COVID-19 Cancer Management Challenges – Using Virtual Tumor Boards
Webinar Logistics

• All participants are muted during the webinar

• Questions – including technical issues you may be experiencing – should be submitted through the question pane

• Questions will be answered as time permits; additional questions and answers will be posted on the website

• Please complete the post-webinar evaluation you will receive via email

• Recorded content will be posted on the ACS Cancer Programs web page within 24 hours
  https://www.facs.org/quality-programs/cancer
COVID-19 Cancer Management Challenges – Using Virtual Tumor Boards

Moderator:

**Heidi Nelson**, MD, FACS
Medical Director, ACS Cancer Programs

Participants:

**Craig Dulniak**, MPP | Cancer Service Line Administrative Coordinator, Abramson Cancer Center at the University of Pennsylvania, Philadelphia, PA

**Kelly Hunt**, MD, FACS | Professor & Chair, Department of Breast Surgical Oncology, Division of Surgery, The University of Texas MD Anderson Cancer Center, Houston, TX; Chair, ACS Clinical Research Program

**Timothy Mullett**, MD, MBA, FACS | Medical Director, Markey Cancer Center Network Development, Lexington, KY, Commission on Cancer Chair-Elect

**Lawrence Shulman**, MD, MACP, FASCO | Deputy Director for Clinical Services, Abramson Cancer Center at the University of Pennsylvania and Director of the Center for Global Cancer Medicine; Chair, Commission on Cancer
AGENDA

- Welcome
- Logistics of Arranging a Virtual Tumor Board Webinar
- Hosting Virtual Tumor Boards During COVID-19
- Hosting a Virtual Tumor Board Across Campuses
- Tumor Boards as Educational Opportunity During COVID-19 and Beyond
- Q&A with the panel
Virtual Tumor Boards in the Era of COVID-19

Craig Dulniak
Lawrence N Shulman

Abramson Cancer Center, University of Pennsylvania
Video Meeting Best Practices to Ensure Your Tumor Board is a Success – For Leaders/Moderators

• DO share the log-in information prior to the meeting.
• DO familiarize yourself with the virtual meeting platform.
• DO assign a moderator.
• DO consider acknowledging or introducing everyone who is on the call.
Best Practices to Ensure Your Virtual Tumor Board is a Success – Getting Started

• DO arrive early. Open any programs, images, or notes that you need for the tumor board.

• DO set up your devices prior to the meeting (speakers, microphone, and camera). Use a headset or earphones to avoid an echo.

• DO test your connection. Use a wired Internet connection instead of wireless when possible.

• DO minimize distractions. Close any computer programs and browser tabs that you will not use for the meeting. Be in a quiet place.

• DO consider your impression. Ensure you have a good camera angle and adequate lighting.

• DO close window shades behind you. Backlight from the sun can cast you in a shadow.
Video Meeting Best Practices to Ensure Your Tumor Board is a Success

• DO mute yourself when not speaking.
• DON’T use external speakers.
• DON’T use the speakerphone on mobile devices.
• If you hear your own voice echoing, it’s not you – it’s one of the other attendees.
Patient Name 1 & MRN

- Age 73
- Initial examination on 3/20/2020
- VAC breast clinic
- Suspicious lesion on mammogram and MRI
- MRI-guided core biopsy on 3/18/2020
- Stage IIA, T1N1M0, PR 100%, ER 100%
- Need for further evaluation and treatment planning

Patient Name 2 & MRN

- Background:
- Bilateral moderate breast MRI findings
- Left breast: 2.3 cm lesion
- Right breast: 2.8 cm lesion
- MRI-guided core biopsy on 3/18/2020
- Stage IIIC, T2N1M0, PR 100%, ER 100%
- Need for radiation therapy and further evaluation

Patient Name 3 & MRN

- Background:
- Clinical stage: T1N1M0, PR 100%, ER 100%
- Need for further evaluation

Patient Name 4 & MRN

- Background:
- Clinical stage: T1N1M0, PR 100%, ER 100%
- Need for further evaluation
59 y.o. female with changing pigmented lesion on her LLE. She lives in [redacted] and initially went to her dermatologist. Shave biopsy showed 0.32 mm “nevus or malignant melanoma.”

She had a Mohs surgery locally which showed residual melanoma with areas suspicious for microsatellitosis, MIS present at the peripheral margin (this was reviewed at HUP but the outside synoptic report called it a 1.6 mm, nonulcerated, SSM with 2 mit/mm²). She was then referred to a local surgeon who ordered Castle Bioscience test (results pending) and was told this would “predict her recurrence.”

She underwent wide excision and SLN biopsy with Dr. Karakousis which showed no residual melanoma and 0/2 nodes. PET-CT showed mildly avid peripancreatic node which she wants to watch.

Please review pathology from Mohs and discuss stage/microsatellites and plan for surveillance vs. adjuvant therapy.
Virtual Tumor Boards and COVID-19

• At Penn:

  • All disease groups charged with forming a COVID team
  
  • Disease teams create COVID-specific pathways for dissemination throughout the network
  
  • Disease teams create complete patient lists to track all patients whether treated by standard of care or alternative COVID pathways
  
  • Deferred surgeries, radiation, etc. detailed so patients are not lost to follow up and so we can plan for post-pandemic surge
Virtual Tumor Boards and COVID-19

• Tumor boards more important than ever – frequency may increase

• Multi-disciplinary nature of tumor boards more important than ever

• Discussions turned from nuances of patient care to acceptable approaches in the face of infection risk and resource constraints

• Oncologists more secure in recommending alternative approaches knowing they are supported by multi-disciplinary teams

• Patients feel better knowing alternative approaches discussed and agreed upon by multi-disciplinary team
Virtual Tumor Boards and COVID-19

• Greater participation internally as well as from network sites

• Participation more active

• COVID-19 has forced us to re-think the way are used to doing things

• Dynamics good – best with individual videos – “connection” and “body language”

• What will the “new normal” be after the pandemic?
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Hosting a Virtual Tumor Board Across Campuses

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Leveraging Community Tumor Boards for Oncology Trial Dissemination
ACS Clinical Research Program Dissemination & Implementation Committee
Investment in Dissemination & Implementation

NIH Research Funding
- Research: $30 billion
- Dissemination & Implementation: $270 million

Swanson, Washington Post, Feb 11 2015
Balas and Boren, 2000
www.nih.org
Alliance ACS CRP D & I Committee

• **Chairs:** Sarah Blair & Diana Dickson-Witmer

• **Goals:**
  • Develop strategies to disseminate trial data
  • Design implementation research programs for cancer guidelines
  • Collaborate with CoC to disseminate and implement standards based on clinical trials
  • Investigate novel approaches to hasten and broaden uptake of practice changes
Tumor Board Video Study

- Show support for practice change from Alliance, ACS & CoC
- Disseminate trial data:
  - Accurately
  - Reflects multidisciplinary perspective
- Facilitate discussion that relates the data to the local community
  - Accounts for local resources & patient population
- Social reinforcement of practice change
  - “Everyone is in”
  - Leverages Tumor Board setting to reinforce
Why Use a Tumor Board?

- Infrastructure in place
- Multiple stakeholders in a single setting
- Viewed as a quality activity
- Discussion impacts patient care:
  - Treatment plan changed in 40% of cases\(^1\)
  - Increases compliance with national guidelines\(^2\)
- Visibility & social reinforcement of practice change
- Patient treatment is discussed and agreed upon by the group

\(^1\)Brauer et al. *HPD (Oxford)*. 2017
A Case Study: ACOSOG Z1071

Focused on clinically node positive breast cancer patients

Often get neoadjuvant chemotherapy

40% will convert to node negative

Standard has been complete axillary node dissection

- Identifying those that had converted to negative problematic

Hypothesis: Sentinel node dissection can reliably identify patients who achieve a nodal pCR and might not benefit from extensive surgery

Boughey et al. JAMA, 2013
**Trial Design**

cT1-4 N1-2 invasive breast cancer

↓

Neoadjuvant Chemotherapy

↓

SLN and ALND

*Endpoint: Compare SLN pathology to the remaining axillary nodes (FNR)*

Boughey et al. *JAMA*, 2013
## SLND for Clinically Node Positive Patients

<table>
<thead>
<tr>
<th></th>
<th>ACOSOG Z1071&lt;sup&gt;1&lt;/sup&gt;</th>
<th>SENTINA (Arm C)&lt;sup&gt;2&lt;/sup&gt;</th>
<th>SN FNAC&lt;sup&gt;3&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nodal Eligibility Criteria</strong></td>
<td>cN1-2</td>
<td>cN1-2</td>
<td>cN1-2</td>
</tr>
<tr>
<td></td>
<td>*Endpoints reported for cN1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Biopsy required to confirm metastases?</strong></td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Number of Patients</strong></td>
<td>cN1=603</td>
<td>592</td>
<td>153</td>
</tr>
<tr>
<td></td>
<td>cN2=34</td>
<td></td>
<td></td>
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<tr>
<td><strong>SN Identification Rate</strong></td>
<td>92.7%</td>
<td>87.8%</td>
<td>87.6%</td>
</tr>
<tr>
<td><strong>Overall FNR (No IHC)</strong></td>
<td>12.6%</td>
<td>14.2%</td>
<td>13.4%</td>
</tr>
</tbody>
</table>

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<sup>1</sup>Boughey et al. JAMA, 2013  
<sup>2</sup>Kuehn et al. Lancet Oncology, 2013  
<sup>3</sup>Boileau et al. JCO, 2015
Alliance Tumor Board Video

Change Package – ACOSOG Z1071

- 10 minute video featuring surgical PI and Radiation Oncology collaborator
- Discussion guide to facilitate discussion about the trial in a local environment
- Summary statement that could be distributed to other clinicians in the community
Data collected

- Survey given to tumor board members before the video
  - Knowledge question
  - Acceptance of Z1071

- Survey given to tumor board members after the video

- Survey sent to 4-5 key stakeholders in each community
  - Organizational readiness for change
  - Feedback on package
Results

Identified Correct FNR

- 22% Pre-Video
- 65% Post-Video

Reported They Were Unfamiliar with Trial

- 46% Pre-Video
- 3% Post-Video
Results

Would Offer SLND to a Majority of Patients

47% Pre-Video
68% Post-Video

Would Never Offer SLND

17% Pre-Video
8% Post-Video
Conclusions

• We cannot rely on passive diffusion of clinical trial data
• Marketing (dissemination) is as important as development!
• Communities were open to change package concept
• Using Tumor Board setting leverages existing local infrastructure
• Video impacted knowledge about the trial and perception of trial data (should we do this?)
Next Steps

• The Z1071 tumor board video can be accessed on the ACS e-learning website.

Abigail Caudle, MD MS
University of Texas MD Anderson Cancer Center

• Borderline resectable pancreas cancer video pilot available soon.
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