United States Cutaneous Lymphoma Consortium recommendations for treatment of cutaneous lymphomas during the COVID-19 pandemic

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Evidence suggests that patients with malignancy[1] and older age have a higher risk of severe events including death[2,3] due to COVID-19.[4] Patients with primary cutaneous lymphoma tend to be older and to receive immunosuppressive therapy long term for disease control. Because both the cutaneous lymphoma and the type of immunosuppressive treatment can contribute to the development of more severe complications from COVID-19, we propose strategies for treating patients with primary cutaneous lymphomas by dividing both into low-, intermediate-, and high-risk categories (see recommendations for individual therapies in Supplemental Table I; available via Mendeley at doi:10.17632/7f3jvhw74s.1).

Abbreviations used:

MF: mycosis fungoides
PC: primary cutaneous
UV: ultraviolet

CUTANEOUS LYMPHOMAS

Low risk

Pagetoid reticulosis, acral $CD8^+$ T-cell lymphoma, $CD4^+$ pleomorphic small/medium T-cell lymphoproliferative disorder, lymphomatoid papulosis, and mycosis fungoides (MF) stage IA, MF stage IB (patch only or limited body surface area), primary cutaneous (PC) marginal zone or PC follicle center B-cell lymphoma.

Intermediate-low risk

Primary cutaneous anaplastic large cell lymphoma, folliculotropic MF, granulomatous MF, granulomatous slack skin, MF stages IB (extensive patches/plaques) and IIA (reactive lymphadenopathy), subcutaneous panniculitis-like–cell lymphoma.

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Intermediate-high risk

MF stages IIB (tumors) and III (erythrodermic), PC diffuse large B-cell lymphoma (not leg type).

High risk

Sézary syndrome; MF stage IV or transformed; primary cutaneous gamma-delta T-cell lymphoma; $CD8^+$ aggressive epidermotropic cytotoxic T-cell lymphoma; extranodal natural killer/T-cell lymphoma; PC diffuse large B-cell lymphoma, leg type.

THERAPIES

Low risk

Topical retinoids, mechlorethamine gel or ointment, topical steroids with or without occlusion, imiquimod, home narrowband ultraviolet (UV) B phototherapy, heliotherapy, oral antibiotics, oral antipruritics, dilute vinegar or bleach soaks/baths, and aggressive moisturization.

Intermediate risk

Oral retinoids (bexarotene, acitretin, isotretinoin), methotrexate, oral steroids, vorinostat, and interferons (alpha or gamma).

High risk

Pralatrexate, romidepsin, mogamulizumab, brentuximab, gemcitabine and other chemotherapies. Skin radiotherapy, photopheresis, and office-based UV therapy are high risk because of travel.

Low-risk therapies that can be used at home should be continued for all patients. The risks of travel and exposure likely outweigh the benefit of in-office treatments such as UV light therapy and total body electron beam radiation therapy. Home-based narrowband UVB phototherapy and heliotherapy can be continued or initiated. For patients with low-risk disease, only low-risk therapies are recommended.

Intermediate-risk therapies may be continued, but dose adjustments may be advised on an individual basis. The least frequent laboratory monitoring possible should be performed to limit exposure while ensuring patient safety. Initiation of these therapies may be postponed using low-risk bridge therapies in the short term. Increase in or initiation of a retinoid or interferon should be considered in cases that necessitate the removal of other high-risk therapies.

High-risk therapies, in addition to their inherent risks, may require travel to the clinic or hospital. These should be used only in the highest-risk patients, and the additional risks of therapy-related travel should be considered. Infusion regimens may be adjusted to increase treatment intervals. Romidepsin and mogamulizumab may be considered on an individual basis with extended intervals and lower doses. Allogeneic stem cell transplant and treatment with cyclophosphamide, hydroxyrubicin, vincristine, prednisone (CHOP), alemtuzumab, and fludarabine are strongly discouraged during the pandemic because they often lead to significant cytopenias that are known risk factors for COVID-19 complications.[2,3] Consider alternative lower-risk therapies whenever possible.

Telemedicine visits should be used to avoid unnecessary exposure, except for critical in-person evaluation and/or therapy. We must dynamically adjust treatment plans to provide optimal care for our patients with lymphoma while protecting them from COVID-19 complications.

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