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Gynecology

# Management of ovarian cancer during the COVID-19 pandemic

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COVID-19 infection spread rapidly in Italy during the early months of 2020. Infection can vary in severity from asymptomatic disease to acute respiratory distress syndrome and multiorgan failure. The COVID-19 pandemic represents a severe stress test for the national health system. Very quickly hospitals have had to assist a large and unexpected number of patients owing to the rapid spread of the disease. This has led to a sudden shortage of hospital beds, medical and nursing staff, personal protective equipment (PPE), and ventilators. Entire hospitals have been converted into intensive care units, retired anesthesiologists have been called back to work, and specialists in other branches have been assigned to assist COVID-19 patients. Only urgent and non-postponable medical services are guaranteed.

Centralization of cancers to referral centers has paradoxically increased because peripheral centers that usually treat less complex tumors have become COVID-19 hospitals. Usual cancer treatment timing is no longer guaranteed. Our main dilemma is deciding which patient to submit to surgery and which to delay owing to the impossibility of guaranteeing a postsurgical intensive/subintensive care bed.

Most patients with ovarian cancer require radical/ultra-radical surgery that combines multiorgan resections. These patients need close observation in a surgical or intensive care unit.[1] Access to these units is progressively decreasing and sending patients to nearby cancer centers becomes impossible because they are experiencing the same problems.

We have adopted other strategies by taking the difficult decision to send patients who require more aggressive surgery to neoadjuvant chemotherapy (NACT) with the hope that at the end of chemotherapy, the peak of the pandemic has disappeared or at least the availability of intensive care beds has increased.

Although NACT reduces the risk of postsurgical death and serious infection,[2] it is still necessary to consider the fragility of the patient undergoing chemotherapy. We well know the benefit of upfront surgery on survival and that it is preferable to NACT in otherwise healthy women[2,3]; however, depriving a patient of respiratory assistance would mean certain death. Decisions on where to allocate resources is becoming a daily dilemma. Real-life treatment is gradually moving away from best practice. As we have seen with daily life, cancer care must also change, and finding new effective strategies is mandatory.[4] Given the spread of COVID-19 infection, this issue could become a common problem worldwide. We hope that our consideration of these issues can help gynecological oncologists think about this arising ethical dilemma. Furthermore, we hope to have made the best choice at the current time and look forward to alternative solutions.

## AUTHOR CONTRIBUTIONS

VDM and LA conceived, wrote and revised the article.

## CONFLICTS OF INTEREST

The authors have no conflicts of interest.

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