



Letter to the Editor

SARS-CoV-2 Infection in Patients with Lung Cancer: Current Clinical Context[☆]



Situación clínica de infección por SARS-CoV-2 en pacientes con carcinoma broncogénico: contexto actual

To the Editor

Since the onset of the global SARS-CoV-2 coronavirus infection pandemic in early December 2019, the associated disease, Covid-19, has become a public health problem of unknown magnitude for the scientific community.¹ The rapid spread of the infection has caused not only a situation of alarm but has made us reflect deeply on the health of our patients with respiratory diseases. We are referring in particular to patients with lung cancer (LC).

Despite the extraordinary advances that have been made in recent weeks,² numerous questions remain to be answered, one of the most pressing being the impact of the disease on patients with cancer in general and with LC in particular.

The most recent information³ suggests that patients with Covid-19 and cancer often have an increased risk of adverse events. This series included 18 cancer and Covid-19 patients selected from a Chinese cohort of 2007 cases, of which 5 (28%) had been diagnosed with LC. The risk of adverse events, ICU admission, or death was 3-fold in cancer patients compared to those without cancer (HR: 3.56; 95% CI: 1.65–7.69). This increased risk may be explained by several factors that include increased susceptibility to infection as a result of the oncological process and the suppression of the immune response by the cancer treatment (antineoplastic agents or surgery). The authors found no differences in the risk of outcomes between patients with LC and those with cancer in another site. In addition to the increased risk of fatal outcomes in patients with Covid-19 and cancer, the older age of this population must also be taken into account, as must the coexistence of cardiovascular and respiratory comorbidities such as COPD that increase the risk of death.

A retrospective review⁴ recently reported 2 patients who underwent pulmonary lobectomy for LC and were subsequently found to be infected with SARS-CoV-2. The histological report revealed that, apart from the tumor findings, both patients presented edema, proteinaceous exudate, focal reactive pneumocyte hyperplasia with irregular inflammatory cell infiltration, and multinucleated giant cells, similar to *post-mortem* findings in patients with Covid-19.

Therefore, it has been proposed that in patients with lung cancer and Covid-19, treatment with antineoplastic agents or surgery should be temporarily postponed, greater emphasis should be placed on personal protection, and symptoms should be closely monitored so that treatment can begin promptly.⁵

These are all key aspects in thoracic oncological disease and suggest the need for clinical practice guidelines or recommendations for the management of patients with these 2 entities. Certain questions are also raised that will need to be answered shortly: do these patients have an increased risk of reinfection? does Covid-19 modify the natural history of lung cancer? what are the logistical consequences of the infection in these patients?

In the meantime, we will have to urge our patients to take note of that catchphrase from the famous 1980s television series: "Let's be careful out there."

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