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Letter to the Editor

How to restructure the management of Italian oncological patients during and after COVID-19 pandemic?

Dear Editor,

Due to the current coronavirus disease 2019 (COVID-19) emergency, oncologists are facing unpredictable issues in their everyday practice and are soon bound to get prepared for a new line of assistance for their patients[1]. First of all, the risk of infection in overcrowded structures or via unprotected healthcare personnel is to absolutely be prevented within oncological units, in view of the higher risk (about four-times greater) of severe events after contagion in our patients compared with patients without cancer[2,3]. An even greater concern for us is towards the sick who are currently under active treatment in which severe secondary events of COVID-19 are much more critical and even more so in the older population[2] and in patients with serious comorbidities, such as cardiovascular diseases and diabetes. In Italy, according to data reported by the Istituto Superiore di Sanità on 2 April 2020, 17% of patients who died of complications from the COVID-19 infection were cancer patients[4]. More resources will be needed, especially to increase hospital beds and health personnel, as those suffering from major diseases and in need of hospitalizations, which cannot be postponed, should not be overlooked because of the persisting risk of the COVID-19 infection. Second, a political and social reorganization will be necessary to ensure continuity of oncological treatments notwithstanding reduced resources (both clinical wards and personnel are being converted and moved to infectious disease activities). The COVID-19 emergency should not induce the healthcare system to neglect many other life-threatening conditions; many patients need therapies that cannot be postponed nor administered in dangerous environments.

Based on our direct experience of clinical needs and of the unwanted emergency, we wish to propose some interventions to face the changing situation. Indeed, we think it is our duty to present our technical advice for a great organizational change, which will only be efficient if based on needs and hints from the field.

Frequent and attentive check-up of the healthcare personnel would greatly reduce the risk of infection transmission within sanitary institutions.

To obviate overcrowding and ensure interpersonal spacing, hospital entrances, waiting rooms and clinics should be remodeled and enlarged as much as possible. In addition, visits are to be attentively scheduled to avoid unnecessary waiting times within clinical spaces. Following the example of great oncological centers, telemedicine should be used to follow-up selected outpatients, and for triaging emergent problems (thus limiting the use of day-hospital for diagnosis). Patients with low progression disease or those followed-up for at least 5 years after termination of active treatment would not need physical visits, if not in selected cases[5].

While avoiding the access to hospitals or clinics as much as possible, continuing treatment should be granted, while the risk of adverse events should be reduced. Oncological management nowadays does not require as much inpatient assistance as a few years ago. Supporting therapies have greatly increased tolerability and safety of active treatment, while digital online instruments for communication and oral targeted therapies are available and may facilitate treatments at home. Domiciliary administration of therapy may be associated with new commu-

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nication systems especially telematic, such as telemedicine. Blood test results previous to drug dosing should be monitored by telemedicine, so that chemotherapy sessions are not necessarily carried out in day-hospitals. Information about treatments, adverse events and management should be provided by phone calls or online platforms, and oncological visits should be avoided as much as possible. Therefore, nurses will be central to this type of organization; they will need new skills to schedule home treatment and contact patients by phone calls or telemedicine instruments. Physical visits will be limited to restaging or serious adverse events. Such changes in the management of patients require new assistance protocols to be produced, personnel to be trained, resources to be reallocated, and budgets for outpatient or day-hospital services to be revised. This new type of organization will consider local needs and structure availability. Greater emphasis should be placed on the reorganization of general medicine; closer interactions between the oncologist and that of the general doctor would limit patients' presence in specialized centers. In addition, anticancer treatment-induced complications of COVID-19 should be prevented; de-escalation of chemotherapy to limit cytopenia and discontinuation of the use of checkpoint inhibitors has been proposed, although no evidence is available at present on the effectiveness of such interventions[3].

Last, but not at all negligible, reflection: for a specialty such as ours and for the innate Italian culture in which the empathy between the doctors and their patients is crucial, we will be forced to give up the physical proximity of the patient, the hug and the handshake, which can do so much in establishing an alliance for an optimal path of care: for how long, we do not yet know.

Conflict of Interest

The Authors declare that they have no conflict of interests.

Declaration of Funding Interests

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