



Bladder Cancer and COVID-19 | Mid-Central Regional Update for Patients and Families.

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BCAN | Stephanie Chisolm:

Hello, and welcome to bladder cancer and COVID-19. We're here talking about regional updates for patients on what they need to know. My name is Stephanie Chisholm. I'm the director of education and research at the Bladder Cancer Advocacy Network.

BCAN | Stephanie Chisolm:

I would like to introduce you all to our wonderful panel of speakers. We have urologist, [Dr. Cheryl Lee](#) from The Ohio State University. Welcome Cheryl. We have medical oncologist, [Dr. Peter O'Donnell](#) from the University of Chicago. Welcome Peter. And radiation oncologist, [Dr. Omar Mian](#), from the Cleveland Clinic. And then we have community urologist, [Dr. Jason Hafron](#), who is here representing the Michigan Institute of Urology. Welcome to all of you. We're so delighted to have you here.

BCAN | Stephanie Chisolm:

I'd like to open it up and really kind of kick off this conversation with the idea that everyone is really used to hearing about social distancing. And some people are experiencing what we're calling medical distancing, where perhaps they're getting a call from their doctor's office, or they're due to schedule an appointment and they're finding out that their practice is not letting them schedule appointments right now until this COVID-19 pandemic dies down a little bit. And that's the concept of medical distancing.

BCAN | Stephanie Chisolm:

So, with that in mind, I'm going to open it up with Cheryl, if you wouldn't mind, could you just talk a little bit about what might be going on at your institution in medical distancing, how are protocols changing at the hospitals and then of course in the doctor's offices to help protect not only the patients and their families, but also the staff. What's going on in The Ohio State University Hospital system?

Dr. Lee:

Well, thank you for that question. It's a very important one, Stephanie. I'd like to welcome all of the participants in the webinar today. This is a really important issue to consider, that is the medical distancing. And I'll start by saying at The Ohio State University and as other centers around the country, our primary goal is to keep our patients safe, keep our healthcare workers safe, and at the same time prepare for a large influx of patients affected by this very difficult infectious disease, the COVID-19.

Dr. Lee:

I think what patients should also know is that many healthcare systems around the country were not necessarily prepared for very large influxes of patients with this disease that sometimes requires an ICU stay and a ventilator to support breathing. In order to prepare for some of these patients, we've had to relax our normal work ethic, our normal work efforts in the clinic and in the operating room.

Dr. Lee:

What that has meant is that for more elective problems, we are actually postponing evaluations, surveillance and even treatment just so our hospital can be prepared for these very sick patients coming in. Another important issue that hospitals are facing and The Ohio State University has also faced this is having enough of equipment and gear meaning gowns, gloves, masks, so that the people who are on the frontline taking care of the sick COVID patients in the emergency room or in the ICU or even on the floors have the right protection so that they continue to stay healthy and they can continue to take care of patients.

Dr. Lee:

So, as we try to preserve this kind of equipment for these frontline healthcare workers, and these are doctors, nurses, respiratory therapists, medical technicians, EMTs, everything, everyone. But as we try to preserve the gear and the equipment needed for these people, that means we can't use it for other things we normally would, like procedures in the clinic and procedures in the operating room. So, because of this, we are deferring some treatments.

Dr. Lee:

Also, as a way to protect our patients and our healthcare workers. We're trying to reduce exposures. And here I think is where patients really are impacted by this medical distancing. To reduce exposures, we are leveraging technology with telehealth either phone visits or video visits, to try to communicate with our patients to survey our patients, and to understand what needs they have. Sometimes we're postponing problems that can wait a month or two. So, when a patient is called and their appointment is canceled or delayed, this is part of that reason is to not only reduce some of the exposure of the healthcare workers but also to reduce exposure to the patient.

Dr. Lee:

Because as we think about our population of patients that primarily get bladder cancer, we're talking about individuals over age 65, generally, and this is a group of patients, particularly those who have other conditions like hypertension, diabetes, or obesity, or again, advanced age that these patients if they get COVID-19, they may have a much more aggressive course with it. So, that's a long answer to say that when we medically distance our patients, it's not because we're not still committed to their treatments and their care and their surveillance. But we're trying to protect them. We're trying to protect healthcare workers, and we're really trying to make sure we can care for these very ill patients with COVID-19.

BCAN | Stephanie Chisolm:

Thank you so much, Dr. Mian, let's talk about radiation oncology because I think that there's some interesting stuff there and then we'll get to Dr. O'Donnell.

Dr. Mian:

Let me also just say thank you, Stephanie, so much for organizing this. This is a great resource for patients and BCAN is always kind of out there in front in this way, and I think that's great. So, thank you also for inviting me and to all the participants who are here with us today.

Dr. Mian:

I would just echo some of the things that Dr. Lee just said. We're also trying to navigate this quickly changing medical distancing era that we're in. And the trick here is to not let our patients feel distant from us, even though we have to kind of change the way we're doing things day to day. So, a couple of the things I just say for the patients that do come in, one of the things you'll notice is quite different. This backdrop that you see behind me is our [Cleveland Clinic] Cancer Center building, which has a number of entrances but they're almost all closed except for one or two access points to that building. At which there's nurses and healthcare workers stationed and so everyone who comes in including the healthcare workers has the temperature taken, is asked a few questions by a very nice group of providers in terms of contacts and symptoms they may be having.

Dr. Mian:

And we have this sort of triage in place, just right at the door to protect everyone who is inside that building. As you might imagine, many of those patients are perhaps more vulnerable than the general public to the virus. So, that's one thing. Another thing we've done to try to kind of approach this medical distancing is we've moved a lot of our visits to virtual visits. We're all becoming sort of rapid experts at telehealth and that's certainly been the case with my practice. For patients who don't need an urgent visit, we still have in-person clinics. But for the most part, my follow-up clinic, those patients under surveillance, I tend to see them more by virtual visit and keep those encounters distant in that way.

Dr. Mian:

In terms of your question, Stephanie, how are we doing things different? Are we seeing delays and treatment? How have these precautions impacted care? There are a couple of things. We're noticing our volumes are down for one. We have a pretty robust clinical trial accrual prior to this has really slowed down quite a bit and we're being it's not that our interventional trials aren't running. It's that we're kind of being a bit more selective about accruing patients who may need extra visits if they're being cared for as part of a clinical trial.

Dr. Mian:

And we're prioritizing keeping our care workers safe, the caregiver safe, as well as keeping patients safe and minimizing their visits. But other than that, we have not stopped treating. For those patients who need treatment, we're committed to not delaying that care. We're just trying to do it in the safest way possible. And so, we've put in a few extra upfront triage steps for new patients, We will sort of risk stratify them into who needs to be seen when and how whether that's a virtual visit or an in-person visit. And for our patients in follow-up, it really depends what symptoms they may be having, how quickly they need to get into the scene, or are they just there for routine surveillance, or routine follow-up visit that kind of thing that can be transitioned to a telehealth visit or can be delayed for some short period of time. But I think we were all trying to be mindful of this idea that delaying care can impact outcomes and we want to make sure we do that in a very sensible way.

BCAN | Stephanie Chisolm:

Thank you. Great. Dr. O'Donnell, can you talk a little bit about what's happening at the University of Chicago and then what you're seeing in general in medical oncology?

Dr. O'Donnell:

Sure, it's my pleasure to be here today. And thanks again for BCAN organizing this really important topic. So, the point I want to make at the beginning is that obviously, all of us are concerned about COVID. And for anybody watching the news, it seems like that's all anybody cares about right now.

Dr. O'Donnell:

But we all still care about the fact that some of you have bladder cancer and you're dealing with this. And I think that actually, sometimes it almost can become where if you're not talking about COVID, then nothing else is important. And I think nothing could be farther from the truth here. The fact that some patients are dealing with bladder cancer right now, it is the most important thing in their life right now. It's more important than COVID to them.

Dr. O'Donnell:

And so, I want to acknowledge that, that all of us in the bladder cancer community are very attuned to that, that a cancer diagnosis trumps everything else. And so, we all have to take steps to make sure that those patients that are going through the bladder cancer journey are cared for in the safest possible way. And as the other doctors have said, that does mean changing the ways that we are caring for every patient that might have bladder cancer. So, some of the things that we've done at University of Chicago, very similar to what the other institutions have talked about, but I'll talk about some of the other different aspects that we've undertaken.

Dr. O'Donnell:

At our hospital, we're doing it week by week because of things changing, day by day or week by week. I'll look at, with my nurse, we look at our entire roster of patients for the upcoming week. And what we do is we call each of those patients and we have a shared decision-making discussion about whether that visit that was planned needs to happen in person. And for example, if a patient is receiving active treatment, like [chemotherapy](#) or [immunotherapy](#), oftentimes that is an important visit to keep. I think we're going to talk later in the hour about when can treatments be skipped? But obviously, if a patient needs treatment, that's going to be an in-person visit.

Dr. O'Donnell:

And so, we'll go over and confirm by a phone call a week in advance that the patient wants to keep that visit. For other visits, like routine follow-ups where a patient might have just been on surveillance and being seen for a routine visit, that's one where obviously, we're going to triage that to a video visit or a telehealth visit. I found that the patients actually are wanting this sometimes before we can even call the patient a week in advance, they're calling us and saying, "Doc, I don't feel real comfortable coming to the hospital right now, where on the news I see so many COVID patients at your hospital." So, they're also feeling more comfortable with a virtual or a telehealth visit for some of those routine surveillance type of visits.

Dr. O'Donnell:

And then you have the third category of patients where perhaps they're needing a scan or a procedure or something like that. And then it becomes, do we really need to do that scan right now? Or can we do the labs that maybe you need via a home draw. We use a lot of home nurses that go out to patient's home. And we'll draw labs and then we'll have those laboratories back. And we can use those laboratory results along with a telehealth visit. We're using creative ways like all these other medical centers are to

try to really decide who needs to come to the medical center. And even if you do have to come to the medical center, there's additional steps that are in place to try to protect your safety.

Dr. O'Donnell:

So, two days before your visit at University of Chicago, you're going to get a call from a nurse who's going to ask you about upper respiratory related symptoms or fever. And if you named that any of those are positive, then you're going to be triaged to a special floor of the medical center and get tested for the coronavirus before you would actually be seen for your visit. And so, there's a screening process in place that enables us to try to have anybody that really makes it into the Cancer Care area as having been prescreened for COVID.

Dr. O'Donnell:

The second thing that we do is once you're in our cancer care area, everyone is socially distanced within that area. So, all patients are sitting six feet apart or more in the waiting rooms. All of our patients are wearing masks. All the staff, of course, are wearing masks. And then even in the chemotherapy suite. We're skipping IV infusion chairs so that patients are never right next to another patient. And so, these are all just sort of practical steps that we all have to undertake right now.

BCAN | Stephanie Chisolm:

Great. Thank you guys so much. Dr. Hafron, you're in the community practice. What is going on there that's a little bit different. And remember that you're also in Michigan. So, these are four different locations. So, what's happening in Michigan in the community practice?

Dr. Hafron:

Well, I don't think we're seeing much difference than what Dr. Lee or Dr. Mian or Dr. O'Donnell has described. We're taking very similar precautions in our practice. With that being said, I practice outside of Detroit and we're really at the peak of our COVID infections right now. We've been hit pretty hard in this area, Southeast Michigan. I think we're number three right now behind New York and California. So, it's pretty intense. So, we're at the highest. We're at redline right now. Our hospitals are being pushed to the extreme. Our main hospital has pretty much become a COVID hospital.

Dr. Hafron:

With that being said, we're doing anything and everything to protect our patients and to continue our care. And, as has been alluded to with the other speakers is, we've been able to become creative and been able to manage our patient or continued to deliver the care. Most 90% of our practice has gone to telehealth. I think seeing patients appreciate that. Patients don't want to come out. And telehealth has been a godsend. It's been very helpful, patients appreciate it. And it's very reassuring to talk to patients and reassure patients that they're going to be okay, and we're continuing to monitor them and do what's necessary.

Dr. Hafron:

As far as our office, we are minimizing our offices to patients that only need to be seen, patients that are undergoing active treatment. The patients we're seeing, we're screening the patients, prescreening the patients, checking temperatures at the door, separating the patients, everything that has been described before. We're doing anything and everything to protect our patients. But we're not stopping treatment. If patients have bladder cancer, which is a lethal disease, and these patients need to be treated. Personally, I think the hardest part is the patients that require major operations primarily cystectomy.

Dr. Hafron:

Because now that we're in this peak period, the hospital has stopped us from doing cancer operations, we're only allowed to do emergent surgeries. So, I think from my perspective, it's been hard talking to my patients, reassuring my patients that we're going to have to delay your procedure because we don't have the resources right now to run full operating rooms.

Dr. Hafron:

And for me personally, as a physician and talking with my patients, that's been hard. But today, we've been delayed for two weeks, and today we just got reopened. So, the hospital later this week is going to allow us to do surgery again for major cancer operations. Even in the throes in the density that we've seen in Detroit, it really only delayed us a week or two in our surgery schedules and we will get these patients to the operating room that they need. We have eliminated all of our elective or nonessential surgeries so that we can really just focus on doing cancer surgery that is time dependent. And even in the or horribly hit area, we basically delay to patients a couple weeks, which in the long run is probably not going to make a huge difference.

BCAN |Stephanie Chisolm:

Wow. And remember, all of this is taking place, this conversation we're having on April 14th. A week from now, two weeks from now, things might be completely different as we are really moving to try to understand this and get a handle on all of these procedures and changes. I really do appreciate this update about what's happening in this area. I think it's very varied and you're all on the same page in terms of protecting the patient. And I think that that's so important.

BCAN |Stephanie Chisolm:

So, I'm ready to move on to the next question. And we could start again with Dr. Lee. When is it okay to have delays in treatment and surveillance? Patients would like that reassurance to know when it would be okay if you don't come in for your next BCG installation or your next cystoscopy. Are there certain times when there's a little bit of wiggle room? Can you talk about that at all? Dr. Lee?

Dr. Lee:

I want to really underscore a couple things that were said, but as it relates to this question about when is it okay to delay? One, the situation is very different state to state. And what one state or area of institutions may be able to do to treat a patient or may have to delay a patient may be very different one or two states over.

Dr. Lee:

So, whatever comments we make today, I want to make sure that our audience does know that things are fluid and they are changing. And certainly, all of the speakers here but all providers taking care of bladder cancer patients want our patients to get treated, but we have to think about risks and benefits.

Dr. Lee:

And we know that if we're talking about from the surgical perspective, [earlier stage cancers](#) we have a lot more leeway in terms of delaying treatments and delaying surveillance than we do in patients who are higher risk or higher stage. But let's take the patients who have non-muscle invading bladder cancers. Some of these patients may be in a low-risk setting with lower grade disease and low volume tumor. They actually have a very low risk of that disease ever really impacting their life or their survival. And although the tumors can come back, generally that would not affect their long-term survival.

Dr. Lee:

So, those patients are ones if they're feeling well, we can delay [cystoscopy and the surveillance](#) of the bladder. We can delay removing tumors that are identified. And so, I think those patients should take some comfort in knowing that those delays are unlikely to have long-term ramifications for them.

Dr. Lee:

Now, if we look at the patients with higher risk disease, early invasive cancer with T1 disease or carcinoma in situ, those patients certainly have a risk in those tumors coming back and even progressing over time. But as has been said before, this period that we're in is likely going to delay some people, their surveillance and our treatment over a matter of several weeks to a few months.

Dr. Lee:

And in that context, again, we shouldn't be seeing major changes in patient survival outcomes over that timeframe. So, for those patients if they do miss their cystoscopies surveillance, particularly if they have not had a recurrence of cancer in some time, the delay again is unlikely to have long-term serious ramifications. Now for those patients who are recently diagnosed with invasive disease or high-risk disease, if the hospital or the state is in a position where they can still see patients in the ambulatory or clinic space, we are prioritizing those patients to get their [BCG](#) and to get their surveillance.

Dr. Lee:

So, in other words, the longer it's been since you've had a recurrent tumor or an active tumor, the more we feel comfortable perhaps delaying your surveillance by some short period of time until we're out of this COVID-19 crisis. I'll also preface the comments for those patients with invasive cancer but still non-muscle invading cancers, that even having a [resection of your bladder tumor](#) can be a challenge, if hospitals are at a setting where they're only allowed to do life threatening emergency surgeries.

Dr. Lee:

A delay may be required in those centers. We're fortunate right now in Ohio State that we are not in that situation. So, we are able to do those procedures. But for those who are not, I think as a patient is delayed, their status and urgency to have resections or diagnostic procedures or treatments will change over time. And as the conditions change in the hospital, I'm sure providers will be getting back to those patients as quickly as possible.

Dr. Lee:

Now, I do want to just make a comment about [cystectomy](#). I think many of us, nearly all of us in the field would agree that we would consider these essential procedures, particularly for patients with muscle invading cancers. We have prioritized these surgeries. And again, we are fortunate that we're in the situation that we can do those procedures now but I can tell you that many centers across the country cannot.

Dr. Lee:

So, these dangers that I would say if at all possible trying to get these at least surgeries done is of the utmost importance. I will say for the patient population again that we deal with, they're at higher risk for more aggressive outcomes from COVID-19 if they do acquire it. We want to protect our patients from exposures too, because patients who even when they're asymptomatic and have the virus, if they have elective surgery, they may have more serious outcomes from the COVID-19, simply going through this process of having left of service especially major elective surgery. So, we want to really be careful about who we're operating on.

BCAN | Stephanie Chisolm:

Dr. O'Donnell. You obviously taking care of patients who have more advanced disease as a medical oncologist. So, when is it okay to delay? When is it this kind of thing where we'll talk next about urgent care, but when is it okay to delay either a follow-up or a treatment?

Dr. O'Donnell:

Great question. The situation of metastatic disease is one where we're balancing, competing risks. We're balancing the risk of how fast that cancer is moving. Does the patient have symptoms right now from their cancer, such as pain, versus the risk that whatever treatment they were going to start brings to them from a standpoint of having to come to the medical center with usually a good bit of frequency when you're on an active treatment. At our center, we've made some institutional decisions about that. For my patients that are receiving chemotherapy, I haven't recommended any patients to interrupt or discontinue their chemotherapy. My patients that are typically receiving chemotherapy for metastatic disease are receiving that because their cancer is an immediate threat to their life.

Dr. O'Donnell:

And you could actually argue that that threat to their life is much more pressing than the theoretical threat of catching COVID at the medical center. We've already talked about all the steps that all of our medical centers are taking to try to make sure that the environment as the hospital to receive therapy is as safe as possible. And so, with those precautions put in place, I actually think that the larger threat to my patients' life is not receiving their anti-cancer therapy. So, we've chosen to go forward with chemotherapy in all of our patients. Immunotherapy is an interesting topic. So, I'm talking now about the newer, more modern immunotherapy treatments, not chemotherapy.

Dr. O'Donnell:

And in those situations, there's actually pretty convincing data that the immunotherapy drugs stay in a patient's system long enough and have a durable effect, even when they're not receiving treatments on a regular basis that those immunotherapies are activating the immune system even in the absence of regular infusions of the drug.

Dr. O'Donnell:

And so, we've counseled our patients to actually skip some of the immunotherapy sessions. Because of the fact that those drugs stay in the system longer and have durable activity even in the absence of regular infusions. Our policy on immunotherapies has been generally to skip every other session, because of the length of time that those drugs usually stay in the bloodstream. It's deemed safe to skip every other session. Of course, none of us know how long this is going to go on. In an ideal world, we'd like to give those drugs on the FDA-approved schedules that they're supposed to be given on, but we think for during the height of this as we're in right now, that some patients certainly should be skipping some of those immunotherapy sessions.

Dr. O'Donnell:

And I've done that with almost all of my patients, and I think the patients are very grateful for that, if we reassure them that the drugs are likely to still work, if they can skip every other session. So, that's how we've approached it from an immunotherapy standpoint. The other situation that I might just comment on briefly is the space of the neoadjuvant setting. So, treatment prior to a cystectomy with a systemic drug via chemotherapy or on a clinical trial, immunotherapy drugs in that neoadjuvant setting.

Dr. O'Donnell:

For all of those patients, we've adopted the practice of going forward with therapy. We consider that curative intent therapy. In a neoadjuvant setting and in the setting of drugs that you're receiving prior to a cystectomy, the goal there is cure. We are trying to cure the patient of bladder cancer. And so, that is paramount in our minds. And so, we are not withholding or delaying any therapies for patients in that neoadjuvant setting.

BCAN | Stephanie Chisolm:

That's good to know. Dr. Mian, for patients that are maybe on bladder preservation with the combined chemosurgery and radiation, are you making any changes in your protocol based on other research that's been done that you can go shorter, go more radiation for a shorter period of time. Is there anything that's happening there?

Dr. Mian:

No, it's a good question. I think we're still sticking to the standard of care. And as has already been mentioned, we're taking the treatment of our potentially curable patients who have aggressive disease very seriously. We're not trying to do anything that would compromise their outcomes.

Dr. Mian:

And so, therefore, we stick to standard therapies. But as all of you will have known, just from watching the news, there's a federal level response, a state level response and municipal level response. And there's something similar going on in all of our medical societies, from the [AUA](#), to the [American Society of Radiation Oncology](#), to the [American Society of Clinical Oncology](#). These are all groups that have put out recommendations for how to approach treatments and how to handle patients during this time.

Dr. Mian:

Those get filtered through individual hospital systems like the Cleveland Clinic, Ohio State, University of Chicago, and individual hospitals within those systems. And I'll say that some of these decisions like the length of fractionation, which is the length of time a patient may be on radiotherapy are made at that level based on resources, based on whether a unit is able to treat patients who have a known exposure, for example.

Dr. Mian:

So, answering in very general terms, I would say, one of the things we're trying to do and again, this is adhering to guidelines is we're trying to use shorter courses of radiation within evidence-based guidelines, for example, 20 treatment regimen with concurrent chemotherapy for that patient that might be eligible for bladder preservation for a [trimodality therapy approach](#). And so, we were sticking to more shorter regimens. That's something, frankly, that we would have tried to do even before this all started, but now it's more in the front of our minds to kind of reduce exposure for patients. So, it's a very good question.

Dr. Mian:

I have a handful of patients right now who are being treated in this way and getting shorter overall length of treatment times. I think the number of touches in that way is not really as big of a risk factor for those patients as things like paying attention to their contacts within the community as well as things like their immunosuppression.

Dr. Mian:

I'll just tell you that at the Cleveland Clinic, we currently have as of today, 150 COVID positive patients hospitalized within our system, about a third of those, third to a half at any time are in the ICUs. We have about a hundred doctors or nurses, caregivers that have been diagnosed positive. There's a very small number of them that have been hospitalized. And as you might imagine, we pay very close attention to whether or not the caregivers cluster in any particular unit. For example, are they all coming from one unit where they're doing respiratory care for exposed patients, that kind of thing. And I bring this up, because at least the present, we're not really seeing that this clustering is happening.

Dr. Mian:

And so, even for caregivers who are in the hospital for the good part of their time, a lot of the spread we think that we're seeing and a lot of the patients we're seeing coming in, it's really community exposure. And I'm not saying that they're not at risk by coming out and as you all know, we have to be distancing.

Dr. Mian:

But we I feel like have done an effective job of minimizing people's exposure within the hospital. And so, again, echoing the comments that have already been made, we are not taking a small risk, what we think is a small, but serious risk of exposure to the virus and using that to trump the very real risk of a patient with an invasive and muscle invasive bladder cancer and their treatment. And so, that's kind of how we've approached that. I hope that answers your question, Stephanie.

BCAN | Stephanie Chisolm:

It does, thank you. And I think that as we process this and get to the other side, there'll be some really interesting research studies that are being done following how things have changed and whether we still need to go back to the old way of doing some of these things or if there were better ways of doing them. Dr. Hafron, what all do you see as far as when do you think it's okay for patients to not come into your practice, come into your office for treatment or surveillance? Do you have anything else to add?

Dr. Hafron:

Very similar to what everyone else has presented but basically low risk AOA guideline, low risk bladder cancer, we're delaying a month. But anyone with high risk bladder cancer, CIS, muscle invasive T1 high grade, according to the AOA American Neurological Association we're seeing and we're having them come in for their cystoscopies. We're having them treated with BCG or intravesical therapy, whatever we're using.

Dr. Hafron:

So, we've been able to keep treating these patients. Again, like I've mentioned earlier, the only delay we've had is with our ability for our hospitals to keep up, but we're at our peak now and that's starting to open up. But I think what's also important for patients and looking at the initial Chinese data, is that cancer patients may be at increased risk for COVID. And makes sense they're potentially immunocompromised. It's not a great study, but some initial signals we're seeing out of China, I think, as important as the patient's urologist and taking care of them is that they do what the government, the CDC and all major societies are recommending is social distancing.

Dr. Hafron:

If they do come into the office, they need to be wearing a mask. If they're sick, don't come in. They need to wash their hands and do everything that the government's recommending, because potentially they might be at increased risk. So, I think a lot of times, patients will minimize it or not hear the message or kind of blow it off. And I think, as their treating physician, we need to remind them and if a patient does show up that is minimizing the risk that we need to reinforce that, that social distance is important. They need to be putting on a mask, handwashing, and all that, that everything that what the government is saying needs to be practiced, especially if you have bladder cancer.

Dr. Lee:

Yeah, I just want to say although I mentioned that we were still in a position at Ohio State where we were going forth with cystectomies, for those patients living in communities where the hospitals are not able to do those procedures, there's been a fair amount of data over the past 10 to 15 years looking at delay in cystectomy. Even patients with muscle invasive bladder cancer really delays up to three months weren't associated with worst outcomes. Now, no one wants to wait three months, but again, if someone is able to have their surgery within that time period, there's some comfort in knowing that their outcomes may not be grossly different.

Dr. Lee:

And after neoadjuvant chemotherapy, the risk of delay at 10 to 12 weeks was not greater in patients after neoadjuvant chemotherapy who then went on to cystectomy. So, some small degree of comfort for some patients who are having to have some delay in their radical surgery.

BCAN |Stephanie Chisolm:

Absolutely, most patients can't sit peacefully knowing that the cancer is still there and they want to make some steps. They've already made a decision with you and their treatment team and they were ready to go. They've already gotten their mind set for this. So, now we can just sort of flip around a little bit and talk about what constitutes an urgent need for care. So, maybe we'll go backwards and start with Dr. Hafron. What do you see as an urgent need for care when you really do need to get in whether it's for a televisit, to just get things checked out or to have people actually come into your office from that bladder cancer perspective? What should they expect when they come into your office?

Dr. Hafron:

Well, I think what we're doing a lot of is the televisit are widely available. So, I know in my practice and in our large group practice of 50 urologists, if a patient has a question, we are available, we can jump on a FaceTime or televisit pretty easily and over the phone, it's pretty miraculous. And as we've been just doing this for a few weeks, how much information you can get from a televisit, so we can prescreen them and see if there is an urgent matter that significant blood in the urine or significant urinary symptoms. And if we feel it's necessary, we'll bring them in, but we do the prescreening.

Dr. Hafron:

But we also again, I think we got to educate the patients because we see it quite frequently. They're not coming in with a mask on. When I asked them about what are you doing, and I find out they're going to the store or they're doing other things, I say, "You're in the age group above 60 with cancer, there is a significant risk and you really need to minimize your social contacts. You really need to stay at home. Because unfortunately or fortunately, I see what's going on in the hospital. And these are real. There is a significant impact on COVID in our area. And if you minimize your risk and do everything that's recommended, you can make a big difference."

Dr. Hafron:

So, I think getting back to your question, I think what we try to do is telescreen them, we're developing all these new verbs and things, see how urgent it is and we can bring them in because reality is a lot of urologists because our non-essential surgery has been reduced and for us, it's been shut down, we're available and there's a lot of doctors, a lot of urologists that have extra time on their hands, so we can offer our services to our patients that are concerned or have questions.

BCAN |Stephanie Chisolm:

Dr. Mian, what about radiation oncology? What is an urgent need for care for them to come in to see you?

Dr. Mian:

Well, I think it wouldn't be too dissimilar from the other specialties here. I would say that the patients are experiencing a sudden change in their symptoms, they should at minimum be evaluated quickly. Patient shouldn't delay there. And I'd say the things that would warrant coming in to be seen. I generally see patients with muscle invasive disease, but things like bleeding, new onset blood in the urine would be an important one, blood in the stool, other kind of new intractable pain. I'd want to hear about that right away. And there's going to be those patients in that group that can be managed with distance health and there's going to be a good fraction of them that need to be seen and shouldn't delay their

care. But I would say the majority of my patients are not being seen for urgent or emergent reasons. These are more scheduled visits can be handled in a more controlled way.

BCAN | Stephanie Chisolm:

So, Dr. O'Donnell, there are a number of adverse events that are linked to both chemotherapy side effects and then the adverse events relating to immunotherapy. When is it urgent say that somebody needs to go right to an emergency department? Or when should they wait? And when do they need to just make an urgent appointment for you to come into your practice?

Dr. O'Donnell:

That's a complicated question. And I'm not sure the answer is all that different from if we weren't in the COVID situation. And you need to talk to your individual treatment team, your nurse, your doctor who knows you really well. One of the factors that's going to be in their mind is, are your symptoms potentially related to COVID? Are they related to your disease? Are they related to the treatment we're giving you? And that's very individualize. That takes knowing what treatment you're on. What's the timing of that cycle that you're on? Are you at a point where your immune system is likely to be at a low point from chemotherapy?

Dr. O'Donnell:

At one point, I'll make regarding immunotherapy, is one of the rare but serious toxicities of immunotherapy, some immunotherapies in lung inflammation, which can look very much like what COVID can present us. And so, your doctor needs to have that in mind knowing that you're on a treatment that could potentially cause a lung toxicity, and not just have some ER physician, not be aware of that and think that this is all an infectious cause. So, it's a really complicated question that you ask and it really involves just speaking with your doctor and telling them what's going on. Your doctor will know how to triage that correctly.

Dr. O'Donnell:

The other point I'll make here, I think the other important message is that and it echoes with some of the other docs here have said is that if you're a new patient with a new diagnosis, don't delay. We can do a lot from a video or telehealth new patient visit. We are seeing new patients virtually without having to see you in person in the clinic right now. And oftentimes that will allow us to start lining up some of the things that we'll need when we can start treating you. For example, we can do a lot with reviewing your pathology or the scans that you've had and reviewing those reports and those tissues without having you physically at the medical center.

Dr. O'Donnell:

And some of my patients, I'll even initiate PDL1 testing, for example, which is something that we want to get sent off and wait for the result. And we can do all that from a virtual new patient visit. Even practical things like I'm in Chicago and we're a high population density center, but if my patient actually lives out in the suburbs, I can send them to get a CAT scan close to home at their local hospital where the COVID numbers are actually lower and it's probably safer to do that, get the scan close to home rather than them having coming to the big medical center where most of these patients are and getting the CAT scan there.

Dr. O'Donnell:

So, practical things that can be lined up from that first telehealth visit that allow us to initiate a lot of the steps that we're going to need to undertake any way to treat a new patient.

BCAN |Stephanie Chisolm:

Dr. Lee, do you have anything to kind of wrap up this urgent need? When is it urgent in your mind?

Dr. Lee:

Dr. Hafron summarized enough as did others, that for us it's gross hematuria, bloody urine, urinary obstruction, where someone's having trouble voiding, pain, particularly kidney pain or flank pain. Those are all signs that are really going to catch our attention to know that we need to see someone in person. The second half of your question is what should patients and families expect? One and some others may have mentioned it, but at the James Cancer Hospital and across our center, we've had to restrict the number of visitors coming in with patients. In the emergency room, there are no visitors allowed with the patient.

Dr. Lee:

If someone's having a procedure, they can come in for the procedure and for a major procedure one day after, so there's that to know and expect. Expect universal masking that the healthcare workers will have masks on and then the inpatient unit, they'll have protective eyewear on so people look a little bit differently. It can be isolating because you don't have your family and friends around you and you can't always physically see your nurses and doctors the way you're used to seeing them. But at the James, we've tried hard to at this point because of the level of COVID positive patients we've had in the hospital, we've restricted any COVID-19 positive patients from being in the cancer hospital because of the number of immunosuppressed, immunocompromised patients that are actually in the hospital.

Dr. Lee:

So, you can expect that you can't move freely from building to building because we're trying to have those restrictions. So, I think that's what we're doing at the James. But I'm sure that some of those things are going on at other hospitals too. So, the visits are a bit restrictive, a little bit more isolating, unfortunately.

BCAN |Stephanie Chisolm:

So, how do you think things will evolve over the next few weeks as we learn more about COVID-19 and bladder cancer patients? You've already mentioned that hopefully telemedicine won't go away when this is all over. But are you seeing anything that you think is going to improve bladder cancer care? Or do we know anything that we're beginning to see patterns in bladder cancer patients who might be COVID positive? Dr. Lee?

Dr. Lee:

Well, I think the telehealth is certainly the biggest impact I think for all of us that I think will still be here to stay when this is over. And as I have looked at my practice, which is a practice that heavily relies on cystoscopy, I'm thinking more about the days when there was discussions around virtual cystoscopy.

Dr. Lee:

Will that become something that will develop again or reemerge again? I'm thinking about our surveillance strategies to be honest with you, when we think more about relaxing those or changing how we see patients. We talked about imaging but radiology departments around the country have also been very restrictive of what imaging they will do. So, it may again have us thinking about outcomes after this and what our surveillance program looks like. So, I suspect there will be some changes and some research coming out of this over the coming months. We hope that for many have these very heavy hit areas in the country, they're already reaching the peak of their surge, we hope. And some of us other states are behind a week or two.

Dr. Lee:

But my hope is that we'll be seeing things, hopefully the backside of the curves or the downward trends of these curves with a decreasing number of COVID-19 patients over the next several weeks into May. And hopefully, by the end of May or June, we'll be able to, at least with some proportion of patients or highly prioritized patients begin to get folks back in for their essential surgeries. So, I think that's going to be emerging over the coming six weeks or so.

BCAN | Stephanie Chisolm:

Can you talk a little bit about the virtual cystoscopy?

Dr. Lee:

But just as people may have heard of patients swallowing a small camera pill and people being able to track actually the inner part of the colon or the small intestine through the assistance of these really teeny cameras that will then go through the intestinal tract. Several years ago, maybe three to five years ago, there was some interest in virtual cystoscopy, putting this kind of pellet into the bladder and then being able to use that to look at the inside of the bladder. I think things like that will become of greater interest when we're doing a lot of our surveillance or care or follow-up remotely. So, I think necessity or what is it, "necessity is the mother of invention".

BCAN | Stephanie Chisolm:

A question, for all of you that if people have had things postponed, maybe a surgery being postponed or it's just a cystoscopy postponed, how are you going to decide who gets in first when all of this lightens up and you get to get back to regular practice? How are you going to prioritize that? Is it whoever was out the longest? Who wasn't able to get care the longest? How are you going to rank that?

Dr. Hafron:

I think for us, Stephanie, we fortunately have risk categories from the American Urological Association and the European Urology Association. So, the way we look at it is treating the patients with the highest risk that we get back in. But reality is even though we're in the throes at the peak of our COVID, the delays are minimal. There is some delay. So, I think we've lost some convenience, which has been made up by telehealth, but we're still pretty much able to treat the patients that need to be treated. So, I think a lot of it is just reassuring patients that a week or two delay or a month delay is really not going to make a huge impact. And as we've heard from other centers, even in Chicago, where they're being hit pretty hard, they're still able to maintain chemotherapy and high intensity treatments. So, we look at it based on risk. It's not so much the delay, it's the risk and patients that need to be treated, will be treated.

BCAN |Stephanie Chisolm:

Dr. Lee, do you have something to add?

Dr. Lee:

I was going to say I agree with that completely. I think it's just risk stratification. But a lot of the centers and ours, for example, has used the electronic health record Epic to create patient dashboards so that as we're scheduling patients and getting patients in line, so to speak, we can put markers of prioritization on for that particular patient. So that when all of this is hopefully turning the corner, we'll know which patients really need to float to the top and really be seen as quickly as possible. And those will be the highest risk patients as Dr. Hafron mentioned.

BCAN |Stephanie Chisolm:

And then you mentioned this idea of pre-visit testing, maybe going into your community center to have scans done and then coming into the larger hospitals to come in for your actual patient visits with your doctor. So, we're going to probably see more of that do you think as we go along, helping to keep people out of the largely populated medical centers? I think that's a trend that we're going to see continue.

Dr. Hafron:

I think what we're trying to do is keep patients out of the emergency rooms. We're trying to keep them out of the hospitals. And what's interesting aside from what's been discussed is how well patients have stayed away from the hospitals. So, at our hospital, we're not seeing a lot of our routine consults, the patient with a recent stroke or recent heart attack, or even the stone disease that as urologist we see, a lot of patients are staying away from the hospital. That was kind of interesting and we'll know after time is where are these patients? What's going on?

Dr. Hafron:

Because the disease, the heart attacks, the strokes are still happening, but why aren't they coming to the emergency room, but that's a side note. But I think the key is keeping the patients out of the hospital, keeping them out of the emergency room. And fortunately, with telehealth, we can screen a lot of that and prevent that and move them to an imaging center away from a major medical center, bring them into the office, which at this point is much safer than going to large COVID hospitals. So, I think what the key is for patients is to communicate with the doctor. Call your doctor, tell your doctor, we're available and a lot of this stress or anxiety can be eliminated.

BCAN |Stephanie Chisolm:

I'm going to combine a set of questions here. They're really looking at patients who might have had COVID-19 or currently have COVID-19 and they need to come in. I know you've alluded to this a little bit, but some of your institutions have special floors or some have divided up so that COVID patients go in one direction. Are they still seeing you as their primary caregiver? Or are they seeing another doctor because they also have COVID? What's the situation as they get in there?

Dr. Lee:

At the James Cancer Hospital, we've been able to keep all known COVID-19 positive patients outside of the building. And we've actually restricted specific units in the hospital for patients that we know are positive or being ruled out. So, they would still see a urologist if they had a urologic condition. But certainly, their primary management right now is by one of the hospitalists or intensivists as needed. Now with a larger volume of patients or a surge setting, that might change and we might see that there's a broader use of the team approach where a very experienced intensivist might work with surgical specialists and medical specialists to help care for the population and just get the patients taken care of. Certainly for those patients, when the hospital is full, they might have a team more of a team-based approach.

BCAN |Stephanie Chisolm:

We're coming up on the hour, I just want to open it up and see if you all had any other comments that you would like to make?

Dr. Mian:

Well Stephanie, one thing I would just say is that even though we talked about how this might evolve over the next couple of weeks, months, I feel like there's going to be some things here that are going to evolve over a much slower period. We just don't know we're in the early days with things and there's been some nice developments. There appears to be some flattening of the curves. We're relaxing some of the stratification that we were doing in terms of tiering the most urgent patients, so those are all good trends. I would just caution folks to pay close attention, be in touch with your providers. This is evolving over a short period of time. But I suspect that we're going to have guidelines and changes and ramifications from this that probably extend out for quite a period of time. And we don't know that there won't be a second wave of this down the road here. So, I just think this is an important conversation to keep going. I thought I'd just add that.

BCAN |Stephanie Chisolm:

Thank you. Anybody else?

Dr. O'Donnell:

I'll just add that one of the things that we know is true of bladder cancer before even before COVID is that a delay in diagnosis really puts patients in a bad situation to potentially be cured of their disease. So, that first sign of hematuria when that patient for whatever reason delays getting to a urologist and so, I'm hoping that, what we've talked about with this idea of telehealth, being here to stay could actually decrease some of the disparities that we've seen in patients getting that proper diagnosis of bladder cancer even after all this is over. I think it's a really important message for patients that might be diagnosed with bladder cancer in the future.

BCAN |Stephanie Chisolm:

Any other last comment? I'd like to steer everybody to our webpage. If you're looking for additional information, we posted a number of frequently asked questions about bladder cancer and COVID-19. So, if you check our webpage regularly, you'll see any updates as we provide them. So, again, [BCAN.org/covid-19-faq](https://www.bcan.org/covid-19-faq).

BCAN | Stephanie Chisolm:

And I'd like to thank you all so much for a wonderful program, very informative. The recording will be available for participants. You will be receiving a short survey, please take a moment and let us know your thoughts about today's program. I'd like to thank you all again so much for joining us from all over the mid central states and sharing your expertise with us. Take care.

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