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# REPLY

*From the author:*

I thank Dr Aujayeb and colleagues and Dr McCarthy and colleagues for their interest regarding our article discussing the effects of the COVID-19 pandemic on lung cancer diagnosis and management.[1] As they affirm, COVID-19 has had a significant negative impact upon referral and procedural rates for suspected lung cancer. Correspondence from Dr Aujayeb outlines a number of approaches to mitigate these effects, and communication from Dr McCarthy describes their institution's bronchoscopy response to the pandemic.

The COVID-19 pandemic is characterised by global heterogeneity in terms of prevalence, mortality, health care capacity, testing and vaccination programs. As such, strategies adopted by lung cancer clinicians depend not only on patient factors including age, comorbidities, performance status, risk of infection, and cancer phenotype, but are also determined by the local COVID-19 context.

In Australia, where the pandemic is largely under control, the risk of community-acquired infection is low.[2] As such, the practice of routinely testing patients for COVID-19 prior to tissue sampling procedures for lung cancer diagnosis was curtailed in late 2020. With resumption of full capacity elective procedures, waiting times for definitive diagnosis and management have returned to pre-pandemic levels. However, in countries such as the UK and USA, new cases continue to rise and the trajectory of the disease remains unpredictable, especially with the emergence of highly transmissible mutant strains. As such, patient-specific measures that balance the risk of infection and the benefits of lung cancer care are needed.

In a comprehensive document, the European Society of Medical Oncology (ESMO), along with other leading professional bodies, released recommendations to guide prioritisation of patients at each step of the lung cancer diagnostic and management pathway.[3] The overarching principles are that decisions associated with clear survival benefit should be maintained and that regimens should be adjusted to minimise hospital visitation where possible. Proposed approaches to achieve the latter include conversion to telemedicine consultations, postponement of low-dose CT screening, and modification of drug and/or radiation scheduling to reduce the frequency of cycles and/or fractions.

Recommendations regarding bronchoscopic procedures warrant specific attention, given their aerosol-generating nature. In a recent report, CHEST/American Association for Bronchology and Interventional Pulmonology released statements to guide performance of bronchoscopy while maximising protection of patients and health care workers. In particular, in cases where the indication is diagnosis and/or staging of lung cancer, the guidelines recommend that bronchoscopy be performed in a timely and safe manner. This is contingent upon local resources to pre-procedurally screen for COVID-19 and to provide appropriate lung cancer follow-up. Of note, the detection rate of nasopharyngeal swab reverse transcriptase (RT)-PCR testing for SARS-CoV-2 has been reported as 59-71% among symptomatic patients, and may be lower in asymptomatic individuals.[4,5] Furthermore, the utility in pre-bronchoscopy screening has not been evaluated, and therefore, measures including

use of negative pressure procedure rooms and personal protective equipment are essential.

One certainty in the midst of the uncertainties posed by the pandemic, is that health care services, including those for lung cancer, need to evolve to function in an effective, safe, and timely manner to establish a new “COVID-normal” system.

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