

A Word from the President



Dear members and other friends of NSGO,

Our world looks very different now, in June 2020, than it looked in the beginning of 2020. When we met in Oslo at our Annual meeting in the beginning of March, we already started to experience some effects of the coming Corona -virus pandemic: travel restrictions were issued, and events for Spring 2020 were cancelled. What we did not completely understand then, was how strongly and for how long this pandemic would influence our societies. While I am writing this, we have just received information that ESMO 2020 in September will be a completely virtual meeting, and it seems that the whole of 2020 will be heavily affected by the pandemic.

In NSGO, we are hoping that the planned Investigator meeting in the end of November will take place as an on- site meeting. Our plan for the next Annual meeting (March 10.-12., 2021 in Helsinki) are ongoing. The themes for

the next annual meeting will be Cervical cancer, New diagnostic and therapeutic methods, Quality and patient perspective.

The other activities of NSGO, such as the Surgery Group Workshop, have been put on hold temporarily - we will get back to these with a new situation check after Summer holidays.

The online resources of various professional societies, such as ASCO and ESGO, provide good information on how to manage cancer patients during this pandemic, and scientific research on the topic seems to be active. I wish you all strength and endurance in your important work for our patients, but also relaxing moments in sunny and summery conditions - probably not too far from your homes.

Annika Auranen

president NSGO



Nordic Society of Gynaecological Oncology

**NSGO Annual Meeting
10-12th of March 2021**

Hotel Hilton Kalastajatorppa, Helsinki

A Word from the Editor

Dear NSGO members and friends,

I take this opportunity to thank you all, both participants and organizers, for attending the annual NSGO meeting in Oslo. Amazingly, we managed to conduct this meeting right before lockdown. I hope that you found the meeting both interesting and useful, that you enjoyed the program and social activities, but also had a chance to explore wonderful Norwegian nature.

Our colposcopy pre-course, organized by Ameli Trope, was the only possibility to learn colposcopy “life” this year. Thank you, Ameli, for your support!

I have asked my colleagues from the different Scandinavian countries to describe the situation concerning NSGO activities and clinical activities during Covid-19 pandemic. I hope you will find it interesting to read about Norwegian situation.

Hopefully the coronavirus situation will soon be under control so that we again will have the possibility to meet each other in real!

Olesya Solheim, Oslo

Gynecologic cancer care in Norway during the COVID-19 pandemic

The first case of coronavirus infection in Norway appeared at the end of February and two weeks later, the country closed down with the strictest emergency measures since World War II.

Early reports from intensive care departments in Italy were important wake-up calls throughout

the hospital hierarchy. In addition to increased testing and intensive care facilities, the main task, was to keep the coronavirus from gaining a

stronghold in the hospitals. Thus, the prevention of not-so-sick COVID-19 patients flooding the hospitals was paramount to stop the specialized health care system from collapsing.

The Norwegian health care system’s first line of defense is the general practitioners. Through their 24/7 primary care emergency services usually located (far) away from hospitals they function as the gatekeeper to hospital admissions.

All patients who did not have to go to a hospital were advised to stay at home, while

those who had to visit outpatient clinics or be admitted were thoroughly questioned about possible symptoms before they were let into the hospital. Cancer work-up and surgery were prioritized in order to be ahead of a COVID-19 peak. Friends and family were not allowed to accompany or visit their loved ones.

The aforementioned drastic restrictions included border control and travel bans and closing all kindergartens, educational institutions, theatres, cinemas, gyms, public events. A strict regimen of 14 days quarantine after unprotected exposure to COVID-19 patients, persons returning from abroad, or display of COVID-19 symptoms forced several hospital departments to send scores of workers home.

Due to the extent of the quarantine rules, and the potential impact of an outbreak in hospital departments, many hospitals re-organized their workforces. For example, in order to ensure a pool of healthy doctors, some hospitals ordered doctors to work from home performing phone

and video consultations or administrative tasks, while a few doctors stayed in the hospital performing only essential patient-related work.

COVID-19 affected patient treatment in many ways, including the following:

- Legal treatment deadlines for (cancer) patients were deferred
- All non-cancer, non-urgent treatments were reduced to a bare minimum
- The national dysplasia programme “CervicalScreen Norway” stopped sending out reminders to women, in order to reduce the workload for general practitioners
- Chemotherapy:

Primary treatment was prioritized as other (surgical) treatments came to a grinding halt

Thorough selection of patients for treatment of recurrent disease

- Radiotherapy continued as planned
- Clinical studies were put on hold
- Phone/video consultations replaced outpatient clinic visits

Practically every branch of the «Official Norway» worked around the clock to mitigate the impact of both the virus and the consequences on society from the anti-viral efforts. Crisis leadership groups at every administrative level developed new (and updated existing) preparedness plans at record speed. In-person meetings with physical attendance were cancelled and moved to computer-based platforms like Skype, Zoom, and Teams.

Conclusion and key lessons

A relatively low number of confirmed COVID-19 cases (8.600) and a common effort to follow guidelines and obey restrictions, contributed to an early “flattening of the curve”.

Most of our hospitals never reached very far in terms of admitted COVID-19 patients. To our knowledge, no gynecologic cancer patients have been diagnosed with COVID-19, and the reduction of planned surgeries influenced gynecologic cancer patients only to a minor extent.

As of June 18, fewer than 250 people are confirmed dead from COVID-19. Society is gradually returning to its normal pace, after 3 months of pervasive infection control measures.

A leading philosophy in hospital and health-care logistics planning has been not to have a large stock of anything, including personal protective equipment (PPE). Reliance on «just in time»-logistics, proved a vulnerable mindset, as international demand skyrocketed while both factories and supply chains shut down. COVID-19 has truly challenged this policy.

Current practices of in-person meetings and consultations were also challenged. CEO Grethe Aasved of St Olav’s hospital, Trondheim University Hospital reported that during just the first few weeks of the pandemic there was a 10-fold increase in video consultations compared to all of 2019. Without COVID-19, such a transition would have required years of planning. Both phone/video consultations and webinars are probably here to stay.

Hopefully the COVID-19 situation will force us to rethink the extent of the routine follow-ups after primary treatment. Time will tell if the change in evaluating indications for the treatment of recurrent disease persists.

Norway managed the first COVID-19 wave fairly well, though at significant financial and personal cost. However, it is important not to let a good crisis go to waste, and we believe we haven’t done so.

Johan Kippervik, St Olav's hospital, Trondheim University Hospital

Line Bjørge, Haukeland University Hospital and University of Bergen

The Finnish experience of COVID-19 pandemic and its effect on cancer patients

The actual spread of the Corona-virus in Finland started in the beginning of March, when people who had been on ski holidays in Northern Italy and Tyrol returned home and started to fall ill. Very rapidly, on March 12th, the Finnish Government instituted the Powers of Emergency Act, which gave the government more powers to issue restrictions, such as closing of restaurants and cafes etc and banning meetings of more than 10 people. People over 70 were instructed to restrict contacts and go to a quarantine-like living. The hospitals were demanded to increase capacity for the treatment of infected people. This led to a rapid shut-down of much of the elective health care, but did not affect treatment of cancer patients with the exception of control visits, which were changed to virtual or telephone contacts. Everybody was instructed to work from home if possible, and the schools were closed and went to remote education around 16th of March. The strongest restrictive measure was closing the borders of the Uusimaa District (The Helsinki area with most infections) from March 28th to April 15th. The police inspected all people crossing the borders, and people were allowed to cross only if they had a good reason for this.

What happened in health care? Among other things, the hospitals started to train doctors and nurses for treatment of respiratory distress patients, and put patients with suspected or

known coronavirusinfection to separate wards and acute clinics (cohorting). Visitors were not allowed in hospitals. Fathers of pregnant mothers were only allowed in hospital premises at the time of active labor – and were not allowed to stay inside the hospital after birth. As for cancer treatment:

- Finnish oncologists started to have weekly skype-meetings around issues regarding coronavirus and cancer treatment, and national guidelines for treating patients under these circumstances were rapidly done for different cancer types. These weekly meetings went on from 16th March to the end of May.
- After a few weeks, when it was secured that there was a sufficient amount of PPE in stock, it became mandatory to wear PPE level 1 protection (surgical masks) in all contacts with cancer patients up to one year after chemotherapy
- A decision for the more liberal use of G-CSF was done – all patients on chemotherapy were instructed to use G-CSF as a precautionary measure.
- The patients were very anxious and worried in the beginning, and phone services and internet information was expanded for cancer patients regarding corona-virus. The National Cancer Organisation was active in this also. Recruitment for clinical trials was put on hold – recruitment was allowed to start again at the end of May

Some municipalities put screening for breast cancer and cervical cancer on hold – it is now allowed that this years screenings can be postponed but must be done by end of June 2021.

How did the outbreak actually go in Finland?

The peak with the infections was reached on April 6th (appr 200 new infections daily) from which the numbers steadily declined to 20-40 daily infections on June 1st. During the last 7 days, 51 infections have been diagnosed (appr 7 patients daily). On June 25th, the total number of laboratory diagnosed infections in Finland is 7167 and the number of deceased 327. On June 23th, 22 people in all Finland were hospitalized and 2 people were in intensive care.

The society is returning back to normal. The schools opened for the last 2 weeks of May, and restaurants and cafeterias opened on June 1st. The Powers of Emergency Act was lifted on June 15th, and gatherings of up to 50 people are now allowed. Travelling abroad is also gradually starting.

What did we learn – and what did we not do so well

We learned that our society can quite flexibly bend to all kind of situations, and that Finnish people seem to be very obedient. The teachers made a huge jump to distant education in one day, and the hospitals (at least my hospital Tampere University Hospital) worked with effective, professional, enthusiastic attitude and good spirit. The health crisis did not harm our health as much as we feared.

However, we have learned that social disparities have increased among children and youth, and problems inside the families have increased. Not being able to go to school has been harmful to many children. Also the elderly, who have been forced to stay home with social distancing, suffer from physical deterioration and depression. In health care, we are expecting a worsening of many non-acute conditions, as people have been avoiding contacting health services. The shut

down of elective health care has lead to deep economical deficits in the hospitals, as the

municipalities only pay for performed health care – nobody pays the costs of preparedness. The undone work is going to strain hospital resources for at least 2020 and 2021. The economy in Finland is of course very bad now, and the national loan is increasing as never before.

On the more absurd side, the happenings around our national officials trying to get masks and other PPE quickly led to very strange business deals with not-so-reliable parties and useless masks – and also resignations of top people in the Offices. In all, this exceptional Spring has shown us, that situations like global health crisis are very possible, and can have profound consequences to our society – only after years can we fully see the impact of these events.

Annika Auranen

Tampere University Hospital

Finland

The COVID-19 pandemic in Sweden

The first confirmed covid-19 positive case in Sweden was a young woman returning after a visit to Wuhan China, who tested positive on January 31. She was fully isolated and there was no report of further spread. In the end of February, following viral outbreaks in Italy, Austria and Iran, multiple travel-related clusters appeared in Sweden when about one million people returned home after spring break abroad. In the following weeks, disease control measures, including extensive contact tracing, diagnosed more than two hundred travel-related cases with connection to previously confirmed cases or travels to high risk regions. In the beginning of March, community transmission was confirmed in Stockholm, and contact tracing of the virus was stopped. From start, Stockholm saw a

significantly higher number of cases compared to other regions of Sweden. The first death in covid-19 was reported on March 11 in Stockholm. Unlike many other countries, including our Nordic neighbours, Sweden has not imposed nationwide lockdowns and curfews, but kept large parts of the society open. The Swedish public is instead expected to follow a series of non-voluntary recommendations from the Public Health Agency. Further on in the pandemic, the government was granted more authority for imposing restrictions, but believed that voluntary measures could be as effective as bans. The government banned gatherings of more than 50 individuals, banned visitors to nursing homes and closed secondary schools and universities. Primary schools have remained open, since the preventive effect of this lacks support by research or scientific literature, and because of expected negative effects on society. The Public Health Agency has issued recommendations to the society, including active social distancing, avoiding unnecessary travel within the country, working from home if possible, for people above 70 years or risk groups, staying at home as much as possible, and for those with only minimal symptoms of infection, staying at home. The Swedish strategy aimed at protecting its senior and vulnerable citizens and slowing down the spread of the virus to keep the health care system from getting overwhelmed.

Before the pandemic, there were only approximately 500 beds in intensive care units within the country. This was a great concern based on reports from Italy and Spain early in the pandemic, and much effort was put into increasing the intensive care capacity. In the middle of April, the number of available intensive care unit beds had been more than doubled to 1039 and field hospitals had been created in Stockholm, Göteborg and Helsingborg. The field hospital in Stockholm never had to be put into use,

and the Göteborg field hospital was used for intensive care during a very short time span. All through the pandemic, the intensive care units have had an occupancy of about 80%, and contrary to the initial concern, there has never been a shortage of intensive care beds.

The increasing number of covid-19 infected cases from March has resulted in cancellation or postponement of almost 50% of planned surgeries, including cancer-related surgeries, in all of Sweden, as well as other non-emergent treatments and health care visits. The cancer screening programs have been paused and many visits to outpatient clinics converted to digital meetings. Five months into the pandemic, almost 2500 people have been treated in intensive care units and more than 5500 people have died of covid-19 in Sweden. Unfortunately, and despite bans to visit nursing homes since April 1, more than 90% of all deaths have been in the age group 70 and above, and 50% have lived in a nursing home.

Stockholm has been greatly affected by the covid-19 pandemic with most infected cases in Sweden. All public hospitals in Stockholm have treated covid-19 patients, and ambulances have been directed to the hospital with available beds. Almost 50% of all covid-19 care in Stockholm has taken place at Karolinska and at most, 50% of all inpatient care at Karolinska was covid-19 care. To meet this demand, the hospital has increased the intensive care capacity with almost 500%, increased ECMO beds and hospital beds in general. Health care workers to care for covid-19 patients have been recruited from other specialties within the hospital, from external private clinics or new employees. The top of the curve was around April 15 when 431 patients were hospitalized at Karolinska, of which 132 were treated in an intensive care unit or ECMO. In the beginning of July, we counted a total of 16800 hospital care days and 6900 intensive unit care

days since the first case in March. More than 90% of all hospitalized patients have survived, and about 70% of all in need of intensive care.

Different specialties have been affected differently by the pandemic. Cancer treatments have been prioritized, and gynecologic cancer care has been almost unaffected, with the same operation capacity, actual performed surgeries and oncological treatments. Some of the surgical wards were converted to covid-19 care, but private caregivers accepted patients for postoperative care very rapidly, enabling us to keep up the patient flow. There has been no delay in the treatment of gynecologic cancer. However, the number of diagnosed patients, including advanced ovarian cancer patients, have decreased by almost 30%, probably because of patients' delay due to fear of covid-19. This may result in a much increased number of patients with gynecologic cancer after this summer. A positive effect of this pandemic, despite the much too high number of severely sick and deceased, is the unity of the society. This has manifested itself by many private initiatives; to make protective gear, masks and alcohol gel, to deliver food and goodie bags to health care workers, to go grocery shopping for old neighbours, to offer health care workers hair cuts at work, and many more very innovative examples. Large companies have, during the most intense period, also re-directed their production to produce protective gear and co-operated with hospitals and government agencies to import protective gear. Public and private health care have co-operated, with the private care givers supplying material and anesthetics to the hospitals and taking shifts at the hospitals. It has shown us that in times of crisis, solidarity between people is manifested.

Ulrika Joneborg Karolinska
Universitetssjukhuset/University Hospital,
Sweden

COVID-19 in Iceland and its effect on Gynecologic Cancer Care

The first case of Covid-19 in Iceland was diagnosed on the 28th of February 2020. In the beginning, most infections were diagnosed in skiers coming from the Alps but soon it became more widespread in the community, reaching its peak in late March. In the beginning of the pandemic all travelers from Italy and certain other designated high-risk zones were mandated to home isolation for two weeks. With time these high-risk zones were expanded and at the end of March further travel restrictions were imposed. Iceland's borders remained open the entire time, but travel was limited. The response to the pandemic was led by a task force of the Icelandic health authorities (not politicians). The Pandemic Task Force issued guidelines for the public and health care providers and held daily press conferences for at least 2 months, allowing the public to stay up to date. Generally people trusted these guidelines and cohered.

As in most countries the main focus of the Pandemic Task Force was to "flatten the curve" so that the health care system would not be overwhelmed. The response to the pandemic focused on early detection, rigorous contact tracing and social distancing measures, such as ban of gathering of more than 20 people and implementation of the two meter rule. This led to closing of secondary schools, restaurants, bars and large shops. Elementary schools remained open but with limited hours.

Thanks to the hospital laboratories and the help of the private company deCODE Genetics, the screening capacity was excellent. Covid-19 testing was focused on symptomatic people and those who had contacts with infected individuals. In addition, screening of the general population was conducted. This gave important data on which further guidelines were based.

In a short time the hospitals increased their capacities to deal with Covid-19 patients. The ICU increased their ventilator help capabilities dramatically. A lack of personal protective equipment was never an issue in Iceland. A Covid-19 department at our University Hospital was formed early on, where all suspected and confirmed Covid-19 cases went through. A highly organized Covid-19 team, led by doctors and nurses organized screening and a rigorous contact tracing. All close contacts were contacted and put in home isolation for 2 weeks. This team, telephone-contacted all Covid-19 positive patients daily and gave support and guidance and allowed triaging patients that that needed further assessment and possible admission to the hospital. The public was also instructed to first to call their health care center if needed but only come to the hospital if absolutely necessary.

Iceland had more Covid-19 cases per capita than in most countries. This is partly due to the vigorous screening of the population. The peak of infection rate was reached at the end of March but thereafter we had a steady decline of new cases. In the middle of July the total number of Covid-19 cases in Iceland rounds up to 1840 with 10 Covid-19 related deaths. Even though the ICU at our University hospital was full for some days during the height of the pandemic, with up to 10 Covid-19 patients on respirator at the same time, the hospital and the ICU capacity was never actually overwhelmed. In that sense, Iceland managed to flatten the curve. From the middle of May Iceland has relieved the COVID-19

restriction in stages, now permitting gatherings of up to 500 people and a new definition of the two meter rule. Iceland has now (middle of July) few active COVID-19 cases, only handful of cases have been diagnosed in the last few weeks. Iceland seems to be over the worst but must remain cautious. If the case number goes up the restrictions will as well. For most people, life is slowly returning to normal. Restaurants and bars are open again, with certain restrictions. Tourists are slowly returning to Iceland and screening for COVID-19 is now conducted at the airports/ports.

Gynecologic Cancer Care

Gynecologic cancer care in Iceland is centered at the Landspítali University Hospital where the bulk of Covid-19 patients were hospitalized. Landspítali, along with all health care centers, changed its routines during the height of the pandemic, focusing on care of Covid-19 patients. Hospital staff was at minimum, many worked from home and certain departments were closed. All gathering of personnel was at a minimum, virtual meetings were put in place and all contacts with patients were minimized. Routine follow up visit of cancer patients was changed to a telephone or video call. All elective surgeries were halted but gynecological cancer surgeries were only minimally affected. For duration of 2 weeks, laparoscopies, including robotic surgeries were halted and if necessary, carried out with laparotomy. These precautions were taken at the height of the pandemic but with further

information about the virus they were abandoned. Chemo- and radiation therapies were continued as planned but patient-physician contact was minimized, and telephone conversations were used instead. Although restrictions and precautionary measures have now been relieved, the pandemic has led us to reconsider certain protocols. Some of our routine follow up of

cancer patients, may for example continue as virtual/telephone meetings.

Ásgeir Thoroddsen, Katrín Kristjánsdóttir,
Landspítali University Hospital, Iceland

Dear NSGO member

NSGO is happy to have you as a member and appreciate your interest in the NSGO work.

According to NSGO Office files we have some unpaid memberships.

The membership payment is 375 per year. To pay your membership fee kindly please use our webpage

nsgo.org/membership-fee

If you are unsure if you have paid or for how long you have forgot to pay, please contact Soeren Hjerno (soeren.hjerno@regionh.dk), and he can assist you.

Thank you

Dear members and collaborators of NSGO

First half of 2020 was quite challenging for NSGO-CTU due to COVID19 outbreak. Due to the restrictions all staff was working from home. We had however daily Web-based calls and under the circumstances all went well and we adopted to see each other virtually. As restrictions were loosened, we gradually came back to office during summer. It was also difficult to gather data from the sites due to similar restrictions.

We have during the first half of 2020 spent a lot of time to structure the work of office, create SoPs, Guidelines for all our activities. Remember that less than a decade ago NSGO-CTU was a small organization with only one employee. With substantial increase in activity the number of permanent office employees has increased to 10, we are now globally one of the leading trial organization. This expansion requires greater coordination in office work and SoPs are thus essential.

The first half year was also busy in trial activities like endorsing several trials, trial initiation, trial conduct and preparing trial results. We presented survival data on AVANOVA2 at ASCO and prepared the results of ENGOT-EN3 / NSGO-PALEO study. The PALEO is globally the first randomized trial of a CDK4/6 inhibitor in endometrial cancer and the results will be disclosed at the Proffered session of ESMO 2020.

We are in the process of cleaning the data and waiting for maturity of several NSGO-CTU sponsored trial and continue to lead ENGOT-EN7 / NSGO-RUBY trial.

All this success is due to hard work of our office staff and due to your close collaboration and I thank all of you. NSGO-CTU is globally one of the major clinical trial organization and we are proud of it.

Last but not least we are looking forward to seeing you in person or virtually in our Investigator meeting in Copenhagen on 26th-27th November.

Stay safe

Mansoor

NSGO-CTU Medical Director



**Nordic Society of Gynaecological Oncology
– Clinical Trial Unit**

**NSGO-CTU Investigator Meeting
26-27th of November 2020**

Radisson Blu Scandinavia Hotel, Copenhagen

NSGO SPONSORS 2020

