NCCN Updates Recommendations for COVID-19 Vaccination With Information on Bivalent Vaccines, Children With Cancer, and Other Developments

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NCCN has released updated recommendations from the NCCN Advisory Committee on COVID-19 Vaccination and Pre-exposure Prophylaxis. This latest evidence-based, expert consensus–formulated summary on cancer and COVID-19 vaccination and prevention is available for free at NCCN.org/covid-19. Significant revisions include new recommendations for the recently approved bivalent vaccines and advice on protecting children with cancer.

“There is a lot to keep track of when it comes to keeping people with cancer safe from poor outcomes related to COVID-19. Our committee of leading experts meets frequently to examine all of the latest research and organizes it into a clear, one-stop source for people with cancer, their loved ones, and their health teams,” said Robert W. Carlson, MD, Chief Executive Officer, NCCN. “We’ve expanded our committee for this latest update to include a focus on pediatric patients. Some of the foremost authorities on children’s healthcare joined multidisciplinary physicians from across NCCN’s Member Institutions, which also included expertise in vaccine development and delivery, infectious diseases, cancer management, and medical ethics.”

The updated guidance features comprehensive explanations for who should be considered immunocompromised and what that means for booster eligibility and scheduling. The information is categorized by type of malignancy and/or treatment, and also by type of vaccine.

Important new information includes:

- Immunosuppressed people who have previously received a 3-dose primary series and boosting through prior recommendations are now eligible to receive one of the bivalent boosters if they are aged ≥12 years for Pfizer, or aged ≥18 years for Moderna. This has been shown to improve immune response against Omicron strains in people with full immune system capacity. The committee supports this recent approval but cautions that they are still awaiting data on bivalent booster effectiveness in immunocompromised people.
- Moderna is the preferred mRNA vaccine for pediatric immunosuppressed patients aged 6 months to 17 years.
- Preliminary data show myocarditis cases are rare, although relatively more frequent in adolescent and young adult males aged ≥16 years. Most patients fully recover.

“Protecting kids from harm is one of the most important things we can do,” said Tina Q. Tan, MD, Infectious Diseases physician at the Ann & Robert H. Lurie Children’s Hospital of Chicago and Northwestern Medicine, who joined the NCCN committee as a Co-Leader. “That’s why we recommend vaccination against COVID-19 for anyone over 6 months of age, especially infants, children, and adolescents who are immunocompromised. It is especially important for eligible household members and caregivers to make sure they are vaccinated as well, since immunocompromised children under age 12 or weighing less than 40 kg are unable to receive monoclonal antibodies for protection.”

NCCN’s recommendations point out that vaccine hesitancy in the general population impedes the development of herd (community) immunity, which leaves people with cancer at higher risk. Reducing community spread will help

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people with cancer who are at higher risk of COVID-19 complications and may have less protection from available vaccines. The committee also recommends that after vaccination, patients continue to wear masks, maintain social distancing, avoid crowds, and follow other nonpharmacologic recommendations for COVID-19 prevention.

The updated guidance also includes previous recommendations and statements, such as:

- Antibody testing is not recommended, outside of a research study
- Boosters are recommended for everyone with a hematologic malignancy, regardless of whether they are in active treatment
- mRNA vaccination is preferred in most situations
- Mix-and-matching the 2 mRNA vaccines is considered an appropriate option
- Patients should be revaccinated after undergoing hematopoietic cell transplantation or engineered cellular therapy (eg, CAR T-cell therapy)
- Vaccines are considered safe for people undergoing immunotherapy
- Vaccination status should not impact participation in clinical trials
- Monoclonal antibodies (tixagevimab + cilgavimab) are recommended as prophylaxis (in addition to vaccination) in selected immunocompromised patients at risk for COVID-19 complications

An existing section labeled "Societal Considerations" states: "It is imperative that all patients have equitable access to the vaccines." The section features recommendations for the incorporation of social vulnerability awareness to help address health disparities, including tracking racial/ethnic and socioeconomic data for vaccine distribution wherever possible.

The guidance also continues to assert that the timing for COVID-19 vaccination will not interfere with most other vaccines, such as the annual flu shot, but that different vaccines should be administered at separate injection sites.

To view the full list of recommendations, explanations, and peer-reviewed research citations, visit NCCN.org/COVID-19. The committee plans to continue to update the clinical recommendations and the corresponding patient guide (featuring simplified questions and answers) as needed.

Cancer Screening Gaps Highlight Urgent Need to Address Health Inequities, According to NCCN Policy Summit

On September 16, 2022, NCCN hosted a policy summit to examine practice changes and trends in legislative and regulatory efforts that affect patient access to cancer screening and risk reduction. Speakers included Danielle Carnival, PhD, Coordinator, White House Moonshot Initiative; Lisa Richardson, MD, MPH, Director, Division of Cancer Prevention and Control, CDC; Philip Castle, PhD, MPH, Director, Division of Cancer Prevention, Senior Investigator, Division of Cancer Epidemiology and Genetics, NCI; and Carol M. Mangione, MD, Chair, US Preventive Services Task Force (USPSTF), Barbara A. Levey & Gerald S. Levey Distinguished Professor of Medicine and Public Health, University of California Los Angeles.

During the summit, speakers and panelists explored the current landscape for cancer screening and early detection, along with the continued evolution of

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risk identification and risk-reduction strategies. The conversations were dominated by several hot topics in healthcare, including COVID-19 pandemic impact on screening access; equity and disparities; social determinants of health; personal, practice, and population-level interventions (eg, smoking cessation, HPV vaccination); lifestyle factors (eg, exercise, nutrition); potential benefits and harms of novel technology (eg, multicancer early detection); digital user experience (eg, telehealth); updated screening guidelines; and coverage and reimbursement.

For panel member Maimah Karmo, Founder & CEO, Tigerlily Foundation, the conversation was particularly personal: "I am Black woman who was diagnosed with aggressive stage IIB breast cancer at a young age. I am alive today because I had a mother who educated me about my body, breast health, and about the importance of self-advocating. Due to early detection, I found a lump early, and even though I was dismissed by a healthcare provider, I insisted upon screening and a biopsy, which led to my diagnosis and treatment, and I am alive today. I made a promise to God that I would do everything in my power to ensure young women and women facing disparities had every access to education, screening, and resources that enable them to be proactive with their health, and have a high quality of care and life. This work, Tigerlily, is my living legacy. I am living proof that early detection can save lives."

"There is significant evidence supporting the fact that screening saves lives," noted Robert W. Carlson, MD, Chief Executive Officer, NCCN. "Appropriate screening allows us to detect cancer at earlier stages, when there are more options for treatment and a higher likelihood for better outcomes. Sometimes screening can even prevent cancer by identifying precancerous cells. This is why it is so important to address any setbacks in policy, communication, or resources that could result in people missing out on evidence-based, guideline-recommended cancer screenings."

"We know a great deal about how to advance health and prevent cancer and other chronic diseases; the challenge now is more about implementation than discovery," said panel member Ernest Hawk, MD, MPH, Vice President and Division Head of Cancer Prevention and Population Sciences, The University of Texas MD Anderson Cancer Center. "Impactful prevention has to be intentionally designed and must consistently reach all, especially those most in need, in order to achieve benefits across the lifespan. Effective implementation begins with communication, but cannot end there. It must be strategically prioritized and implemented through combinations of evidence-based actions operating at multiple levels and motivated by both personal and shared social responsibilities to effectively promote health and wellness."

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Addressing Disparities

The theme of disparities in care and how to address them continued during discussions throughout the day, with a particular focus on communication, outreach, and the allocation of resources.

"Racial and ethnic minorities and other socially and economically disadvantaged groups continue to experience a disproportionate share of avoidable deaths from cancer," pointed out Chyke Doubeni, MBBS, MPH, Chief Health Equity Officer, The Ohio State University Wexner Medical Center. "As we address ongoing public health threats, it is critical to direct resources to under-resourced communities to make evidence-based cancer preventive services accessible to people regardless of individual social or

economic circumstances. We should focus on eliminating social and structural barriers that limit access to early detection and treatment and pay attention to how the 'digital divide' could deepen inequities. Insurance coverage should be provided for all follow-up tests needed to get the benefits of screening."

"It's all about equity. Everyone in every community deserves to be screened for cancer and not have to worry about challenges and barriers getting in the way," said Nikia Clark, Senior Community Outreach and Engagement Manager, Roswell Park Comprehensive Cancer Center. "Cancer centers must meet people where they are. Start with the basics of providing tailored cancer information to communities most in need, work with community stakeholders and organizations to help champion the effort, and prioritize funding and resources for outreach initiatives for community engagement that will lead to earlier detection and lowering cancer risk."

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Looking Toward the Future

Speakers examined how cancer treatment and prevention has become more personalized over time, and where it is headed from here.

"Evolving genetic and genomic testing technologies are allowing individual cancer risks to be more precisely quantified; one-size-fits-all prevention approaches are being replaced by tailored strategies," explained Michael Hall, MD, MS, Chair, Department of Clinical Genetics, Fox Chase Cancer Center. "Our improving understanding of genetic risks, environmental factors, and social determinants of health, combined with knowing a person's history of adverse exposure (such as smoking or HPV) allows us to tailor to individuals and populations. This helps make sure limited public health resources are focused on the greatest needs, while sparing lower-risk individuals from unnecessary medical procedures. Genetic risk stratification is the long game for effective and efficient cancer prevention."

Lisa Schlager, Vice President, Public Policy for Facing Our Risk of Cancer Empowered (FORCE), agreed: "Prevention and early detection are critical as we strive to reduce the US cancer burden—especially in underserved, underrepresented populations. While we don't know why many people get cancer, those affected by hereditary cancers are the poster children for prevention and early detection. NCCN has comprehensive guidelines on how to manage individuals with—or at increased risk of—hereditary cancers, who can be identified based on personal or family history of disease. We must be innovative and do more to facilitate effective risk stratification, identifying those at increased risk of cancer and ensuring that they have affordable access to the recommended screening and risk-reducing interventions. Ultimately, this will reduce health disparities and improve health outcomes."

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"One of the most important challenges in fighting cancer occurs well before diagnosis: ensuring effective screening," said Eric Gratias, MD, Chief Medical Officer, eviCore. "Even though early detection often leads to better outcomes, many patients still don't get the regular screenings that they should. At eviCore, we're focused on working with health plans and providers to break down barriers to care by providing patients with proactive education and hands-on support to make sure they get the right cancer screenings on the right schedule."

The summit featured Clifford Goodman, PhD, The Lewin Group, as moderator. Dr. Carlson introduced the program, while NCCN Senior Vice President/Chief Medical Officer Wui-Jin Koh, MD, provided closing thoughts. Kate Mevis,

Executive Director, US Federal & State Vaccine Policy at Merck, Inc. provided perspective on the role of vaccination in cancer prevention.

NCCN's New Patient Guidelines for Marginal Zone Lymphoma Help Patients and Caregivers Better Understand a Rare Form of Blood Cancer

> "With this new guide, patients can understand the distinctive features of MZL, which can be lost in discussions of slow-growing, or indolent, lymphomas in general.

NCCN has published new Guidelines for Patients: Marginal Zone Lymphoma. A cancer of the lymphatic system, marginal zone lymphoma (MZL) is a type of non-Hodgkin B-cell lymphoma that is typically slow-growing, and comprises approximately 8% of non-Hodgkin lymphoma cases.[1]

"As a result of its rarity, many people lack awareness of MZL. During the diagnosis phase, patients should consider the possibility of having their pathology reviewed at a medical center that sees a lot of lymphoma patients, in order to confirm the diagnosis," according to Leo I. Gordon, MD, Professor in Medicine, Northwestern University Feinberg School of Medicine and the Robert H. Lurie Comprehensive Cancer Center. Dr. Gordon is Vice Chair of the panel that develops the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines) for B-Cell Lymphomas, which include MZL.

NCCN Guidelines are the recognized standard for clinical direction and policy in cancer management; NCCN Guidelines for Patients take the same evidence-based clinical recommendations and present them in simple, easy-to-understand wording, alongside charts, images, and suggested questions for patients to ask their doctors.

The patient guidelines for MZL are the latest in NCCN's library of NCCN Guidelines for Patients, published through funding from the NCCN Foundation and available online free of charge. NCCN Guidelines for Patients provide information on nearly 60 cancer types, as well as topics such as treatment side effect management, mental distress, and survivorship. With this new guide, patients can understand the distinctive features of MZL, which can be lost in discussions of slow-growing (or "indolent") lymphomas in general.

MZL develops from immune cells called B cells. That meant management for MZL was particularly impacted during the early days of the COVID-19 pandemic, because some treatment options can reduce B-cell–produced antibodies, thereby lessening the overall immune system response. Now that providers can manage COVID-19 more effectively, patients with MZL are less vulnerable to poor outcomes from infection.

MZL is generally diagnosed in people in their late 50s through mid-60s, although it can occur in the skin of persons as young as 20 to 30 years of age. It is often a chronic, nonfatal disease.

There are 3 main subtypes of MZL based on where they originated in the body, either in the spleen, bone marrow, or lymphatic tissues throughout the body. "MZL can be extranodal, which can involve virtually any organ in the body, including skin, stomach, lung, prostate, or breast," said Andrew D. Zelenetz, MD, PhD, Medical Oncologist, Memorial Sloan Kettering Cancer Center; Chair, NCCN B-Cell Lymphomas Panel. "Splenic MZL involves the spleen, blood, and bone marrow, and is sometimes associated with hepatitis C infection. And nodal MZL primarily forms in the lymph nodes. All 3 subtypes are managed differently."

Treatments are trending away from cytotoxic chemotherapy and toward more targeted chemotherapy and immunotherapy, with clinical trials underway using CAR T-cell therapy.

Dr. Gordon noted that, "not everyone needs treatment right away; many people can be safely observed and spared unnecessary treatment-related toxicity."

NCCN Guidelines for Patients are available for free online at NCCN.org/patientguidelines and via the NCCN Patient Guides for Cancer App. Printed versions can be purchased through Amazon for a nominal fee.

Reference

1. Khalil MO, Morton LM, Devesa SS, et al. Incidence of marginal zone lymphoma in the United States, 2001-2009 with a focus on primary anatomic site. Br J Haematol 2014;165:67–77.