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Adjusting for possible imbalances with respect to the minimisation factors, the differences for all three endpoints remain significant: freedom from immunosuppressive therapy (OR 4.60, 95% CI 1.97–10.75; $p=0.0042$); time to chronic GVHD (HR 0.55, 0.32–0.95; $p=0.031$); and overall survival (HR 0.49, 0.29–0.83; $p=0.0080$).

These results are very similar to our published findings and support our assertion that random assignment to receive anti-thymocyte globulin was the most important factor in influencing the favourable results.¹ We believe that the improved overall survival of patients treated with anti-thymocyte globulin was because of the specific dose and schedule of anti-thymocyte globulin given in our trial. The regimen we used was adapted from a case-control study² in which a survival advantage for patients treated with anti-thymocyte globulin had been shown. In addition, a simulation study³ found that this regimen resulted in a higher proportion of patients receiving an optimal exposure to anti-thymocyte globulin than two other recommended regimens. Nevertheless, as Admiraal and colleagues³ have shown, there is room for improvement so that even better schedules of anti-thymocyte globulin might be advised in future.

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*Irwin Walker, Tony Panzarella,
Gizelle Popradi
walkeri@mcmaster.ca

Juravinski Hospital and Cancer Centre (IW) and Department of Medicine (IW), McMaster University, Hamilton, ON L8V 1C3, Canada (IW); Division of Biostatistics, Dalla Lana School of Public Health, University of Toronto, Toronto, ON, Canada (TP); and McGill University Health Centre, McGill University, Montreal, QC, Canada (GP)

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Handling the COVID-19 pandemic in the oncological setting

We read with interest the Health Policy piece¹ by Remuzzi and Remuzzi regarding the COVID-19 epidemic in Italy. Italy is showing us how a developed country that has never tackled such a health-care problem in the last hundred years is handling this viral outbreak.

History shows us how epidemics have unfolded in similar ways.² However, several factors have changed in the past twenty years. For example, the Internet now helps us share information between health-care communities in real time, and social media can positively affect the public, by educating people and neutralising fake news. Additionally, personalised medicine can now be applied to epidemics. SARS-CoV-2 affects older patients and those who are immunosuppressed particularly badly.³ Patients with cancer are an example of how considering all people equal before epidemics could negatively affect those who are frail. In a report⁴ from Liang and colleagues, patients with cancer living in China had worse outcomes following infection with SARS-CoV-2 than the general population.

How can we protect the specific category of patients who require life-saving therapies to treat cancer? We suggest postponing all high-risk procedures that can be delayed (eg, chimeric antigen receptor T-cell

infusions), which avoids exposing patients who are immunosuppressed to high-risk procedures, and reduces the burden on the health-care system (particularly intensive care units), which are under severe pressure because of the high number of patients with COVID-19 who need treatment. If the procedure cannot be postponed, cancer centres in regions that are not affected (or are affected to a lesser extent) by COVID-19 should be identified and patients should be transferred. This option has been implemented in the Lombardy region of Italy. Rapid diagnosis of patients suspected of having COVID-19 should also be pursued. A report⁵ shows that 86% of people infected with SARS-CoV-2 remain undiagnosed, and this needs to be taken into account. Countries such as South Korea, Hong Kong, and Singapore implemented extensive testing from the early phase of the COVID-19 epidemic, which proved to be effective in controlling the spread of infection. This action preserved the function of their health-care systems. We can observe this difference from the lower case fatality rate of SARS-CoV-2 in South Korea than in Italy and Spain: 1% in South Korea, 8% in Italy, and 4% in Spain as of March 17, 2020.

For patients with cancer who do not need such intensive therapies, home-care options should be considered, such as telemedicine and mobile health-care devices. Moreover, remote monitoring could be a good option for follow-up for patients with COVID-19 who do not require hospitalisation. Close collaboration of the treating physician with infectious disease consultants is of paramount importance in this setting.

Considering the issues we are encountering in our countries, we advise the oncological international community to plan effective strategies in advance to protect this very specific category of patients who need life-saving therapies and who could be severely affected by SARS-CoV-2 infection.

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For case fatality rates see
<https://coronavirus.jhu.edu/map.html>

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***Alberto Mussetti, Clara Maluquer,
Adaia Albasanz-Puig, Carlota Gudiol,
Gabriel Moreno-Gonzalez,
Paolo Corradini, Anna Sureda
amussetti@iconcologia.net**

Clinical Haematology Department, Institut Català d'Oncologia-Hospitalet, Barcelona 08908, Spain (AM, CM, AS); Institut d'Investigació Biomèdica de Bellvitge (IDIBELL), Barcelona, Spain (AM, CM, AS); Spanish Network for Research in Infectious Diseases (REIPI RD16/0016/0001), Instituto de Salud Carlos III, Madrid, Spain (AA-P); Infectious Diseases Department (CG) and Intensive Care Medicine (GM-G), Bellvitge University Hospital, IDIBELL, University of Barcelona, Spain; Department of Clinical Oncology and Haematology, Fondazione IRCCS Istituto Nazionale dei Tumori, Milan, Italy (PC); and Department of Oncology and Onco-Haematology, University of Milan, Milan, Italy (PC)

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