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LETTER TO EDITOR

COVID-19 pandemic: The new normal in breast cancer management - prioritization of care from a breast surgical unit's experience in Singapore



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Dear Editor,

The overwhelming COVID-19 pandemic has forced healthcare institutions around the world to direct resources to manage the pandemic. This has resulted in a sudden acute limitation of resources to care for non-COVID patients with critical conditions. By the end of January 2020, Singapore had the highest number of reported cases outside China.¹

Despite the initial containment strategies, the number of COVID-19 positive cases rose significantly. Hence, the Singapore Government implemented the Circuit Breaker measures on 7 April 2020, to last through to 1 June 2020.¹ The aim was to reduce community spread and flatten the curve. Hence, hospitals were required to reduce our non-essential patient activities viz non-critical outpatient appointments and surgeries.

In Singapore, significant amount of healthcare resources is directed at the management of COVID-19 positive patients, isolation and testing of high-risk groups. Our challenge is to deliver a standard of care (as in non-COVID times) to non-COVID patients when resources are limited. Concurrently, steps need to be taken to minimise the patients' risk of contracting SARS-CoV-2 when receiving treatment. To achieve this, we looked at available guidelines,^{2–5} and drew from our experience (Supplementary Data).

We developed an aid, describing the prioritisation of care based on the DORSON level (Yellow and Orange) and resource availability. Delivery of care was divided into 5 categories along with their respective prioritization principles as follows [Table 1](#):

1. Outpatient visits
 - a. Minimize outpatient visits as much as possible. Replace with telemedicine or tele-consult if appropriate.
 - b. Priority given to conditions that when delayed would increase the chances of relapse or deterioration.
2. Screening/Imaging
 - a. Minimise hospital visits as much as possible

- b. Defer all screening imaging for 6–12 months.
- c. Priority given to conditions that when delayed would increase the chances of relapse or deterioration.
3. Surgery
 - a. Surgery for urgent/life threatening situations.
 - b. Oncologic resection achieved with shortest anaesthesia, least morbidity, shortest hospital stay and fastest recovery.
 - c. To consider alternatives to surgery in selected and suitable cases.
4. Systemic Treatment
 - a. Systemic treatment with least risks of immunosuppression.
 - b. Delay treatment as per current evidence if resources limited.
 - c. Shorter treatment duration (dose-dense), reduce visits as much as possible.
5. Radiation Therapy
 - a. Postpone RT up to 3–6 months, if resources limited.
 - b. Shorter fractions or accelerated partial RT in selected cases.

In conclusion, the COVID-19 pandemic has caused healthcare services worldwide to rush to deal with this highly unpredictable and continually evolving disease. As the situation varies in each country, so do their resources. Singapore is no different, as we grapple with the relentless pace of the virus. While adapting to cope with measures required to battle COVID-19, we also strive to not compromise on the delivery of care to our breast cancer patients.

This requires a tailored strategy, crafted within a multidisciplinary team framework. Treatment delivery may be affected by the severity of the pandemic, availability of healthcare resources, and the need to balance the risks of unnecessary exposure of patients and healthcare personnel. Adding our experience to existing guidelines, we hope that our prioritization aid may assist others in similar circumstances to adapt to the New Normal.

Declaration of competing interest

The authors declare no conflicts of interests.

Appendix A. Supplementary data

Supplementary data to this article can be found online at <https://doi.org/10.1016/j.asjsur.2020.08.020>.

Table 1
 Prioritization Aid for Outpatient Clinic Visits and Management of Breast Cancer based on DORSCON level and Resource Availability.

| Table 1a. Prioritization Aid for Outpatient Clinic Visits | | | | | | |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Conditions/Scenarios NOT to Postpone | | | Conditions/Scenarios to Postpone | | | |
| New clinic visits for urgent conditions: <ul style="list-style-type: none"> • breast infection, • suspicious mammogram or ultrasound findings of BIRADS 4 or 5 categories, • signs and symptoms suggestive of breast cancer • newly diagnosed breast cancer Recently diagnosed breast cancer patients Breast cancer patients within first 2 years of treatment Any patient with recent investigations revealing abnormalities Any patient with recent onset of new symptoms | | | Asymptomatic patients on routine follow up for benign/low risk conditions Asymptomatic patients on high risk follow up, where scheduled screening imaging can be safely deferred for 6–12 months ⁶ | | | |
| Table 1b. Prioritization Aid in the Management of Breast Cancer based on DORSCON Level and Resource Availability. | | | | | | |
| Aspects of Care | Prioritization Principle | DORSCON Level | Resource Availability | High Priority | Medium Priority | Low Priority |
| Outpatient visits | Minimize outpatient visits as much as possible. Replace with telemedicine or tele-consult if appropriate. Priority given to conditions that when delayed would increase the chances of relapse or deterioration. | Yellow Orange | Minimal disruption Limited resources | Potentially unstable conditions (abscess/haematoma) Newly diagnosed/suspected cancer Potentially unstable conditions (abscess/haematoma) Newly diagnosed/suspected cancer | Post-operative visits for dressing and wound care Follow up visits of high-risk patients None | Follow up visits for low-risk patients/benign conditions Post-operative visits for dressing and wound care Follow up visits of high-risk patients Routine screening High risk screening |
| Screening/ Imaging | Minimise hospital visits as much as possible. Defer all screening imaging for 6–12 months. Priority given to conditions that when delayed would increase the chances of relapse or deterioration. | Yellow Orange | Minimal disruption Limited resources | Diagnostic imaging and image-guided biopsy of BIRADS 4 and above lesions. None | Diagnostic biopsy and follow-up imaging for BIRADS 3 and above lesions Diagnostic imaging and image-guided biopsy of BIRADS 4 and above lesions. | Diagnostic biopsy and follow-up imaging for BIRADS 3 and above lesions |
| Surgery | Surgery for urgent/life threatening situations. Oncologic resection achieved with shortest anaesthesia, least morbidity, shortest hospital stay and fastest recovery. To consider alternatives to surgery in selected and suitable cases. | Yellow Orange | Minimal disruption Limited resources | Operations for infection/haematomas Resection of suspicious and high-risk lesions- where outpatient diagnostic biopsy is not possible or unavailable Oncologic resection for cancer cases whereby alternative treatment is least preferred/unsuitable Immediate reconstruction and oncoplastic procedures may be considered provided the prioritization principle are adhered to Operations for infection/haematomas Oncologic resection for cancer cases whereby alternative treatment is least preferred/unsuitable Autologous reconstruction, especially microsurgery should be deferred as a delayed option | Resection of suspicious and high-risk lesions- where outpatient diagnostic biopsy is not possible or unavailable | Prophylactic surgery |
| Systemic Treatment | Systemic treatment with least risks of immunosuppression. Delay treatment as per current evidence if resources limited. Shorter treatment duration (dose-dense), reduce visits as much as possible. | Yellow Orange | Minimal disruption Limited resources | Neoadjuvant chemotherapy in suitable patients to allow for early systemic control Adjuvant chemotherapy for high risk patients Palliative systemic therapy for patients with metastatic breast cancer (to balance QOL vs risks of immunosuppression) Use of neo-adjuvant endocrine therapy in suitable early stage breast cancer if resources to surgery are limited | Adjuvant chemotherapy for intermediate or low risk patients Neoadjuvant chemotherapy in suitable patients to allow for early systemic control Adjuvant chemotherapy for high risk patients Palliative systemic therapy for patients with metastatic breast cancer (to balance QOL vs risks of immunosuppression) | Follow up imaging or re-staging studies if otherwise asymptomatic Adjuvant chemotherapy for intermediate or low risk patients |
| Radiation Therapy (RT) | Postpone RT up to 3–6 months, if resources limited. Shorter fractions or accelerated partial RT in selected cases. | Yellow Orange | Minimal disruption | Acute spinal cord compression and brain/leptomeningeal metastases Post-operative radiation therapy for high risk patients | Post-treatment visits for complications Post-operative radiation therapy for intermediate and low risk patients | Palliative treatment for symptoms control (bleeding, odour, wound care). Post-treatment visits for complications. |

Table 1 (continued)

Table 1b. Prioritization Aid in the Management of Breast Cancer based on DORSCON Level and Resource Availability.

| Aspects of Care | Prioritization Principle | DORSCON Level | Resource Availability | High Priority | Medium Priority | Low Priority |
|-----------------|--------------------------|---------------|-----------------------|-------------------------------------------------------------------|---------------------------------------------------------|-------------------------------------------------------------------------|
| | | | Limited resources | Acute spinal cord compression and brain/leptomeningeal metastases | Post-operative radiation therapy for high risk patients | Post-operative radiation therapy for intermediate and low risk patients |

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