Clinical and Translational Radiation Oncology 22 (2020) 88–89

Contents lists available at ScienceDirect

Clinical and Translational Radiation Oncology

journal homepage: www.elsevier.com/locate/ctro

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In reply to Drs Magrini, Mazzola, Greco, Alongi, Buglione

Thank you for your important reflection on our paper. Our aim is to provide clinicians with an evidence-based guideline illustrating ways departments can both minimize the risk of transmission while managing significantly reduced capacity. This work was the beginning of a conversation about what is possible and sensible in a time of global crisis. We do not intend for it to provide instructions, as the need to adapt to the COVID-19 pandemic will vary in different clinical settings. We are grateful for you continuing that dialogue and also acknowledge the continued update of guidance from both ESTRO and ASTRO and many other national organisations.

We agree entirely that the decisions to choose the most appropriate treatment should be based on a careful risk-benefit assessment on a case-by-case basis. The benefits of our established therapies are unchanged. However, the risks associated with delivery and the available resources to provide it are dramatically altered by the pandemic. Different healthcare teams should be able to assess what the likely risks are in continuing with 'standard of care' treatment and this will vary according to geography, staffing levels, other resources and with different timepoints in the pandemic. We agree that radiotherapy will most often be a preferred modality to chemotherapy during COVID-19 but these alternatives are offered for those extreme circumstances where radiotherapy may not be available through staff shortages.

One important risk of treatment during a pandemic is the patient becoming exposed to infection during repeated trips to a radiation department. There is an irony in asking a population to self-isolate to prevent deaths and then to request some individuals to voluntarily break that isolation to attend a treatment during the pandemic that may not affect survival (e.g. in the case of definitive radiotherapy for low-risk breast cancer or most prostate cancers). Mitigation strategies therefore seem appropriate [1,2]. We recognize that this practice may potentially lead to future higher local recurrences. However, the impact upon survival may be limited. The risks of cancer recurrence must now be balanced with an estimated case fatality rate of 5.6% within 2–8 weeks for cancer patients ill with COVID-19 [3].

As the pandemic progresses, it is expected that healthcare resources including those for oncology will continue to be strained. At the time of writing, hospital staff and training programs around the world have or are preparing for staff redeployment, including in radiation oncology. Personal protective equipment is still scarce, not only N95 masks, but basic surgical masks, too. Leaves of absence due to increased psychological distress, familial burdens including childcare, and infection are inevitable.

With varied and limited infection control resources including testing to determine the prevalence of a new and highly infectious virus among cancer patients and oncology professionals, we cannot currently quantify the risk well. It is now clear that business as usual approaches will not work to control COVID-19. This new uncertainty deserves detailed discussion. Due to advances in technology such as social media, this can now be done both locally and globally with faster turnaround times while still being moderated by ethical frameworks [4]. This way, patients and clinicians can help ensure everyone has guidance to make an informed choice.

These debates will continue in the coming months as we learn to accommodate to the pandemic. We do not propose a universal solution, but a range of dose schedules (including zero) which may have a more acceptable risk profile as guidance. As you have illustrated, these are not simple choices but may be adopted with caution and careful consent.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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DOI of original article: https://doi.org/10.1016/j.ctro.2020.03.009

https://doi.org/10.1016/j.ctro.2020.04.002

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Received 2 April 2020
Accepted 5 April 2020

Available online 15 April 2020