IGCS INTERNATIONAL GYNECOLOGIC CANCER SOCIETY

## THE IMPACT OF COVID-19 ON GYNECOLOGIC CANCER PRACTICE:

# EXECUTIVE SUMMARY IGCS SURVEY ON COVID-19

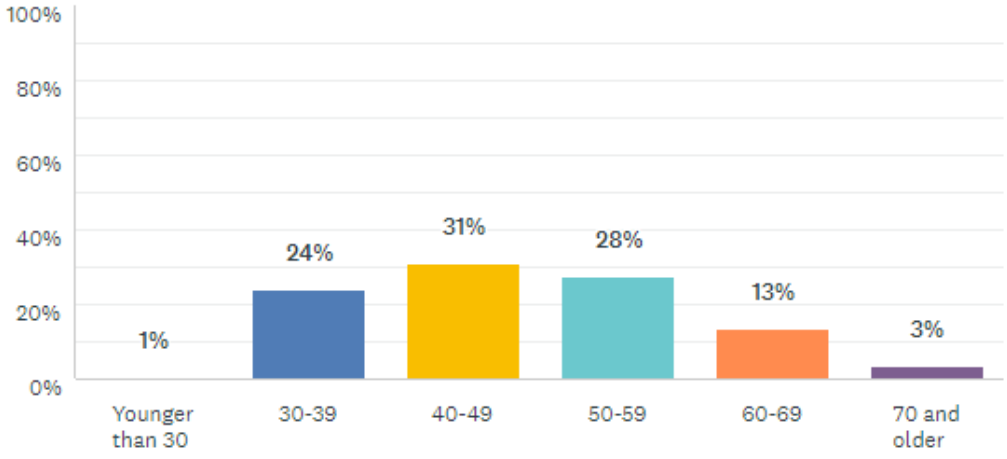
This report reflects the results of a survey of members of the International Gynecologic Cancer Society (IGCS) on the global impact of the recent COVID-19 pandemic on their cancer practice. The coronavirus outbreak has affected millions in at least 186 countries and has profoundly affected the cancer care delivery system apart from affecting the overall health system. Cancer patients are more susceptible to infection by and subsequently developing complications of COVID-19. Cancer is after all an immunosuppressed state due to malignancy and its treatment. There is a paucity of information on novel coronavirus infection and its impact on cancer patients, cancer care providers, and systems of care.

## DEMOGRAPHICS

- There were a total of 270 participants from 62 countries, with representation largely from North America, South America and Asia.
- 83% were Gynecologic Oncologists and the rest included Medical Oncologists, Radiation Oncologists, Pathologists and nurses.
- The primary practice of 97% of participants is in clinical work.
- 70% work in academic medical centers while 26% work in community hospitals.
- 91% work in an urban setting.

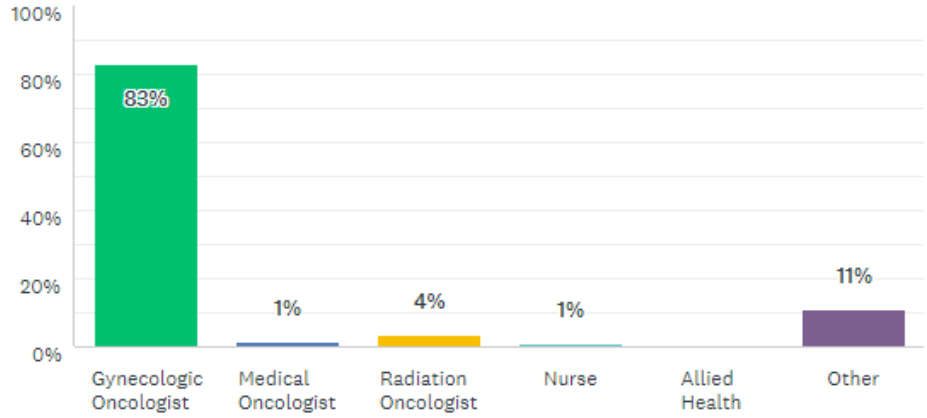
### Age range:

Answered: 269 Skipped: 2



## Healthcare role

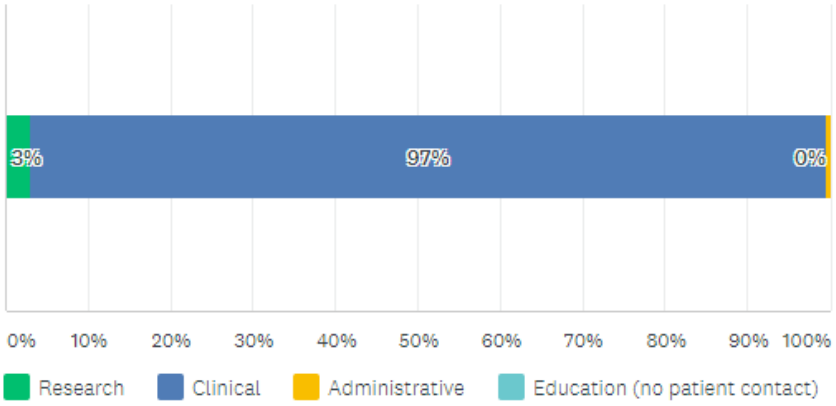
Answered: 267 Skipped: 4




Other Healthcare Roles included Pathologists (4% of the total respondents), Fellows-in-Training (1.5%), Surgical Oncologists (1.5%), OB/GYN and Nuclear Medicine Physicians (< 1%).

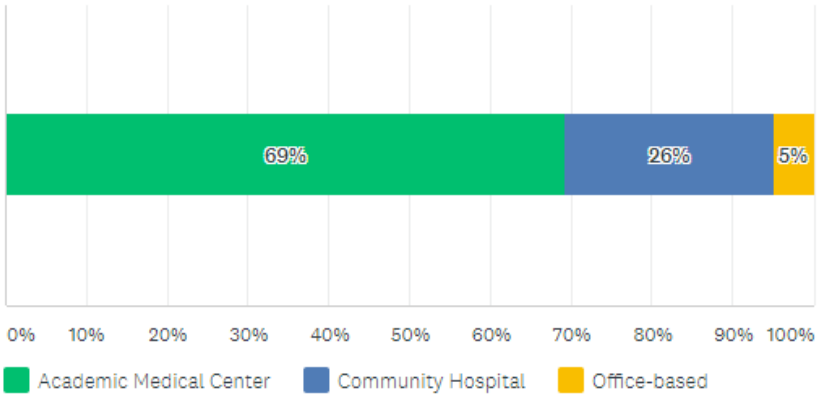
## Primary Practice (where you spend > 50% or more of your time at work):

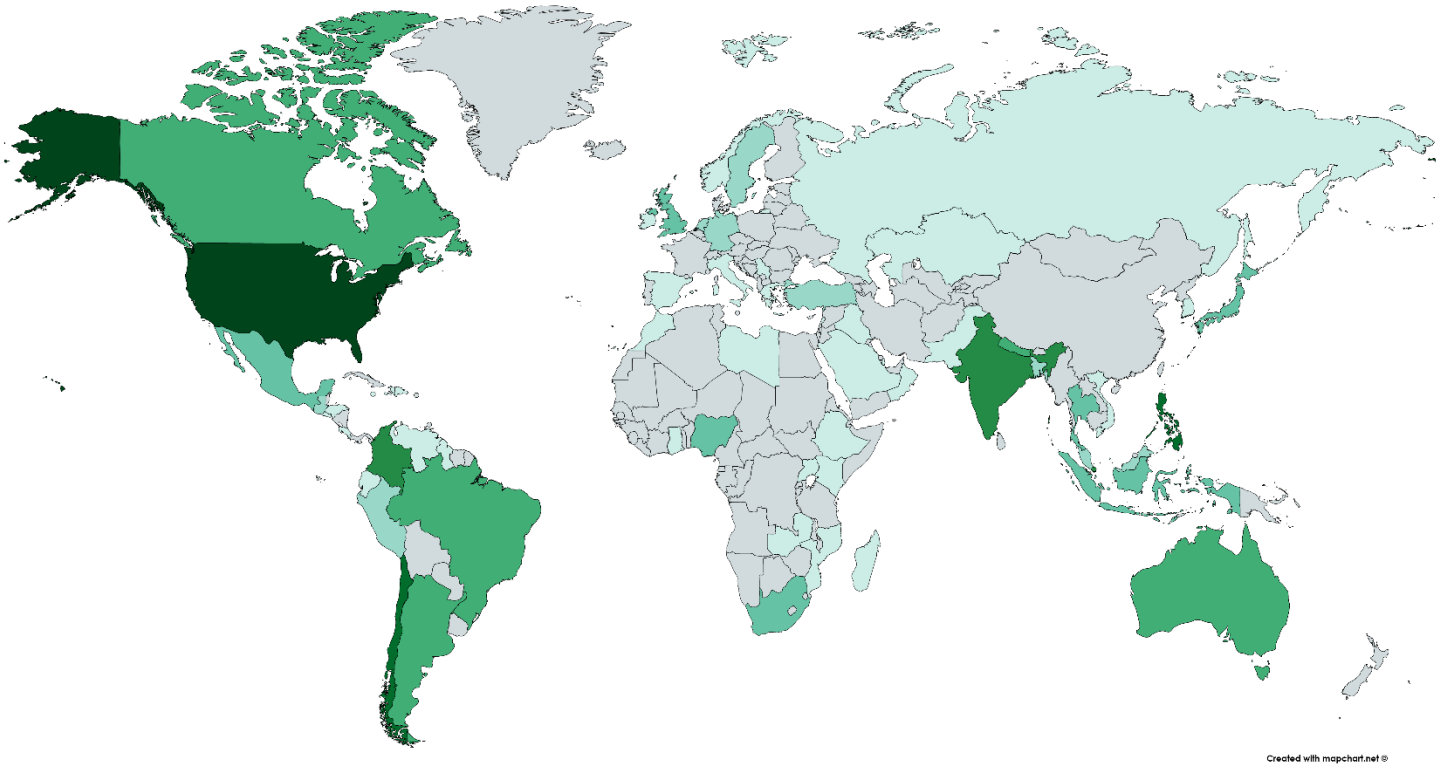
Answered: 267 Skipped: 4




## Primary Practice Setting:

Answered: 267 Skipped: 4






| | | |
|---|---|---|
| United States of America | 10.49% | 28 |
| Chile | 6.37% | 17 |
| Philippines | 6.37% | 17 |
| India | 5.99% | 16 |
| Singapore | 4.87% | 13 |
| Colombia | 4.49% | 12 |
| Brazil | 3.75% | 10 |
| Argentina | 3.37% | 9 |
| Australia | 3.37% | 9 |
| Canada | 3.00% | 8 |
| Nepal | 3.00% | 8 |
| Indonesia | 2.62% | 7 |
| Japan | 2.62% | 7 |
| Thailand | 2.62% | 7 |
| Mexico | 2.25% | 6 |
| Nigeria | 2.25% | 6 |
| South Africa | 2.25% | 6 |
| United Kingdom of Great Britain and Northern Ireland | 2.25% | 6 |
| Netherlands | 1.87% | 5 |
| Peru | 1.50% | 4 |
| Bangladesh | 1.12% | 3 |
| Germany | 1.12% | 3 |
| Guatemala | 1.12% | 3 |
| Malaysia | 1.12% | 3 |
| Sweden | 1.12% | 3 |
| Turkey | 1.12% | 3 |

| | | |
|---|---|---|
| Ethiopia | 0.75% | 2 |
| Ireland | 0.75% | 2 |
| Italy | 0.75% | 2 |
| Lebanon | 0.75% | 2 |
| Morocco | 0.75% | 2 |
| Pakistan | 0.75% | 2 |
| Republic of Korea | 0.75% | 2 |
| Russian Federation | 0.75% | 2 |
| Serbia | 0.75% | 2 |
| United Arab Emirates | 0.75% | 2 |
| Venezuela (Bolivarian Republic of) | 0.75% | 2 |
| Zambia | 0.75% | 2 |
| Antigua and Barbuda | 0.37% | 1 |
| Costa Rica | 0.37% | 1 |
| Dominican Republic | 0.37% | 1 |
| Ecuador | 0.37% | 1 |
| El Salvador | 0.37% | 1 |
| Fiji | 0.37% | 1 |
| Ghana | 0.37% | 1 |
| Greece | 0.37% | 1 |
| Guyana | 0.37% | 1 |
| Haiti | 0.37% | 1 |
| Iraq | 0.37% | 1 |
| Israel | 0.37% | 1 |
| Jamaica | 0.37% | 1 |
| Kazakhstan | 0.37% | 1 |
| Kenya | 0.37% | 1 |
| Libya | 0.37% | 1 |
| Madagascar | 0.37% | 1 |
| Mozambique | 0.37% | 1 |
| Norway | 0.37% | 1 |
| Oman | 0.37% | 1 |
| Qatar | 0.37% | 1 |
| Spain | 0.37% | 1 |
| Uganda | 0.37% | 1 |
| Vietnam | 0.37% | 1 |

## AWARENESS OF COVID-19

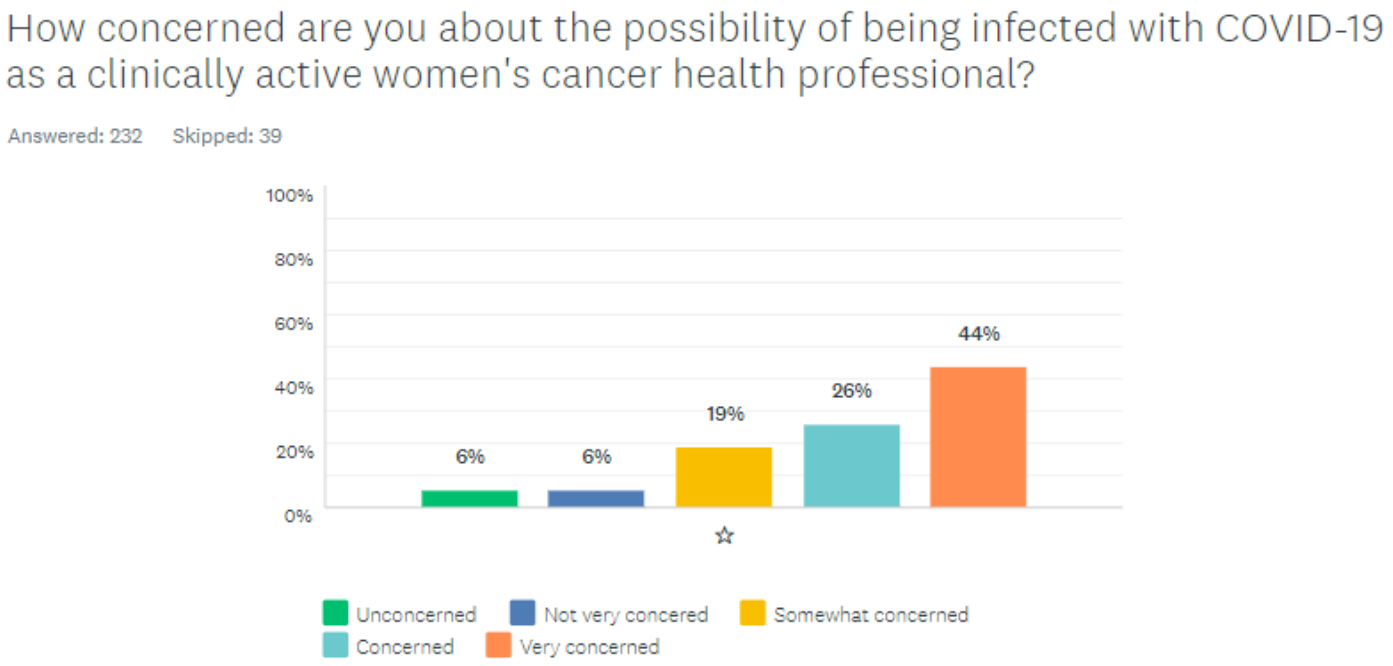
- At the time of the survey, 96% felt that the COVID-19 has already become a 'local' issue.
- At the time of the survey, 70% of the participants felt that the COVID-19 virus is primarily spread through infected fluid droplets.
- 59% agreed that the use of a surgical mask is sufficient for general patient contact in clinics and the wards
- Situations which were considered to require the use of an N95 mask or equivalent included endotracheal intubation (90%), ICU ward rounds (73%) and surgery (68%)

## INITIAL RESPONSE TO COVID-19

- 56% felt that their government's initial response of the COVID-19 situation was timely or appropriate. For those that did not feel that way, 58% felt that the responses and support have improved over time.
- 67% felt that their healthcare institutions' initial response to the COVID-19 situation was timely or appropriate. For those who did not feel this way, 61% felt that the responses and support have improved over time.
- With regards to their institutional policy on PPE for general, average-risk tasks at work, 61% expressed that surgical masks were required at all times in hospitals. For 77% of the participants, the policy has escalated with more PPE required in the preceding 3 months of the survey.

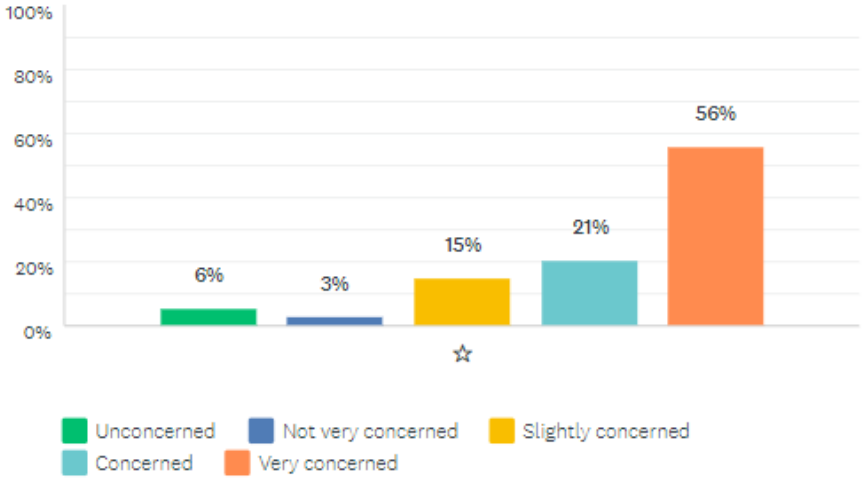
## ATTITUDES TOWARDS COVID-19 AND HEALTHCARE WORKERS

- 70% are concerned about being infected with COVID-19 from their clinical role as a women's cancer health professional.
- 77% are concerned about passing the COVID-19 infection to someone at home.
- 68% did not have a change in living arrangement and continued to live at home with their families with normal daily interactions. For those not living at home, 65% had to arrange for and bear the cost of an alternate living arrangement.
- 50% are confident in managing COVID-19 positive women with cancer.
- Only 34% reported that their staff felt comfortable providing cancer care during the coronavirus outbreak.



How concerned are you about the possibility of passing the COVID-19 infection to someone at home?

Answered: 234 Skipped: 37




## IMPACT ON ONCOLOGY PRACTICE

- 68% have not managed a confirmed COVD-19 case in their practice so far.
- 69% felt that there was minimal to no impact of COVID-19 on women's cancer care in their institutions.
- 49% expressed that there was no reduction in new cancer cases referrals in their institutions. For those working in institutions where cancer care is reduced or stopped, 93% had postponed patient's appointments but these patients will still eventually be seen.
- Using endometrial cancer as a benchmark on elective procedures, 69% expressed that a staging total hysterectomy is still allowed under the current policy.
- 63% of the participants felt that up to 50% of their usual time at work providing cancer care has been diverted to COVID-19 related service or administration while 25% felt that there was no additional time commitment on their part related to COVID-19.
- For their cancer care team including allied health professionals, 69% expressed that up to 50% of the usual time has been diverted to COVI-19 related service or administration while 17% had no additional time commitment.
- 45% expressed that all elective cases for cancer are still allowed to carry on in their institution, while the rest could only proceed in urgent or emergency situations.
- 84% expressed that they did fewer cases in the operating theatre due to the current COVID-19 situation.
- 34% felt that their surgical approach was not affected due to the outbreak.
- For patients with advanced ovarian cancer, 70% were more likely to recommend starting neoadjuvant chemotherapy than before the coronavirus outbreak.
- 58% felt that there was minimal to no impact on chemotherapy services in their institutions.
- 52% felt that there was minimal to no impact on radiotherapy services in their institutions.
- 46% felt that there was minimal to no impact on radiology services in their institutions.
- 55% felt that there was minimal to no impact on pathology services in their institutions.
- 88% expressed that COVID-19 has had an impact on clinical trials in their institutions.

## IMPACT ON ICU SERVICES

- Only 26% felt that there was minimal to no impact of COVID-19 on ICU services.
- 38% have had to postpone cancer surgery in the preceding 2 months of the survey due to shortage of ICU beds.
- 66% felt that a proportion of elective surgical volume for gynecologic cancer has been re-purposed as ICU capacity.

## KEY TAKE HOME MESSAGES

- There is a definite and urgent need for the IGCS to comprehensively evaluate and understand the impact of the COVID-19 pandemic on gynecologic cancer practice and women's cancer care. This understanding goes to the *raison d'être* of the Society in supporting its membership through education, advocacy, and political activism for women living with cancer all over the world.
- Ultimately, patients continued to receive care and care systems continued to function because of the efforts of women's healthcare professionals and less so because of governmental or institutional responses which were felt to be largely inadequate.
- Respondents were more concerned about the health of family members over their personal risk of infection. Interestingly, amongst those who made alternative living arrangements, most of them did so at their own cost without any support from their institutions. This is further evidence that healthcare professionals can be counted on to do the right thing for themselves, their families, and their patients even in the absence of regulation or guidance.
- Most had yet to manage a confirmed COVID-19 case and only half felt confident in managing one in their oncology practice. Only one-third reported that their staff felt comfortable providing cancer care during the coronavirus outbreak. This highlights the need for the timely dissemination of accurate information, provider and patient education, and the importance of collaborative multidisciplinary care.
- There has been a definite impact of COVID-19 on cancer care services, to varying degrees:
    - Half had to postpone appointments of new cancer cases.
    - Half are not allowed to carry on with their elective cases.
    - Most expressed that they did fewer cases in the operating theatre due to the current COVID-19 situation.
    - Two-thirds felt that up to 50% of their usual time at work providing cancer care has been diverted to COVID-19 related service or administration.
    - Most generally felt that there has been an impact on related cancer services such as chemotherapy, radiotherapy, radiology and pathology services.
    - Two-thirds felt that a proportion of elective surgical volume for gynecologic cancer has been re-purposed as ICU capacity and about one-third have had to postpone cancer surgery due to shortage of ICU beds in the preceding 2 months of the survey.

## RESPONDENT COMMENTS

Entire hospital waiting for COVID-19 patients, all other activities cancelled. So far, most of the beds unoccupied by patients. (Gynecologic Oncologist, Academic Medical Center, Urban Argentina)

I am a pathologist so I can't answer some questions. We are not doing elective surgery, but all cancer surgery is still happening. Our pathology department is still busy, but our turnaround times have not been affected. I cannot comment on radiotherapy or chemo.
(Pathologist, Community Hospital, Urban Australia)

Our hospital has made extensive preparations but has had very few cases. Elective non-cancer surgery has stopped but cancer surgery continues. Patient numbers have dropped because of less referrals but we can see patients without restriction. Low value chemotherapy is sometimes not given, radiotherapy unchanged. (Radiation Oncologist, Academic Medical Center, Urban Australia)

Prospective plans of monitoring COVID-19 incidence and prevalence with appropriate levels of standard service modification were made at the outset with high compliance prior to the peak incidence in Victoria. Interinstitutional arrangements were made to modify radiotherapy for palliative and some curative patients to enable shift of work to other facilities as required, not activated to date. Flexibility and collegial approach essential to managing crisis conditions. A whole of government exercise has not been run since about 2008 but this has not in my opinion significantly delayed appropriate action. (Radiation Oncologist, Academic Medical Center, Urban Australia)

Australia has been spared the disasters that have happened overseas. We are able to function as "business as usual" because all cancers are considered "Category 1" cases here with no restriction on access to appropriate care. PPE is also not rigidly enforced/required due to our low COVID numbers, so also not possible to answer that question correctly - there has been no requirement to increase use of PPE outside of normal practice. This is also influenced by a rapid transition to non-F2F consultations. We are all consulting predominantly using video or phone, where-ever possible. Appropriate use of PPE, if required, during F2F consultations. Impact of COVID-19 on staff has been predominantly in administrative duties - preparing for potential changes in case of sudden escalation in numbers and needing to re-deploy into other areas. This has not had to be enacted in my centre. Increased moves to "work from home" situation, reducing exposure risk for all ancillary staff was instituted early. Community lockdowns also have been very beneficial in our environment contributing to low overall numbers of COVID-19 patients. Being in a major Cancer Centre also means we are separated from the General Hospital environment. Policy ensuring that there is limited risk to all cancer patients was instituted early, with transfer out to the General Hospital of any suspected cases. We have been very lucky in Australia to miss the peaks in COVID-19 cases that have overcome other health systems around the world! We are very grateful for our isolation from the rest of the world in this instance. (Radiation Oncologist, Academic Medical Center, Urban Australia)

About outdoor patient's management. It is reduced in my institution. (Gynecologic Oncologist, Academic Medical Center, Urban Bangladesh)

Gynaecological oncological patient is more prone to be affected and get severe. (Gynecologic Oncologist, Academic Medical Center, Urban Bangladesh)

Patient flow has been greatly reduced due to lock down. (Gynecologic Oncologist, Academic Medical Center, Urban Bangladesh)

I live in Brasilia, very few severe cases here. Actually, in the public hospital where I work, because non-Oncological cases were postponed, I have more ICU beds available for gynecological cancer patients than before the outbreak... (Gynecologic Oncologist, Office-based, Urban Brazil)

Most affect is due to patients staying at home and afraid of going to their preventive appointment and/or exams. Delaying their preventive care. (Gynecologic Oncologist, Office-based, Urban Brazil)

Much higher use of virtual appts at the detriment of patient care. Use of PPE makes it hard to communicate with older patients. (Gynecologic Oncologist, Academic Medical Center, Urban Canada)

The response is inappropriate this virus is not dangerous (Pathologist, Academic Medical Center, Urban Canada)

COVID-19 have had a mayor impact in the practice on GynOnc in our country. It is a problem unresolved until now. Think at least one or two months in order to return to a regular practice. And also, with a great pressure because of new cases of gynecological cancer unresolved. (Gynecologic Oncologist, Academic Medical Center, Urban Chile)

The impact of COVID-19 pandemic I think is enormous. The cancer patients are going to be the silent victims on this world tragedy. (Gynecologic Oncologist, Academic Medical Center, Urban Chile)

There has been a change in practice. The institution adapted, and most of it has COVID free areas. A lot of teleconsult is being done, but the institution is open for in-person consult of new cases. Nevertheless, the volume has been reduced because of quarantine. I have the feeling people in the city is afraid of consult and are postponing visits. Also, volume has been reduced because we treat people from other cities or regions, and because of quarantine there is no public air or land transportation so people can't get to the institution, and up to my knowledge they are not being referred anywhere else. This has impact in surgery volume because at the time we are able to still operate everything (of course delaying preinvasive disease or low-risk malignancy adnexal masses). (Gynecologic Oncologist, Community Hospital, Urban Colombia)

In my institution, patients with COVID-19 are not seen, but the outpatient clinic has been closed and they will not see new cases of cancer for 4 weeks, therefore surgical, chemotherapy and radiotherapy treatments have decreased considerably. (Gynecologic Oncologist, Academic Medical Center, Urban Guatemala)

All care being taken, cancer patients getting treatment as required no delay. (Gynecologic Oncologist, Community Hospital, Urban India)

As ours is a pure cancer hospital, the service is continuing. Screening activities are suspended. Surgeries are being done with individual case basis (Gynecologic Oncologist, Academic Medical Center, Urban India)

Because of general lockdown, the cancer patients are unable to reach the hospital for consultation or they have considerable difficulty in reaching the hospital and therefore the overall patient number has reduced by 60% (Gynecologic Oncologist, Community Hospital, Urban India)

Has taught us to be more cautious and thorough (Gynecologic Oncologist, Academic Medical Center, Urban India)

Huge impact on cancer care (Gynecologic Oncologist, Academic Medical Center, Urban India)

In unsuspected cases (Detailed history) and cases with no history of contact or travel, patients can be treated as with no coronavirus condition. (Gynecologic Oncologist, Office-based, Urban India)

Most centers don't have COVID-19 cases but are sitting prepared in anticipation. (Gynecologic Oncologist, Academic Medical Center, Urban India)

Ours is a green zone at present. Due to lockdown, had difficulty with access to hospital. Hence, numbers are less than usual. (Gynecologic Oncologist, Academic Medical Center, Urban India)

Patients do follow all the norms for prevention of COVID-19 when they enter the hospital - using masks, sanitisation of hands and social distancing for OPD visits. (Gynecologic Oncologist, Community Hospital, Urban India)

My hospital become COVID-19 referral hospital. Non-COVID cases only chemotherapy, radiation, hemodialysis. No elective surgery can be performed. (Gynecologic Oncologist, Academic Medical Center, Urban Indonesia)

No more gyne-oncologist doing private practice in my place (Makassar-South Sulawesi, Indonesia) (Gynecologic Oncologist, Academic Medical Center, Urban Indonesia)

In Lebanon in general, we had limited cases of COVID-19, cancer cases have decreased because patients feared going to hospitals to seek care, not because hospitals cancelled surgeries, and sometimes because of the delay by the social security (coverage of the surgery delayed) (Gynecologic Oncologist, Academic Medical Center, Urban Lebanon)

1. Still accepting new cases but stable follow up cases are postponed. 2. No elective surgery but more receive neoadjuvant chemo or hormonal therapy while waiting for surgery when it is allowed. 3. Used other hospital facilities which do not involve in COVID-19 for chemotherapy. (Gynecologic Oncologist, Community Hospital, Suburban Malaysia)

It is up to the oncologist to decide whether to postopone or delay surgery, according to individual risk. (Gynecologic Oncologist, Community Hospital, Urban Mexico)

We have had to change the treatment of some patients mainly with ovarian cancer. (Surgical Oncologist, Academic Medical Center, Urban Mexico)

Our hospital (comprehensive cancer center) is assigned as a COVID-19 free hospital in order to take over cancer patients from other hospitals. We only have 1 ward with COVID-19 patients. (Gynecologic Oncologist, Academic Medical Center, Urban Netherlands)

Lack of testing kits has made it difficult to accommodate cancer patients as there are no means of doing preoperative testing. (Academic Medical Center, Urban Nigeria)

There is limited access to gloves, surgical masks in my institution. The department provided only a single cloth masks per person which should be washed by the health care providers and reused. I have not seen an N95 masks in my hospital. In general, I feel this survey considered only the ideal situations of Gynae cancer care and not the resource limited settings. (Gynecologic Oncologist, Academic Medical Center, Suburban Nigeria)

There is total cancellation of elective cases and closure of gynecological clinic where these patients are seen and plan for surgery. Since gynae clinic is not operational in my center, most of these patients are not seen at all. They are seen only on emergency situations. Thus, COVID-19 is most likely to affect oncology cases the most. I'm worried about my patients and patients with suspected malignancy, especially in developing countries like ours where patients tend to present late with its

antecedent morbidity and mortality. (Gynecologic Oncologist, Academic Medical Center, Urban Nigeria)

Regarding use of PPE question, you did not provide a response for no use of PPE (so no masks or gloves). We don't use any PPE in patient contact. Thanks (Gynecologic Oncologist, Academic Medical Center, Urban Norway)

Nutshell, in my institute (government setup) Elective surgery all types including oncology surgery is not allowed so endometrial cancers, early ovarian cancers are being operated in Private set up. The number has decreased significantly. Patients go to general gynecologists for operation and do not come to Govt hospital for the fear of COVID-19 patients in govt hospitals. (Gynecologic Oncologist, Community Hospital, Suburban Pakistan)

Basically, all services for gynecologic oncology patients were cancelled due to the COVID-19 including elective surgeries, chemotherapy, radiotherapy and outpatient clinics. 😔 (Gynecologic Oncologist, Academic Medical Center, Urban Philippines)

Unprecedented situation highlighted lack of readiness for an outbreak (Gynecologic Oncologist, Community Hospital, Suburban Philippines)

We are early in the pandemic and are awaiting the system to be flooded with COVID-19 cases. We think the situation with regards to cancer treatment will be affected then. (Gynecologic Oncologist, Academic Medical Center, Urban South Africa)

We are in the early days of the local epidemic; things are bound to change significantly. (Gynecologic Oncologist, Academic Medical Center, Urban South Africa)

We were still very anxious and stressed even though the impact to us was not as much as to other nations around the globe. (Gynecologic Oncologist, Academic Medical Center, Urban Taiwan)

Still waiting for cancer surgery (Gynecologic Oncologist, Community Hospital, Urban Thailand)

Following guidelines published by IGCS in their editorial by Pedro Ramirez. (Gynecologic Oncologist, Academic Medical Center, Urban United Arab Emirates)

For the first month surgical activity was severely impacted with only virtually all our activity focused on COVID-19. After a month the number of COVID-19 cases fell and we then increased our cancer activity. The number of suspected cancer referrals has dropped dramatically though so not seeing so many cases. (Gynecologic Oncologist, Academic Medical Center, Urban United Kingdom)

We have moved surgery from the main hospital to a satellite hospital with no COVID-19 cases and dedicated ICU beds which has sustained supply. (Gynecologic Oncologist, Academic Medical Center, Urban United Kingdom)

As teleconference increases safer platforms should be considered (e.g. Zoom) (Gynecologic Oncologist, Community Hospital, Urban United States of America)

I am a Pathologist. We have had to focus a lot on providing and rationing testing for patients and health care workers. (Pathologist Academic Medical Center, Urban United States of America)

While my concerns about personal exposure to COVID-19 during cancer care are low, my risks of exposure during redeployment to COVID-19 units is high. I suspect many surgeons have been redeployed to other units. For patients, I have had several patients choose to delay cancer care despite the hospital having capacity to perform elective cases out of concern for infection. (Gynecologic Oncologist, Academic Medical Center, Urban United States of America)

We just have 2 Cancer Hospitals in Caracas Venezuela, and they just evaluated COVID-19 patients with cancer, just that. (Gynecologic Oncologist, Academic Medical Center, Urban Venezuela)

Our institution is not doing any long cases, cases needing transfusion or premalignant cases. It's challenging especially for ovarian cancers where histo-pathological diagnosis is required before commencement of treatment. (Gynecologic Oncologist, Academic Medical Center, Urban Zambia)

## ABOUT THE SURVEY

The International Gynecologic Cancer Society (IGCS) conducted an International Survey of Gynecologic Cancer Care Providers from April 23 – June 1, 2020. The objective was to survey women's care professionals on the impact of the initial months of the COVID-19 pandemic on women's cancer care. IGCS distributed the survey directly to its members via email, social media and through the IGCS website.

Survey questions were prepared by Dr. Joseph Ng, Senior Consultant, Division of Gynaecologic Oncology, Department of Obstetrics & Gynaecology, Yong Loo Lin School of Medicine, National University of Singapore, and the National University Cancer Institute, Singapore. Dr. Ng is a member of the IGCS Council and serves as Vice Chair of the Mentorship & Training Committee.

The data analysis and executive summary was prepared by Dr. Li Min Lim, Associate Consultant, Division of Gynaecologic Oncology, Department of Obstetrics & Gynaecology, Yong Loo Lin School of Medicine, National University of Singapore.