Public Health in Practice 1 (2020) 100047

Contents lists available at ScienceDirect

Public Health in Practice

journal homepage: www.journals.elsevier.com/public-health-in-practice

Letter to the Editor

Learning from the adaptations made to cancer care pathways induced by COVID-19

Amongst all of the analyses we are seeing regarding cancer care and COVID-19, it is prudent to identify the themes and potential oversights that are of particular importance. Commonalities are most clearly demonstrated in two recent and high-impact modelling studies in *The Lancet Oncology*.

These studies by Sud et al. and Maringe et al. exploring the impacts of delay to 2-week-wait referrals and delay to diagnosis [1,2]. The articles rightly and importantly draw attention to the backlog of undiagnosed patients with cancer and resultant mortality burden unless drastic action is taken in the near future. They call for urgent policy interventions and potential prioritisation of certain patient groups to manage the build-up. However, neither address how such calamitous effects could be mitigated in the first instance and prevented if further spikes occur. There is little doubt that we are likely to see further COVID-19 waves and so further changes to patient care in the short term. The fundamentals of cancer care are different, we must act accordingly.

The unpredictable nature of the pandemic means that immensely adverse changes have been made to all aspects of cancer care since March 2020 [3,4]. This was principally due to risk stratification, and in line with most other healthcare nationwide. However, it is vital to draw attention to the compounding effect that pandemic-induced changes to treatment protocols and deferrals will have had for patients diagnosed pre-COVID-19.

In oncology, it would at first appear that the presence of a more vulnerable patient group would justify a wholly protectionist philosophy. Thus, monitoring rapidly became remote, treatments were withheld, surgeries delayed. Innumerable patients were placed on 'watch-and-wait' strategies due to the perceived COVID-19 risk conferred by therapy-related immunosuppression. Even the perceived risk of travelling was deemed to be too great to continue treatment for vast cohorts of patients.

However, it is our belief that because of that exact fact, the vulnerable patient group, these changes to oncological care should potentially have been slower than elsewhere. These patients are so specifically vulnerable because of the very nature of their cancers. Cancers that, in many instances, can be afforded no remit from therapy, no delay to resection.

Delays of only 2 months in cancer care lead to a substantial proportion of patients progressing from curable to incurable disease [1]. Calculating the effects of these unfavourable changes is challenging, especially when there was such variation in implementation. This in turn leads to an underrepresentation of cancer deaths in such modelling as they do not consider the effect of suboptimal or delayed cancer treatment [2].

It is crucial that the recommendations from Sud et al. and Maringe et al. are heeded imminently with regards to patients entering a cancer pathway. However, for those already under care, lockdown will lift, accessibility to services will resume, but the delay-induced damages are likely irreparable. Furthermore, the threat of further COVID-19 waves is undeniable [5], it is essential to consider how we can learn from the reactive decisions made.

Amongst an abundance of lessons to learn from COVID-19, the uniqueness of cancer care may just be the most important.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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https://doi.org/10.1016/j.puhip.2020.100047
Received 26 August 2020; Received in revised form 9 September 2020; Accepted 1 October 2020
Available online 12 October 2020