We read the article “Radiation for Glioblastoma in the Era of COVID-19: Patient Selection and Hypofractionation to Maximize Benefit and Minimize Risk” with great interest. We suggest caution interpretation of recommendations for very poor PS (KPS<50) subset.
Radiation for Glioblastoma in the Era of COVID-19

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We read the article “Radiation for Glioblastoma in the Era of COVID-19: Patient Selection and Hypofractionation to Maximize Benefit and Minimize Risk” with great interest. We congratulate authors for drafting guidance for selecting glioblastoma who would benefit from hypofractionated radiation (RT) in the era of COVID-19.

The authors suggested elderly glioblastoma (aged ≥65 years) should strongly be considered for hypofractionated RT regimens, 40 Gray (Gy)/15 fractions (Fr). For patients with very poor PS (KPS<50 i.e. ECOG 3-4), palliative regimens authors recommended of either 34 Gy /10 fractions, 25 Gy /5 fr or TMZ with the omission of RT and suggested each supported by prospective trial data.

We suggest a cautious interpretation of recommendations for a very poor PS (KPS<50) subset. We want to highlight these referenced landmark studies did not represent patients with very poor PS. The IAEA trial included patients of age 50 years and KPS of 50-70; elderly and frail age 65 years and KPS of 50-70; elderly age 65 years and KPS of 80-100. With a median OS of 7.9 months with 25Gy/5Fr compared to median OS of 6.4 months with hypofractionated RT 40Gy/15Fr there was no survival difference.

Similarly, Nordic trial studied patients of age 60 years and above with WHO performance scores 0–2 (even if neurological deficits gave them a performance score of 3). Importantly, 78% of patients in this study had ECOG of 0-1. Although temozolomide alone is an appropriate option in individuals over 60 with ECOG 0-2, its use in the current pandemic requires careful attention. The temozolomide alone had a higher risk of neutropenia (12%), thrombocytopenia (21%) and infection (19%). In the current scenario, as temozolomide induced immunosuppression could increase the risk of contracting COVID-19. Thus recommendation of its use in patients with poor PS (KPS<50) deserves extreme caution.
We recommend best supportive care or an ultra-short course IAEA regimen may serve as a better option for poor PS patients, in the current COVID-19 times.

References:


