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Concerns in Redirecting Uro-oncologic Patients During COVID-19 Pandemic



To the Editor:

COVID-19 pandemic dramatically struck northern Italy during the last few weeks, causing a multiregional health system crisis for the overwhelming number of patients who required hospital admission, particularly, with regards to the occupation of intensive care units in case of acute respiratory syndrome. A survey among leading European urological centers showed a reduction in oncologic surgery of at least 40%-50% in March.¹ The following weeks of April saw a drastic reduction of the remaining elective surgery. National Health Systems of Italy and England proposed to suspend nonurgent elective surgery for 3 months.² Unfortunately, the burden of surgery delay increases the doubling time of the waiting list to an uncertain interval, which would be very long especially for non-oncologic surgical diseases. Regarding specific uro-oncologic nondeferrable procedures (ie, radical cystectomy, TURBT for high-risk diseases, nephroureterectomy, radical prostatectomy for high-risk prostate cancers, radical nephrectomy for T3-T4 renal tumors, and radical orchiectomy),³ it has been suggested that they should be centralized in tertiary urological centers, which could remain COVID-19 free using a proper patient triage and being excluded from patient recruitment of the emergency department. However, in this pandemic, which has

manifested as nothing that has been seen before, several tertiary centers in Italy as well as the other Western countries, such as Spain, France, UK, and US, have suffered sudden redistribution of medical resources and the conversion of hospitals into a single-disease taskforce. Moreover, the long surgical waiting lists of community hospitals, including nondeferrable oncologic cases, indicate poor compliance with similar surgical priorities of tertiary referral centers.⁴ Also, the reorganization of surgical activities has promoted the onset of a novel factor influencing the attempt to normalize surgical planning, namely the fear to contract COVID-19. Indeed, it has been shown that any reassembly of hospital structure, in the COVID-19 era stops the proposed operation of several patients.⁵ In our experience, in a community hospital of more than 430 beds in north-west Italy hit by the COVID-19 storm, the elective surgical activity was reduced to 20% on March 20 and collapsed to zero afterward, for a long 3-week interval. As on April 15, a careful observation of the institutional data showed a progressive decline of the disease curve, including no more COVID-19 patients in ICU (Fig. 1), so we were able to plan oncologically urgent interventions, such as radical cystectomy once a week. Moreover, it has been devised to enter into a contract for agreement with COVID-free private clinics, to meet, in conjunction with the National Health System, the need for other non-deferrable uro-oncologic surgeries, mainly TURBTs, radical prostatectomies for high-risk prostate cancer, and prostate biopsies. This strategy led us to regain 60% of our previous surgical activities. There are territorial differences in terms of COVID-19 penetration and health care

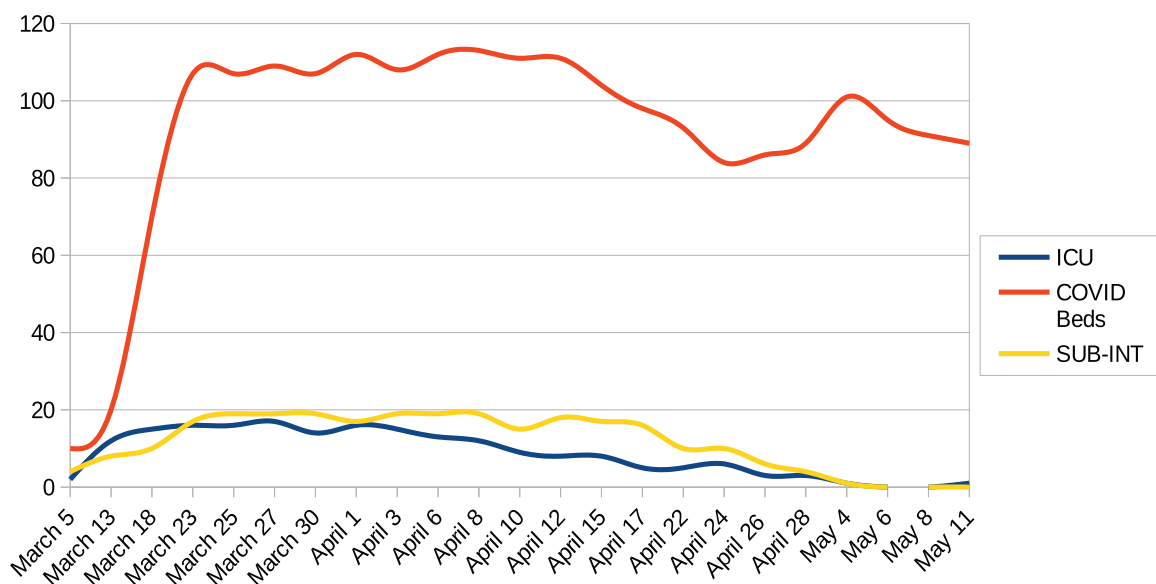


Figure 1. COVID-19 bed occupation, including ICU beds, sub-intensive care beds, and general care beds of a community hospital during the pandemic. (Color version available online.)

system resources. The pandemic scenario could rapidly change due to inadequate social behaviors or in case of a second wave of infection. However, any efforts and suggestions to mitigate the secondary effect of delaying uro-oncologic treatment should be pursued.

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The Good, the Bad, and the Ugly of the COVID-19 Pandemic in a Urology Residency Program in Singapore



To the Editor:

The COVID-19 pandemic has affected Residency training worldwide in an unprecedented fashion.¹⁻³ Residency Programs have been abruptly asked to respond in innovative and dynamic ways in the face of the pandemic.⁴ We share important lessons and insights about the impact on a Urology Residency Program in an Academic Medical Center in Singapore. We focus our discussion around the Academic, Administrative, Professional, and Personal Developmental aspects of Residency training.

THE “GOOD”

Academically, this crisis has presented a perfect opportunity to revisit fundamentals on disease pathophysiology and

natural history. Due to the need to prioritize resources, residents were challenged to examine the necessity of certain treatment procedures, and the expected natural history if treatment was delayed. Residents even developed guidelines and clinical decision-making tools for prioritizing surgical cases. Residents also dedicated more time “paying-it-forward” by teaching undergraduates who similarly transitioned to virtual-learning, thereby consolidating their own knowledge.

Administratively, Residents participated actively in streamlining departmental protocols for the management of common urological conditions during the pandemic. This was achieved mainly through the expansion of our Tele-consultation services. Interprofessional learning was evident with closer interaction with Primary Care colleagues to streamline management pathways, and stronger linkages with other frontline disciplines to provide patient-centric healthcare.

Professionally, we observed significantly closer mentorship by Faculty as cases were meticulously reviewed. Faculty and Residents demonstrated adaptability while under pressure to defer elective cases. Compared to routine clinics or ward rounds, several-fold more cases were discussed. An interesting observation was that Attendings managed to share clinical pearls and insights for seemingly “routine” and “straightforward” cases, further benefiting Residents in their learning.

THE “BAD”

Academically, patient caseload reduced significantly, for the greater good of resource distribution for COVID-19 patients.⁵ Emergency Urological operations remained constant but elective operations reduced by 70% within 2 months. This had significant impact on Residents’ case-logs, with mandatory training requirements at risk of being unfulfilled. Reduced surgical exposure was partly overcome by simulation and virtual-learning of procedures.

Administratively, cross-hospital clinical rotations were restricted to reduce risks of cross-contamination. Furthermore, incoming residents were at risk of missing the commencement of Residency at our institution. This was circumvented with coordinated Ministry of Health efforts, supported by nationwide sponsoring Programs, to ensure that Residents could fulfil required clinical rotations regardless of the hospitals they were based at.

Professionally, physical team segregation has caused significantly reduced social interaction. Yet, through virtual-means, strong camaraderie remained strong within, and across, teams. Residents also had precious opportunities for longer apprenticeships with Attendings, compared to what normal-length subspecialty rotations would typically allow.

THE “UGLY”

Personally, each healthcare professional faces an “ugly” possibility of contracting COVID-19, and more significantly, have placed our loved-ones at risk of transmission as well. Yet, we are grateful for, and galvanized by, supportive families and the wider society.