

Caring for Patients with Advanced Stage Cancer at the Time of COVID-19

“Nothing resembles a person as much as the way he dies.”
Gabriel García Márquez, *Love in the Time of Cholera*

As is known, during the past month Italy has been struck by the SARS-CoV-2 epidemic, and this, as expected, strongly impacted our health care system, where many hospitals have been turned into “COVID-19 hospitals.” At the time of writing, all other European countries, which had been lagging behind at the beginning, are now confronted with the outbreak.

Last week, one of our patients was admitted with severe respiratory distress due to SARS-CoV-2 infection. The patient was being treated at our institution with third-line chemotherapy for advanced-stage cancer and recently had experienced mild decline in performance status, with impairment in some activities of daily living. This means that this 78-year-old gentleman would probably die in a geriatric ward, far away from his family, who in the meantime has been isolated after having close contact with an infected individual. In turn, that would mean his family will not be able to assist him, and on their behalf, dressed-up health care personnel will try to deliver the best possible care, trying to cheer him up through their face-covering masks.

As oncologists, we normally rely on solid evidence to provide recommendations for treatment, but evidence is indeed scarce and limited when it comes to further treatment lines in advanced-stage disease. The Italian Ministry of Health on March 10, 2020, provided recommendations for the management of oncological patients during the COVID-19 emergency. They acknowledge data on the impact of respiratory virus infections on morbidity and mortality in patients with cancer [1], which show that the risk of being hospitalized is fourfold higher compared with age-matched subjects, and Chinese data on SARS-CoV-2 [2], which seem to point to a higher likelihood of more severe course with a higher risk of events, defined as admission to intensive care units and/or death. In this last group, a risk factor is having received chemotherapy in the past month.

Moreover, epidemiologic data point to older patients as the more exposed to COVID-19 events [3], and we should be alert and aware of the risk older patients are experiencing during this outbreak. We must take a step forward beyond American Society of Clinical Oncology key opportunity statements, which remind us not to use cancer-directed therapy for patients with solid tumors who either have low

performance status or did not benefit from prior evidence-based interventions, with no strong evidence supporting the clinical value of further anticancer treatment, and make the huge effort of being objective in our clinical decisions [4]. This is the time in which we are urged to accurately balance risks and benefits. If a modest—if ever present—survival gain is counterbalanced by a high risk of ending up admitted with COVID-19, we should refrain from further oncological therapy, openly discussing potential trade-offs of cancer-directed treatment with patients.

It is indeed very difficult not to be subjective when we care for patients who in most cases we have known for long time. Yet, there are some available tools to help us in defining prognosis in patients with cancer [5], which can improve objectivity in clinical judgment. Now that the COVID-19 outbreak has been declared a pandemic, and more and more countries are faced with this new enemy, we as oncologists should be brave enough to allow patients to receive their end-of-life care safe at home with their loved ones and not in a sterile hospital ward where they cannot hold their loved ones' hands before they close their eyes forever.

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