Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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A risk-based approach is best for decision making on holding mass gathering events

Memish and colleagues,[1] in their response to our Comment,[2] perceive conflict between the current best-practice risk management advice on physical distancing and the scientific evaluation of cancelling or continuing mass gathering events during the coronavirus disease 2019 (COVID-19) pandemic. Although we have already acknowledged the need to balance these two considerations in order to maintain public understanding and trust, we do not accept that conflict is inevitable as our approach requires all mass gatherings to be considered in context, including the prevailing advice on physical distancing and movement restrictions. An open and transparent process to explicitly consider the risks of a mass gathering can, in fact, promote public confidence in the decision.

The validity of our approach is exemplified by the emergence of the novel Middle East respiratory syndrome coronavirus (MERS-CoV) in Saudi Arabia in 2012.[3] MERS has a fatality rate 10–15 times greater than COVID-19, and has spread globally; it has significant epidemic potential (as illustrated by the MERS-CoV outbreak in South Korea[4]) and remains on the WHO Blueprint List of priority pathogens, yet we have never advocated cancelling the annual Hajj pilgrimage in the epicentre of MERS activity. This was because we adopted a risk-based approach and concluded that the risks were manageable in the context of the mitigation measures that Saudi Arabia had put in place; 7 years of safe and successful Hajj since MERS-CoV emerged suggests that the decision was correct. We have not yet seen what decisions might be made by the Saudi Government about the impending Hajj in 2020, in the context of COVID-19, but we urge that those decisions are made on the basis of an evidence-based risk assessment process such as the one we describe in our Comment.[2]

Any risk assessment and risk management framework for a mass gathering might inherently result in cancellation or postponement, as in the recent decision by the International Olympic Committee and Japanese Government to postpone the 2020 Olympic Games.[5] In the current COVID-19 pandemic, it is inevitable in many countries that the outcome will be to cancel or postpone events, either because the risk is too great or because the capacity for mitigation measures is not available, or both. That is an appropriate and valid use of a risk assessment tool. The evidence base for mass gathering health is still evolving and needs to be expanded, and risk assessment frameworks also need to be refined further. Preventing global spread of infectious diseases from mass gathering events and protecting global health security require public health decisions based on evidence and an agreed rational framework for decision making. A systematic process to assess the event encourages us to consider explicitly the reasoning behind the decision, what we expect the decision to achieve, and what evidence exists to support that reasoning. This, in turn, helps us evaluate whether the decision achieves what is expected and so informs future decisions. It also requires consideration of the negative impacts of a decision to cancel an event (jobs, mental health, the economy) and to look for ways to mitigate the adverse effects.

Crucially, we must look to the future. Whatever the course of the COVID-19 pandemic, countries, individually and collectively, will reach a point when they want to start removing restrictions and rebuild communities and economies. This will include decisions on re-starting mass gatherings. These decisions will need to be carefully reviewed and phased to ensure that the COVID-19 pandemic is not reignited; here, we advocate our risk-based approach as a sensible and rational way forward to consider those decisions.

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Urgent dental care for patients during the COVID-19 pandemic

During the initial phase of a pandemic, when a vaccine is not available, personal protective equipment (PPE)[1] plays a major part in disease control. Dental and oral surgery procedures using drills or ultrasonic devices cause aerosol release, and routine dentistry has therefore been suspended in several countries, including the UK, to reduce virus transmission. There is an urgent need for organised emergency dental care delivered by teams provided with appropriate PPE.[2] This also allows for redistribution of PPE to urgent care when there is inevitably an initial shortage and distribution challenge.

Timely and major reorganisation of dental care services is challenging. Early management of acute dental emergencies is important to avert patients from Accident and Emergency services and to avoid hospital admissions. One concern is that with the suspension of routine dental care, more patients than usual could need admission for the management of acute dental infections that threaten the airway and require intensive care.

Patients with substantial swellings can progress to life-threatening emergencies, which can increase risks in the setting of reduced health-care availability. For such patients, extractions of the causative pathogenic teeth should be prioritised over restorative rescue, and input from dedicated oral surgery and oral and maxillofacial services and close follow-up should be instigated as locally appropriate. This approach has many benefits, including stewardship of antimicrobials, but is a deviation away from routine dentistry that should be thoroughly discussed with patients. Decisions on undertaking treatment should therefore be made with appropriate patient consent. Clinicians might wish to follow up patients digitally (eg, through video calls), if appropriate, to ensure patient safety, but also to minimise repeated patient contact.

Testing for coronavirus disease 2019 (COVID-19) in dental professionals should be undertaken with the same high priority as that of medical health-care workers in hospitals. The risk of a dental practitioner being positive for COVID-19 and potentially infecting patients attending emergency dental services should not be underestimated. Proactive and preventive measures need to be established as mainstay protocol to contain the spread of the virus.

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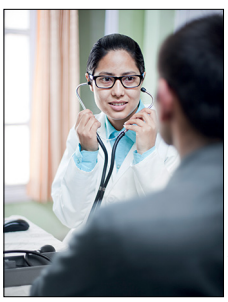
Cancer medicine: a missed opportunity



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Richard Horton's Comment on the broken promise of cancer medicine[1] inspired us to provide another perspective on the issue. Vijayalakshmi, in her 50s, and Sangeeta, in her 30s, both died in 2019 because innovative medicines were not available in India or clinical trials were unavailable. Scores of men, women, and children die every day worldwide due to lack of available treatments.[2] Access has been long debated and although India has a national cancer programme and several treatments available through insurance, care has been unaffordable because insurance does not cover all costs. As patients, we welcomed the World Health Assembly resolution on cancer prevention and control[3] and the related 2018 WHO Technical Report addressing the pricing of cancer medicines.[4]

This report[4] comprehensively addresses pricing approaches and the effects on availability and affordability of cancer treatment. It also provides an overview of financing gaps and incentives for research and development.[4] However, the report missed the opportunity to involve patients and patient organisations; although a civil society was consulted, the report was not representative of constituency. Challenges in cancer care are presented from a narrowed government's perspective, disregarding the vital role of patients, families, and carers. The report makes very important judgments, such as the value that medicines give to patients lives and the effect of extending patients' lives, without regard to patients' views.[4] Patients not only have experience with the disease, but often the best perspective on interrelated challenges of treating cancer, and their input could have helped explain the actual costs across the care continuum, from prevention to end-of-life care.

Considering that for many patients in developing countries, cancer care is still an impoverishing out-of-pocket

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