Effect of COVID-19 Lockdown on Oncologic Patients Undergoing Treatment at a Tertiary-Care Hospital in India

TO THE EDITOR: For over a year, we have been witnessing an unprecedented worldwide event in the coronavirus disease 2019 (COVID-19) pandemic. India has reported around 27.6 million positive cases and 320,000 deaths to date. The first case of COVID-19 in India was reported on January 30, 2020. Since then, we have witnessed two waves of infection. The first wave peaked in mid-March 2020, after which there was a downturn of cases. The second wave started in March 2021, peaked toward mid-May 2021, and is presently on a downslope. India combated this novel COVID-19 pandemic. India has reported around 27.6 million positive cases and 320,000 deaths to date. The first case of COVID-19 in India was reported on January 30, 2020. Since then, we have witnessed two waves of infection. The first wave peaked in mid-

The lockdown was no doubt effective in controlling the pandemic but at the expense of a decrease in care to oncologic patients. There was a lack of inpatient care due to limited admissions, as many hospitals were converted to COVID-19 hospitals; there was a lack of routine checkups, as outpatient departments had to be closed down; and there was a lack of treating physicians, as they were deputed to become the frontline warriors fighting the pandemic. Other contributing factors were a lack of transportation, preventing patients from reaching the hospital, and a lack of income, preventing patients from purchasing their medications.

Some measures taken at our institution to improve care to this high-risk group included relaxing restrictions for patients regarding follow-up appointments (i.e., relaxation in number of follow-up appointments per day so that more patients could attend the outpatient department), and conducting telemedicine services as an alternative to in-person appointments. Despite our efforts, there still will be some patients who are left out; some setups lack infrastructure, and some lack staff because they have been deployed to the current priority, the pandemic. During the pandemic, we should give this high-risk group adequate medical care and support rather than focusing entirely on COVID-19. Otherwise, when this pandemic someday ends, another will begin—a pandemic of patients with non-COVID-19 illnesses who either were left untreated or were undertreated during the COVID-19 pandemic.

Jasim Jaleel
Althaf K. Majeed
Chandrakshhar Bal
Rakesh Kumar
*All India Institute of Medical Sciences
New Delhi, India
E-mail: rkphulia@yahoo.com

Published online August 19, 2021.
DOI: 10.2967/jnumed.121.262667

Not Yet Time to Abandon the Deauville Criteria in Diffuse Large B-Cell Lymphoma

TO THE EDITOR: We read with interest Rekowski and colleagues’ article (1), which reported improved response discrimi-
imation using ΔSUV_{max} compared with the Deauville scale (DS) for interim PET (iPET) in diffuse large B-cell lymphoma but assessed only complete metabolic response versus no complete metabolic response considering binary cutoffs of DS-1–DS-3 versus DS-4/DS-5 and DS-1/DS-2 versus DS-3–DS-5.

In a prospective blinded study on 189 patients with diffuse large B-cell lymphoma after 2 cycles of rituximab plus cyclophosphamide, doxorubicin, vincristine, and prednisone (R-CHOP), we reported that DS-5 was associated with inferior progression-free survival and overall survival compared with DS-1–DS-4 whereas no complete metabolic response (DS-4/DS-5) was not (2). DS-5 was defined as an SUV_{max} at least 3 times the SUV_{max} in liver and/or new lesions. DS-5 and international prognostic index were independent predictors in multivariable analysis; a change in SUV_{max} (ΔSUV_{max}) of less than 66% was predictive in univariable analysis only. Eleven of 14 patients with a ΔSUV_{max} of less than 66% had DS-5, suggesting that both identify an increased risk of treatment failure. Comparable findings have been reported after 1 (3) and 4 (4) cycles of R-CHOP and in Hodgkin (5) and primary mediastinal B cell (6) lymphomas, whereby only the proportion of patients with DS-5 had inferior progression-free survival and overall survival.

We recently reported a comparative study of reading methods and timing of iPET in 1,692 patients with diffuse large B-cell lymphoma (7). iPET after 2 and 4 cycles of R-CHOP significantly discriminated responders irrespective of reading method using DS-1/DS-3 or DS-1/DS-4, or a ΔSUV_{max} of at least 66% as a good response, with predictive values greater than 80%. This finding is relevant for clinical practice, in which R-CHOP is standard treatment and an early complete metabolic response using DS can be reassuring for patients and doctors. Multivariate hazard ratios at cycle 2 were 4.91 for DS-5 versus 2.93 for a ΔSUV_{max} of less than 66% and at cycle 4 were 6.20 for DS-5 versus 4.65 for a ΔSUV_{max} of less than 70%. Two-year progression-free survival for iPET2-positive patients was 36.7% (95% CI, 26.3%–51.5%) for DS-5 and 56.3% (95% CI, 48.5%–65.4%) for a ΔSUV_{max} of less than 66%. For iPET4-positive patients, 2-y progression-free survival was 33.3% (95% CI, 18.9%–58.7%) for DS-5 and 47.2% (95% CI, 33.4%–66.7%) for a ΔSUV_{max} of less than 70%. ΔSUV_{max}, however, identified a larger proportion of poor responders than did DS-5, 12.7% versus 5.6% of the population at cycle 2 and 10.2% versus 5.0% at cycle 4.

Considering de-escalation in trials, all reading methods detect a good response at cycle 2. Considering escalation, DS-5 identifies patients with the worst prognosis at cycles 2 and 4. Cycle 4 is the optimal timing for detection of a poor response, with more poor responders identified using a ΔSUV_{max} of less than 70%, but carries the disadvantage of later treatment escalation. Regardless of the method used, the positive predictive value is suboptimal, and combining baseline metabolic tumor volume (8) and circulating tumor DNA (9) with early metabolic and molecular response appears promising.

It is premature to abandon the Deauville criteria in diffuse large B-cell lymphoma.

DISCLOSURE

Sally F. Barrington is supported by the National Institute for Health Research (NIHR) (RP-2-16-07-001). King’s College London and UCL Comprehensive Cancer Imaging Center are funded by CRUK and EPSRC in association with MRC and the Department of Health and Social Care (England). The views expressed are the authors’ and not necessarily those of the NHS, NIHR, or Department of Health and Social Care. The PETRA project is supported by the Alpe d’Huzes/KWF fund, provided by the Dutch Cancer Society (VU 2012-5848). No other potential conflict of interest relevant to this article was reported.

REFERENCES


Sally F. Barrington* Jakoba J. Eertink Henrik C. W. de Vet N. George Mikhaeel Otto S. Hoekstra Josee M. Zijlstra

*King’s College London, United Kingdom
E-mail: sally.barrington@kcl.ac.uk

Published online April 23, 2021. DOI: 10.2967/jnumed.121.262317