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RT to pathologically node-negative neck. Of a total of 72 patients, 14 in the oral cavity, 93% of patients had stage III/IV disease (TNM-7) and 71% of tumours involved or crossed the midline. At a median follow-up of 53 months, only two patients experienced treatment failure in unirradiated neck, and both of these patients also experienced treatment failure locally as well. The unirradiated neck control rate was 97%. Another randomised phase II trial is currently recruiting patients to investigate swallowing function after avoiding Adj-RT in pN0 [3].

Evidence exists that limiting radiotherapy dose or volume results in an improved quality of life [4]. Would the authors of this study, in their experience, suggest there is still a need for Adj-RT to ipsilateral pN0 neck or a need for Adj-RT to contralateral neck that has been staged surgically as negative, if there is ipsilateral pathologically proven positive nodal involvement?

Conflicts of Interest

The authors declare no conflicts of interest.

<https://doi.org/10.1016/j.clon.2020.04.003>

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Effect of the COVID-19 Pandemic on Cancer Clinician Decision Making: Known Knowns and Known Unknowns



Madam — COVID-19 is a global pandemic [1] and poses a significant challenge to cancer patients. Cancer-specific mortality rates are well established. Conversely, the COVID-19 case fatality rates must be interpreted with caution with regards to the lag time effect [2].

Oncologist will have to recognise the uncertainty in quantifying the risks of COVID-19 to cancer patients. This is no different from routine treatment decisions while acknowledging uncertainties in treatment efficacy and potential side-effects.

Liang *et al.* [3] suggested the postponement of cancer treatments but an alternative approach is to stratify treatment modalities according to treatment intent, effectiveness and individualised risk benefit assessment with careful discussion with patients [4]. Radiotherapy delivery during the COVID-19 pandemic poses logistical challenges. Treatment gaps require mitigation and shorter hypofractionated regimens are recommended [5].

No clinical protocols can replace the clinical acumen of oncologists in recommending treatment decisions to patients. The risks of COVID-19 would need to be weighed against the risks of cancer progression and the potential loss of a curative window. Considerations should also account for service disruptions, staff shortages and oncology unit capacity. Frank communication, compassion and honesty in

what we as clinicians do and do not yet know about COVID-19 are what we owe to our patients.

First they are patients, then they have cancer and third they can contract COVID-19 during cancer treatments. These are all separate statistical events and we must not assume all three events have already occurred.

We must take great care when extrapolating data from cohorts of COVID-19 patients to the wider cohort of patients with cancer, who may or may not contract COVID-19 subject to the efficacy of global control measures. It is in such uncertain times that oncologists would do well to heed the wisdom of William Osler to ‘cure sometimes, relieve often, comfort always’ without abandoning good clinical reasoning and evidence-based medicine.

Conflict of interest

The authors declare no conflicts of interest.

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<https://doi.org/10.1016/j.clon.2020.04.010>

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