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LETTER TO THE EDITOR

In reply to: "A COVID-19 screening tool for oncology telephone triage"

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To the editor:
We read with great interest the paper of Emmika Elkin [1], which describes the development and implementation of a corona virus disease-19 (COVID-19) screening tool specific for telephone triage of oncologic patients.

This proposed screening tool is based on the detection of the most common signs and symptoms of COVID-19 infection with a strong focus on those overlapping to those cancer or cancer therapy related. This kind of triage system is largely used all over the world, including in our hospital [2, 3], but the strength of this specific screening tool consists in the attempt to evaluate not only the presence of symptoms, but also their characteristics and intensity. Indeed, a tool used for evaluating the general population, and not specifically cancer patients, could not adequately discriminate between COVID-19-related or cancer-related symptoms. Moreover, the differential diagnosis for COVID-19 in cancer patients is often extremely broad, and includes many conditions such as chemotherapy-, immunotherapy-, and radiotherapy-induced adverse events (e.g., interstitial pneumonitis in patients receiving immune checkpoint inhibitors or mTOR-targeting agents, viral and bacterial pneumonia, and obviously tumor progression) [4]. If the triage is limited to assess just the presence of few aspecific symptoms, it should lead us to perform an unnecessary large number of nasal swabs.

Indeed, although theoretically preferable, universal swab screening for COVID-19 in all cancer patients, at every access to the hospital, would create several logistic and resource-related issues.

As highlighted by colleagues from the Memorial Sloan Kettering Cancer Center [5], unnecessary testing could lead not only to a delay in the administration of cancer treatments, but also to an increased risk of infections, a loose of time in unnecessarily treating patients, and unjustified expenses for lab procedures and logistics. As a consequence, they did not recommend routine pre-treatment COVID-RNA testing for asymptomatic patients with solid tumors [5].

A step forward would indeed be the adoption of a more accurate, easy to use, and constantly and rigorously updated screening tool specific for the oncological patient. Moreover, this "virtual swab" should be customizable according to the type of tumor, the type of treatment, and their different possible adverse events (for example ageusia/dysgeusia or conjunctivitis during chemotherapy, myalgia during hormonal therapy, or respiratory symptoms in case of an immune-related pneumonia).

Unfortunately, its use alone could not be enough to completely solve the triage problem in these difficult times.

We do think that, due to the importance of this problem, a managed screening strategy should ideally include an accurate triage tool, the availability of faster molecular and serologic diagnostic tests, together with the chance to discuss each not univocal case with an infectious diseases or a virology specialist, in order to rule out other infectious diseases and/or interpretation mislead. Moreover, each Institution should consider the possibility to put in act some kind of diagnostic protocol to avoid that patients could reach out to "sliding doors" where diagnosis would be not so accurate, as needed.

Data availability Not applicable.

Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethics approval Not applicable.

Consent to participate Not applicable.

Consent for publication All authors read the final version of the paper and approved its submission for publication.

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