

Evolution of Cancer Care in Response to the COVID-19 Pandemic

We agree with Souadka et al. that health care systems and oncology centers must prepare for the possibility for subsequent epidemic waves, as intensive societal control measures are relaxed [2]. In the acute phase, out of necessity we have had to make adjustments to typical treatment protocols to account for anticipated disruptions of health system capacity. For example, in the short term, should significant delay in operative intervention be unavoidable, then consideration may be given to using chemotherapy in the neoadjuvant setting.

Unfortunately, during the early phases of the pandemic, due in part to fear of infection, patients may have even avoided health care settings for acute medical conditions; this has been hypothesized as an explanation for the significant decrease in admissions for acute coronary syndrome during the Italian outbreaks of COVID-19 [3]. However, in the long term we need to optimize ongoing access to care to ensure safe delivery of therapy for both acute and chronic medical conditions; the large-scale implementation of virtual and telemedicine is one such intervention that has been rapidly deployed to maintain continuity of care [4, 5].

Although marked shortages of personal protective equipment have occurred during the initial pandemic wave, as governments and corporations attempt to scale-up production of personal protective equipment, health care systems may be better situated to prepare and respond for subsequent waves of COVID-19. We fully agree that personal protective equipment plays a critical role in effective infection prevention and control programs, and ongoing efforts are essential to ensure the appropriate personal protective equipment is available as needed for patient care. Furthermore, oncologic surgeries that include aerosol generating procedures will further necessitate the use of N95 respirators.

We recognize that hospitals have implemented triage processes, dedicated staffing, and isolation or cohorting for patients under investigation and with confirmed COVID-19. However, we must also recognize the challenges in clearly defining “COVID-free” space (s) given the high burden of subclinical or asymptomatic COVID-19 [6]. In light of the potential for presymptomatic transmission and the presence of asymptomatic and atypical presentations of COVID-19, in high-incidence regions it may be prudent to assume that all patients are potentially incubating SARS-CoV-2, regardless of the presence of symptoms. Further studies are required to determine the role of universal microbiologic screening for patients requiring regular health care

contact, recognizing the limitations of polymerase chain reaction sensitivity for identifying SARS-CoV-2. Some centers have already begun implementing such universal screening prior to scheduled surgeries [7,8].

Furthermore, should COVID-19 become endemic, then more longstanding structural changes will be required in oncology institutions to ensure uninterrupted delivery of care. However, the ultimate course of the COVID-19 pandemic remains to be seen, and the interventions required will be influenced by the degree and duration of protective immunity from prior infection, the availability and implementation of novel vaccines, and identification of effective therapies [9].

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