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# Adapting head and neck cancer management in the times of COVID-19.

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## Editorial

# Adapting head and neck cancer management in the times of COVID-19.

We are living in ‘unprecedented’ times! How many times have we heard that in the last three months? Indeed, it almost does not register any more.

We are fortunate that few of us have experienced war in recent times. But for those of us who have, the current situation is reminiscent of life and health care during wartime.

The COVID-19 pandemic has touched every dimension of our lives: Our daily behaviours, our interactions with family and friends, our leisure time, and quite dramatically our work. As clinicians, the effect on clinical practice has been possibly the hardest with which to contend. The nature of the adaptations that have become increasingly necessary, and the scale and speed with which they have had to be implemented, has truly been ‘unprecedented’.

Operating capacity has been slashed, as operating rooms are converted into intensive care space, and operating staff redeployed to man those beds. Ward beds are no longer available to accommodate routine surgical cases. Those patients requiring post-operative intensive care can no longer have their operations. Operative theaters are rationed, with each case reviewed and approved only by committee.

As a result, we are adapting by doing less extensive surgery, even if it may mean worse functional outcomes, and by accepting delays that we would not normally countenance. Other patients are recommended radiotherapy instead of surgery. And in some regions, systemic therapy is being considered as a means to delay surgical procedures.

Medical and radiation oncology services have had to adapt rapidly too. Many have experienced increases in caseload, because of the reasons above. Yet at the same time, they have had to cope with considerable reductions in staff, due to COVID-19 infection or self-isolation. Many services in regions considered “hot-spots” for COVID-19 have therefore had to re-consider the standard risk benefit ratio with which we are normally comfortable. They have had to consider hypo-fractionation radiotherapy regimens, to shorten treatment durations, reduce visits and exposure to hospital, and to increase patient throughput. In addition, many have weighed up the benefit of concomitant chemotherapy against the significant increase in acute toxicity, potential complications and associated hospital admissions, as well as the need for more intensive monitoring. As a result, some have opted for the omission of concomitant chemotherapy in the curative setting.

Because of the lack of evidence and literature about COVID-19, we have had to undertake these decisions with a high degree of uncertainty. There are many unanswered questions: will

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4 COVID-19 patients tolerate radiotherapy in a similar way to non-COVID patients; is  
5 immunotherapy protective or a risk factor for COVID-19 infection and severity; does  
6 immunosuppression associated with HNC and its therapy impact COVID-19 outcomes; does  
7 COVID-19 infection increase the risk of complications of surgery; what is the best tracheostomy  
8 technique to reduce aerosol generation; are remote follow-up consultations or no consultations  
9 at all safe for head and neck cancer patients; and who should be prioritised for treatment in the  
10 setting of severe shortages of capacity - should a highly curable patient be prioritized over a  
11 palliative patients with symptoms?  
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16 As never before, we have become acutely aware (and appreciative) of the critical role that  
17 research has in guiding our daily practice. And yet, we have had to suspend many research  
18 activities. How do we try to maintain ongoing research, given the necessity to halt clinical trial  
19 enrollment to preserve resources and to comply with physical distancing? How do we make up  
20 for lost opportunities due to closure of laboratories doing critical correlative science?  
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23 We have been collectively exposed to stresses that we may have never encountered before.  
24 Many of us have had to care for patients outside their own specialties. Some of us have had to  
25 learn to do venesection or use the stethoscope again after many decades. And we have all  
26 reached out for the physiology book or the online tutorial on the respiratory system and blood  
27 gases.  
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31 We have also learnt that some of us - especially in otorhinolaryngology, dentistry, maxillofacial  
32 surgery, ??and ophthalmology?? - appear to be at even higher risk of COVID-19 infection and  
33 occasionally death, presumably due to high viral loads in the upper airways and regular  
34 exposure to aerosol generating procedures, such as nasal endoscopy, dental procedures,  
35 tracheostomy and upper airway surgery. Severe curtailment of the procedures have now been  
36 instituted in many centres.  
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40 Our physician-patient relationships are also being strained. How do we balance the need to  
41 provide the best possible care with restrictions on access to personal protection equipment,  
42 operative theaters and intensive care? How do we best balance accurate assessments of  
43 toxicities with travel and exposure risks to our patients with face-to-face visits? How do we  
44 seamlessly transfer care from major referral centers to local community oncologists and  
45 reassure patients that this will not affect outcomes?  
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49 Further, some of us have had to take very difficult decisions on who would be ventilated and  
50 who should not. These are decisions that we are used to in our normal clinical practice in  
51 oncology, but not at such frequency, scale or for non-cancer indications.  
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54 These are unprecedented psychological stressors. We need to ensure that working practices  
55 allow for downtime and recovery so that we do not burn out. And like no time before, we need to  
56 be able to support and care for our fellow clinicians and colleagues. Petty disagreements,  
57 dysfunctional working relationships and unhelpful specialty territorial boundaries have no place  
58 in these 'unprecedented' times.  
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6 One of the important ways of reducing the stress of uncertainty and unfamiliarity in clinical  
7 practice has been the rapid development of guidance by different professional bodies. Their  
8 availability has been very welcome to the overstretched, overstressed clinicians working on the  
9 front line. However, due to lack of time, resources and available evidence, these are usually  
10 developed by local or national bodies and are based on small group expert opinion.  
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13 In this issue, a new international guideline for the treatment of HNC patients with head and neck  
14 cancer by radiotherapy during COVID-19 pandemic (1) is published. The authors completed  
15 three rounds of a Delphi consensus process, that involved 30 radiation oncology experts from  
16 around the world, including China and south-east Asia who have had to deal with the virus the  
17 longest. The resulting guidance, endorsed by ASTRO, ESTRO and the Head and Neck Cancer  
18 International Group, makes available the considered consensus advice of this international  
19 group of experts. There are several strengths of the approach used by this guideline: The  
20 qualitative scientific methodology, the involvement of experts from across the globe, and the  
21 consideration of two different pandemic scenarios, early risk mitigation and severely reduced  
22 resources. Remarkably the whole process was undertaken in under two weeks, a testament to  
23 the efforts and commitment of the authors, and an example to us all of what can be achieved.  
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29 Additional international efforts are underway. Using the same methodology, an international  
30 consensus guidelines is currently being developed for surgery by the Head and Neck  
31 International Group. Other efforts are under way to prospectively collect, collate and rapidly  
32 publish data relevant to decision making for the head and neck cancer patients, so that we can  
33 address with data the questions raised above.  
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36 As with all such guidelines, these of course need to be interpreted and implemented locally, as  
37 conditions differ from region to region, country to country and hospital to hospital. Even in the  
38 same hospital, the situation is changing on a weekly and sometimes daily basis.  
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41 But, now is the time to rally our extraordinary worldwide community of head and neck cancer  
42 practitioners. Together, we can get through this crisis with thoughtful guidelines such as these.  
43 And never has there been more need than in these 'unprecedented' times!  
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46 Stay well.  
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## 51 Reference

- 52 1. Reference to the Guidelines by Thomson and Yom  
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