be withheld or postponed. Thus, while awaiting specific evidence-based guidelines, the comprehensive management of patients with lung cancer during the COVID-19 pandemic should involve specific and careful attention to their clinical and radiological pulmonary signs, more so than for patients with other types of tumour. From a practical viewpoint, it seems reasonable to suggest that patients with lung cancer undergo systematic testing for SARS-CoV-2 at the beginning of treatment and whenever it is deemed necessary by the treating physician in the course of therapy. This strategy might become more feasible with the increasing availability and progressive use of real-time PCR assays that can provide COVID-19 status results within an hour.¹⁷ Furthermore, the availability of laboratory IgM or IgG testing to evaluate

the exposure and immunity to SARS-CoV-2 infection will be helpful when the COVID-19 pandemic begins to decline. Allocating resources for these methodological approaches to patients with lung cancer should facilitate the most appropriate clinical management by multidisciplinary lung cancer care teams.

LC has served as consultant or advisor to Bristol-Myers Squibb and Merck Sharp and Dohme. SP has received education grants, provided consultation, attended advisory boards, or provided lectures for AbbVie, Amgen, AstraZeneca, Bayer, Biocartis, Bioinvent, Blueprint Medicines, Boehringer-Ingelheim, Bristol-Myers Squibb, Clovis, Daiichi Sankyo, Debiopharm, Eli Lilly, F Hoffmann-La Roche, Foundation Medicine, Illumina, Janssen, Merck Sharp and Dohme, Merck Serono, Merrimack, Novartis, Pharma Mar, Pfizer, Regeneron, Sanofi, Seattle Genetics, Takeda, and Vaccibody, from whom she has received honoraria (all fees to institution). J-CS was employee for AstraZeneca from September, 2017, to December, 2019, and has shares in Gritstone. AMDG has served as a consultant or advisor to Incyte, Pierre Fabre, GlaxoSmithKline and Bristol-Myers Squibb, Merck Sharp Dohme, and Sanofi. FB has served as a consultant, advisor, or lecturer for AstraZeneca, Bayer, Bristol-Myers Squibb, Boehringer-Ingelheim, Eli Lilly Oncology, F Hoffmann-La Roche, Novartis, Merck, Merck Sharp and Dohme, Pierre Fabre, Pfizer, and Takeda. CG has received honoraria as consultant or advisor or speaker bureau member for AstraZeneca, Bristol-Myers Squibb, F Hoffmann-La Roche, and Merck Sharp and Dohme, and has received funds (to organisation) from Merck Sharp and Dohme. MR has served as a consultant and provided lectures for Amgen, AbbVie, AstraZeneca, Bristol-Myers Squibb, Boehringer-Ingelheim, Celgene, Merck, Merck Sharp and Dohme, Novartis, Pfizer, Roche, Samsung. MM has served as a consultant or advisor to Roche, Bristol-Myers Squibb, Merck Sharp and Dohme, Incyte, AstraZeneca, Amgen, Pierre Fabre, Eli Lilly, GlaxoSmithKline, Sciclone, Sanofi, Alfasigma, and Merck Serono. AC, MA, and VV declare no competing interests. We thank Nicholas Landini of the Diagnostic Radiology Department of Ca' Foncello Regional Hospital (Treviso, Italy), for providing the CT scan images of a COVID-19-positive patient with pneumonia. NR declares no competing interests.

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