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An Oncologist's Perspective from Seattle, Epicenter of America's First COVID-19 Outbreak

Dr. Birnholz:
From the ReachMD studios, this is COVID-19: On the Frontlines. I'm Dr. Matt Birnholz. Joining me today to share an oncologist's perspectives from Seattle, epicenter of the first American outbreak of COVID-19, is Dr. Gary Lyman. Dr. Lyman is a Professor of Medicine in the Division of Oncology at the University of Washington, and Senior Lead of Health Care Quality and Policy at the Hutchinson Institute for Cancer Outcomes Research in Seattle.

Welcome to you, Dr. Lyman!

Dr. Lyman:
It's a pleasure to join you.

Dr. Birnholz:
To start us off, Dr. Lyman, can you share with us some updates from your base in Washington?

Dr. Lyman:
Well, COVID-19, of course, was first identified in a US patient here in Washington. In fact, I'm sitting here in Kirkland, Washington, just outside of Seattle, where the first case was identified in a long-term care facility about 2 miles from here. Since then, of course, the number of cases has grown considerably in Washington State. Fortunately, for the last 2 to 3 weeks, largely at the Governor's urging, a lot of social distancing and protective measures have been put in place, so we are starting to see some lessening in the daily increase in cases which we think is the result of the efforts of the health department, the governor and the university as well as, of course, regular citizens to adhere to these enforced recommendations to stay at home as much as possible social distancing, of course a lot of hand washing and the common sense measures to avoid people who are ill or if you are ill to stay indoors and not infect others.

So I think the good news here—although we were the first with cases and the number of deaths rose very quickly because of the nursing facilities, the long-term care facilities that were extensively infected before all this was recognized—we were also the beneficiary of a research project going on at the University of Washington focused on the common influenza infection that comes every season but they identified in late January, early February something else was going on, and of course that led to the identification of the first case of COVID-19 in the United States and allowed us to begin to investigate that very early on.

Of course, we do have still a crisis here, in terms of hospital beds, ICU beds and ventilatory support. We currently have around 50 cases of COVID-19 within our hospital system and more than 30 patients in the intensive care unit, so we also have quite a profound effect here but the indication is that the number of new infections has started to slow, and the modeling would suggest out of the university that the peak of our infections has been delayed. It's been pushed back probably 3 to 4 weeks, and it's been flattened somewhat, so we will not see as many cases as we had originally projected, and they'll come somewhat later than originally anticipated, which means, hopefully, that the healthcare system will be able to handle this with additional beds and ventilators that we've requested. It was bad news to begin with. It's still bad news, but we do think we're seeing trends toward improvement.

Dr. Birnholz:
And focusing specifically on the Hutchinson Institute, how has the COVID-19 pandemic affected operations at your oncology center?

Dr. Lyman:
Well, the cancer center here is a consortium that includes the Fred Hutchinson Cancer Research Center, the Seattle Cancer Care Alliance—this is where outpatients receiving cancer therapy are managed and the University of Washington Medical Center where, if

they need to be hospitalized for emergent care or intensive care unit care, they are hospitalized at the medical center, but it's all one consortium, and it has been a fairly consistent and organized approach to COVID-19. Currently when patients come for treatment, if they require cancer treatment, they are screened at the door in terms of exposures, symptoms, and temperature, and if there's any indication that they might be infected based on that screen, they are immediately tested. Now, that capability is not available everywhere but again, fortunately, we've developed both in-house testing and commercial testing to allow us to test patients who again have either symptoms or exposure or an elevation in temperature. If they test positive, of course they are quarantined; they are isolated to protect others. If there's no indication, then they come in.

We are using, of course, protective measures for the staff, and we have had infections within the staff. We're trying to prevent that as much as possible with PPE, personal protective equipment, and so far, that's been, available, although our peak is yet to come, as it is in most centers throughout the country. That peak is gonna probably come later in April so, we're still anticipating there may be, some stressing of the availability of all these personal protective equipment as well as beds, intensive care unit facilities and ventilatory support. So we're not out of the woods yet by any means, but there is a structured, unified approach to managing patients.

Also, we have asked providers oncologists, radiation therapists and surgeons, that if a patient doesn't need to undergo treatment right now, if there's an opportunity to delay treatment or to put them on a different kind of treatment like hormonal therapies that they do that and put off chemotherapy, for instance, which we know can further suppress the immune system and may well—at least the data out of China and now out of Italy would suggest that cancer patients going through treatment are at higher risk of contracting the COVID-19 infection and at higher risk of serious complications if they do get the infection, so more likely end up in intensive care units and a higher mortality rate. So, when treatment is not urgent, we encourage delaying it. If it is urgent, then we are also recommending aggressive supportive care for these patients, whether it's efforts to minimize the immunosuppression or the fall in blood counts. If it's additional protective measures that need to be imposed, we're encouraging that patients undergoing cancer treatment wear a mask when they're out if they have to be out but go out as little as possible except for their medical appointments so there is a systematic approach but again, the worst is probably yet to come, and we're trying to be prepared for that time.

Dr. Birnholz:
And Dr. Lyman, given your vantage point as an oncologist, what are some of the special considerations you and your colleagues have needed to take toward COVID-19 inparticular? Have any other adjustments been made at your institution, for instance?

Dr. Lyman:
Well, there certainly have been adjustments. In addition to the screening that I mentioned as patients come along, we have been very busy reorganizing, putting on hold elective surgeries to free up surgical beds to become intensive care unit beds for the growing need for intensive care. We are again putting off treatments if they are elective, whether it be surgery or other cancer therapies or look for alternative therapies. This is a very stressful situation, not only on patients wondering how vulnerable they are and whether they'll get through this but also on the staff, that none of us were prepared or trained for this kind of experience. We're trained to deliver care under the usual circumstance where each patient is managed in a routine fashion. Here, we're stressed both because our patients are exceptionally vulnerable because of their treatment, their immunosuppression, their older age, the fact they have other illnesses in addition to the cancer. At the same time, we're putting ourselves at risk, and the provider has to worry about their own health, but for many of us even more importantly our family when we go home at night or interact with, people in the community. We're doing the best we can to make sure we don't carry that virus home and expose others. So, it's a very stressful situation.

We have just issued a call to bring some retired doctors back into service because of the need to increase the number of personnel caring for patients in general, including cancer patients. That's a 2-edged sword because many of the retired, workforce, of course, are older, some have other conditions, so they also may be somewhat more vulnerable than the younger workforce. Programs are in place to help with counseling and support of the medical staff but as I said, we're all in this together. We will get through it. We wanna make sure we get through it, with the least of a bad outcome we can deliver for both patients and our colleagues.

Dr. Birnholz:
To that end, Dr. Lyman, what other barriers have you and your colleagues faced, and are there any pressing needs in particular that you're currently working through?

Dr. Lyman:
Well, there's been, not just here but in many places, but we're not immune to it either, the lack of protective equipment and a limitation on the number of ventilators to deliver, ventilatory respiratory support if it's needed. So, again, the governor has made appeals for additional equipment from the national stockpile and has only gotten a small proportion of what's been requested, but I hear that's been true in other parts of the country as well. We were originally scheduled to have one of the military hospital ships come here but because of the crisis in Los Angeles, it has gone there, so at the moment the military has set up another additional hospital, and there will

probably be others, being built in facilities, athletic fields, and other facilities here being converted into hospital beds, and these are primarily for patients without the COVID-19 infection but are occupying beds in our main hospitals. By moving those patients to these new ancillary facilities, that will increase our bed capacity for COVID-19 patients that we are anticipating over the next 2 to 3 weeks, so all this kind of reshuffling.

So again, adding beds, intensive care facilities, more ventilators are still being requested—and again, that protective equipment which is so critical to keeping doctors, nurses, support staff safe so they don't get the illness themselves and they also are able to continue to work and take care of our patients.

Dr. Birnholz:
And concerning some of these challenges, what strategies have you or your colleagues implemented to help address them, and have they had an impact so far?

Dr. Lyman:
Well, I think the most important thing and the entire country was behind the curve in terms of testing. Again, as I indicated earlier we began testing very early on, almost by accident because we were running studies of the Spanish influenza, seasonal epidemic and identified this very early, and then we began to ramp up testing, even though the Centers for Disease Control had incredible difficulty with their testing and it took many weeks to begin to resolve that. Even now there is not nearly enough testing going on anywhere, including here, although we are better than most areas.

Testing lets you know how big the problem is, where the problem is, and where you need to focus your resources, so that's critically important. Then with proper isolation, social distancing, and identification of exposures so that you can isolate individuals who are potentially infected, all those efforts again here seem to have started to work, and we're hoping that if there's strict enforcement. We're actually calling for a national concerted effort for the next few weeks to just minimize the contagion and minimize the spread of this infection and minimize the opportunity for the virus to far exceed the capacity of the health systems that deal with it. I think here, we're probably better positioned than many, but time will tell if we've really done enough, and we're continuing to try to do more. I can't praise the healthcare providers enough who are on the front lines putting themselves at risk, maybe even their family at risk. They're all working overtime and doing an incredible job, but again, the worse is yet to come here, as in most communities.

Dr. Birnholz:
And on the flipside, have any clinical or administrative strategies adopted within your area been downright detrimental to patient care?

Dr. Lyman:
Well, you know, certainly isolation, protective measures have a downside, and that is they, of course, separate deliberately the doctor and the nurse from the patient wearing masks, being on a ventilator of course. You know, a number of patients have gone on to die from this, and they often are dying without their family around. That's done deliberately because we don't want those family members becoming infected and further spreading the infection, but it's a dire consequence of the measures we've been forced to take to reduce the risk of infection and spread of infection throughout the community. But at the moment there doesn't seem to be a safe way to do it any other way, but that's the necessary evil that comes with the protective measures that we and others have been forced to take to rein in this, epidemic.

Dr. Birnholz:
Lastly, Dr. Lyman, what lessons have you learned along the way that you want to pass along to our listeners?

Dr. Lyman:
Well, I think the biggest lesson is here we can never get complacent, whether it's as a country, a region, a state, or as a healthcare institution. We need to be prepared for this. We had a similar pandemic over 100 years ago. Of course, none of us lived through that at that time, and I think we grew increasingly complacent, and this pandemic has taught us a lesson. We are a global community, and the opportunity for a more lethal virus and more contagious virus to emerge in one part of the world and then spread so rapidly to the rest of the world is very real.

So, while it's taken over 100 years since the last true pandemic, I don't think it's gonna be another 100 years until the next one comes along.

Dr. Birnholz:
Well it's a sobering reminder, but an important one to take away from our conversation today. I want to thank my guest, Dr. Gary Lyman, for joining me to offer his perspective as an oncologist near the nation's point of origin for COVID-19 in Seattle. It was great speaking with you today, Dr. Lyman, and our best wishes and support to you over there.

Dr. Lyman:
Thank you very much.

Dr. Birnholz:
For ReachMD, this is COVID-19: On the Frontlines. For continuing access to this and other episodes, and to add your perspectives toward the fight against this global pandemic, visit us at ReachMD.com and become Part of the Knowledge. Thank you for listening.