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Editorial – Cancer patients and COVID-19: history repeats itself

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Since the first cases of SARS-CoV-2 infection during the late 2019, COVID-19 rapidly spread worldwide. The COVID-19 pandemic has upset all our certainties, redirecting the role of our health system[1,2].

During each pandemic wave, the health resources has been shifted towards COVID-19 patients and subsequentially, as infections rate decreased, redirected to no-COVID-19 patients forcing health system to a permanent alert for uncertainly future[2,3].

The first COVID-19 wave took all by surprise, and it determined a high death rate[3-5]. Moreover, due to the pandemic, many other pathologies have been neglected, both due to the fear of COVID-19 and the suspension of some health services[5-7]. However, this catastrophic experience also taught us to face further waves with greater confidence and awareness.

As the COVID-19 death rate continues to decline, European countries are gradually reducing restrictive measures. During the last two years, we have somehow learned to live with this virus and its related restrictive measures[6]. Nevertheless, each time the wave of SARS-CoV-2 infections increased, we observe a sharp decline of surgical procedures[1-6].

In order to avoid further delay in treatments for surgical patients, many strategies were adopted according to many scientific recommendations[6-8]. We started the "telemedicine and telephone triage" before getting patients into the hospital, moreover all patients that were scheduled for surgery underwent to nasopharyngeal swab test for SARS-CoV-2 detection[6]. Outpatient surgery was introduced whenever possible and awake surgery were preferred in order to reduce hospitalization and both to decrease the risk of hospital SARS-CoV-2 infection and to reduce hospital bed occupancy as much as possible[6-9]. Moreover, most of the surgical procedures that could be postponed had been delayed[6].

Despite all these measures, at the end of the first wave, the waiting lists for surgery have grown out of all proportion. In addition, in that period, we have also observed an increasing number of tumors in advanced stages, no more suitable for surgery[6].

Nowadays, at where we stand for? Unfortunately, history seems to repeat itself.

The new epidemic wave has forced health policy to allocate larger hospital spaces to COVID-19 patients. Surgery beds had been halved, elective admissions had been suspended, conversion to intensive care for COVID-19 patients, nurses and anesthetists from the operating rooms have been transferred into COVID-19 wards. In this way, the surgical activity was abruptly reduced, reserving the interventions only for cancer and emergency patients, failing to satisfy the ordinary requests[10].

Furthermore, in this latest wave we are observing a new phenomenon: asymptomatic COVID-19 patients. These can be heath cares and patients waiting for surgery. Both these asymptomatic COVID-19 patients are temporarily isolated waiting for nasopharyngeal swab testing negative for SARS-CoV-2 infection, causing a further reduction in the number of health workers and surgical procedures postponed and added to a long waiting list[10].

In 2021, despite the commitment of health policies, economic funds dedicated to the emergency and new temporary employment contracts for healthcare workers, we were unable to dispose the waiting lists accumulated in 2020 for elective surgical pathologies[6-10].

Today, it is urgent to plan what in a few weeks, after the last wave of pandemic emergency, will in all likelihood become a new health emergency in view of the end of the state of emergency and the possible reduction of economic resources and the long-awaited lists for surgical procedures.

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Conflict of Interest

The authors declare that they have no conflict of interests.

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