Coronavirus disease (COVID-19) and CLL patients

Statement of the CLL Advocates Network
Date: 10 April 2020 (Version 2 – updated based on current guidelines)

CLL Advocates Network is closely monitoring the strategies being implemented in various countries to manage the COVID-19 virus. Much of the information about COVID-19 does not address the concerns of people with chronic lymphocytic leukaemia (CLL). With this statement, we wish to fill this gap and provide extra advice for CLL patients.

Most resources agree that the following individuals are at increased risk of severe or fatal COVID-19:

- Older adults (60+ yrs.)
- Individuals with coexisting chronic illnesses (e.g. chronic lung or heart diseases)
- People contracting secondary infections

The following are at high risk of severe or fatal COVID-19:

- Immune depressed individuals

CLL patients - whether treated or not, young or old - are immune depressed. Treatment can add to the immune deficiency. In view of the foregoing, CLL patients are therefore at high risk of getting COVID-19 and having more severe symptoms than the general population.

Since there are no specific anti-viral medications or vaccines for COVID-19, the best way to prevent illness is to avoid being exposed to the Coronavirus that is thought to spread mainly from person-to-person via cough, sneezes or hand contact. Here are some commonly admitted rules to be followed by all citizens – young and old, healthy or ill – to reduce exposure risk:

1. Avoid close contact with others (keep distance of min. 1.5, ideally 2 meters).
2. No hugging, kissing, or shaking hands. Move away from people before coughing or sneezing.
3. Avoid touching your face (eyes, nose, or mouth) with unwashed hands.
4. Wash hands often with soap and water for at least 20 seconds. An alcohol-based hand sanitizer with at least 60% alcohol may also be used but is less preferable.
5. Strictly follow social-distancing measures.
6. Sneezing and coughing into your arm/elbow. In case of blowing nose, use a tissue and immediately trash the tissue.
7. Avoid traveling.
8. Work from home if possible.

CLL patients are urged to be extremely cautious and to strictly follow the restrictive measures suggested by health authorities of their respective countries, in order to avoid the risk of contamination and to prevent the spread of infection. The UK strongly advises those with very serious conditions (this includes “people with cancers of the blood or bone marrow such as leukaemia”) to stay at home for the next 12 weeks commencing 21 March and to keep apart from the general population (“shielding”).

CHANGES TO CLINICAL PRACTICE IMPACTING CLL PATIENTS

Some professional organisations have made somewhat different management recommendations. Please look to your local guidelines where available.

USA - American Society of Hematology (ASH):

ASH clearly recommends to postpone treatment initiation if possible. For patients who require immediate therapy, ASH affirmed that it still offers the best treatment option considering disease and patient-specific factors. When there is more than one option, preference should be given to treatments that can be provided in the outpatient setting and require fewer clinic visits and lab assessments. ASH highlights that there are attempts to avoid or skip treatment with monoclonal antibodies (rituximab, obinutuzumab) especially when given in combination with targeted agents. Initiation of venetoclax requires multiple and extended clinic visits with lab testing and should be avoided if possible unless considered the most appropriate treatment for a particular patient.

To the questions whether anything is changing for patients without COVID-19 who are already on therapy for CLL, ASH states that – whenever possible – it seeks to minimize the number of visits for those who are stable and doing well. When follow-up is necessary, utilizing laboratories closer to home and using telemedicine is recommended. Most continue ongoing CLL-directed therapies in unaffected patients with exceptions being monoclonal anti-CD20 antibodies and IVIG.
Furthermore, to the questions whether patients with CLL should continue to get immunoglobulin replacement, ASH summarizes its current practice as follows: In CLL patients without COVID-19, IVIG treatments are continued only for highly selected patients with a history of hypogammaglobulinemia and active or recurrent severe infections where the potential benefits are outweighed by the risks of coming to clinic for the infusion. Even in these cases, less frequent infusions should be considered when possible (e.g., every 6-8 weeks) targeting an IgG level of 400-500 mg/dl. In CLL patients with COVID-19, IVIG can be continued. Given the higher risk of thromboembolic (TE) events with COVID-19, ASH recommends assessment of risks vs. benefits in each patient and close monitoring for TE symptoms.

Finally, to the questions whether in a patient on treatment for CLL who is tested positive for SARS-COV2 the therapy is changed/modified and whether a different approach will be chosen based on the type of therapy (BTKi, PI3Ki, venetoclax, antibodies, chemoimmunotherapy etc.) or the severity of their viral infection, ASH sets out as follows: “For outpatients with mild symptoms, we don’t modify therapy. A decision regarding treatment modification in patients with more severe symptoms depends on weighing the aggressiveness of CLL and a history of frequent infections versus the theoretical risk of more severe COVID complications. Currently, there is not enough evidence to suggest that the approach should be different for specific classes of targeted CLL drugs and decisions regarding holding or continuing treatments are made on a case-by-case basis. There is general agreement on holding monoclonal antibodies for COVID+ positive patients. If the patient is on a BCR signalling inhibitor (ibrutinib, acalabrutinib, idelalisib, duvelisib), discontinuation can sometimes result in CLL flare and cytokine release that can mimic some of the symptoms of COVID-19. Generally, resumption of the BCR signalling inhibitor results in resolution of these symptoms in a relative short period of time.”

UK – CLL Forum - The UK CLL Forum Practical guidelines for managing CLL in COVID pandemic:

This advice is the consensus view of a body of experts in CLL in current UK practice to mitigate the consequences of the Covid-19 pandemic. It is not part of routine practice but to help mitigate the risk of infection in haematology patients.

The UK CLL Forum Practical guidelines for managing CLL in COVID-19 pandemic clearly set out that there will be significant changes to treatment and care of UK CLL patients to mitigate risk during the pandemic. Main changes are about mitigating against risk of infection of corona virus by avoiding unnecessary
treatments or chemotherapy that may increase risk or delaying treatment where possible, i.e. as long as delayed treatment does not harm the patient.

Changes furthermore also aim to reduce the time spent in clinic and therefore reduce the risk of contracting infection. Therapies resulting in less hospital attendance are therefore preferred. During the crisis, it is now current practice to offer BTKi therapies.

General observation: A key issue for physicians and care teams in the UK will be keeping patients informed and under observation. Many HCPs are likely to be redeployed during the pandemic as regular facilities are repurposed for COVID-19 management. Community access to primary care for bloods etc. is likely to be interrupted as COVID-19 impacts local services.

The full UK CLL Forum’s current recommendations to fellow UK doctors can be accessed here.

Germany - German Society of Haematology and Oncology (DGHO):

The German Society of Haematology and Oncology (DGHO) has published the following recommendations for CLL patients during the pandemic:

- Any therapy indicated according to the current guidelines should be carried out or continued. The DGHO believes that a controlled tumor disease is generally better for infection control.
- With asymptomatic disease and low therapy pressure, e.g. slow increase in lymphocytes, the onset of first-line or relapse therapy may be delayed. For this, further risk factors, the disease dynamics and the regional care situation need to be taken into account.
- The substitution of immunoglobulins in hypogammaglobulinemia with functional antibody deficiency is recommended. If there is a risk of therapy-induced neutropenia, supportive administration of G-CSF (Granulocyte-colony stimulating factor) is indicated.

WHAT TO DO IF YOU HAVE CLL AND CONTRACT CORONAVIRUS OR COVID-19?

1. If you have symptoms compatible with COVID-19 or have been in close contact with a coronavirus infected person, follow your country-specific procedure (perhaps a dedicated call centre).
2. Inform your haematologist/oncologist by phone or email or fax (don’t come to the hospital on your own to protect healthcare providers and other fragile hospitalized patients or outpatients).
3. Don’t stop your treatment unless your haematologist or oncologist asks you to do so, but ask your haematologist to contact the team taking care of you in case of confirmed COVID-19 as adjustment may be needed.

DESPITE ISOLATION, YOU ARE NOT ALONE!

Stay in touch with family and friends by phone or online, and watch out for virtual offering to engage with your local support group.

As most CLL patients, you might have experienced protective isolation in the course of your disease. Being cut off from the outside world certainly poses a challenge, but you have managed this in the past, and will manage it again. Probably this is a good time to give courage and strength to others who are less experienced with isolation!

INFORM AND KEEP INFORMED

News and recommendations are changing quickly so watch for further updates from authoritative sources.

For further information, please refer to the reliable sources of COVID-19 information below.

PLEASE HELP US

- Inform immune compromised patients of the risk COVID-19 represents to them.
- Advocate and raise awareness with your local government and healthcare providers.
- Remind your local Health Policy decision makers and other stakeholders of the high risk patients with haematological malignancies.
- Make sure your local authorities and other stakeholders are aware that it is not just the older population that is affected by COVID-19, but also younger adults are falling seriously ill from Coronavirus.
- Share best practices.

Tag us on Twitter or Facebook! And most importantly: keep safe!

Your CLL Advocates Network Team
Contact us at info@clladvoicates.net
Sources:

Information for high-risk persons:


Public Health England

US Center for Disease Control

Government of Canada

German DGHO (German Society of Haematology and Oncology)

CLL specific sites:

American Society of Hematology (ASH)
https://www.hematology.org/covid-19/covid-19-and-cll

CLL Support Association
https://www.cllsupport.org.uk/coronavirus/

CLL Society
https://cllsociety.org/covid-19/

UK CLL Forum
http://www.ukcllforum.org/

Onkopedia (a guideline portal for practising doctors in Germany, see 6.2.13 Chronische Lymphatische Leukämie (CLL))

Other cancer sites:

Bloodwise
https://bloodwise.org.uk/blog/coronavirus-and-blood-cancer

One Cancer Voice