

## EDITORIAL

### Cancer does not care about coronavirus



In early January 2020, the first documented case of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) appeared in the United States. As the global coronavirus disease 2019 (COVID-19) pandemic charged on, we watched various cities, counties, and states within our own country and other countries throughout the world respond to this crisis. Observational information from health care workers on the frontlines, governmental agencies, such as the Centers for Disease Control and Prevention (CDC), the World Health Organization (WHO), and various medical societies often left more questions than answers with respect to who was getting infected, risk of transmission, accurate testing, method of treatment, and means of protection. With so many unknowns, immediate social distancing and “shelter-in-place” orders were required as temporizing measures to prevent already often saturated local health systems and hospitals from being overwhelmed.

The extensive damage caused by this pandemic, both directly to human life and indirectly to the socioeconomic conditions, cannot begin to be summarized in this editorial. I would like to address the topic of cancer care with specific references to my area of expertise, that is, head and neck cancer, during this COVID-19 pandemic.

The debate regarding how prepared we were as a health care community to handle such an outbreak will be deliberated for years to come. Both known chronic diseases (i.e., heart disease or diabetes) and acute or new diseases (i.e., cancer, trauma, bacterial/viral infections) will continue to affect the population at various rates throughout this pandemic. The importance of treating patients with these diseases during such a pandemic should be considered a high priority because often, these patients are immunocompromised as a result of age, systemic disease, cancer, or malnourishment and are at the highest risk for the worst effects of any such viral pandemic.

Head and neck cancer care has been affected on multiple levels during COVID-19.

In the current situation, we understand that a delay in diagnosis or access to care could occur as a result of patients being too fearful to go to their primary care providers (doctors/dentists) because of “stay-at-home” orders and health care practitioners’ offices being closed because of governmental orders and shortage of personal protective equipment (PPE). Early implementation of telemedicine, along with community physicians and

dentists continuing to evaluate and provide care for patients with emergency and acute conditions, has helped offset this issue.

Globally, hospitals in many countries have been so overrun by COVID-19 cases that cancer care has come to a halt in those countries. I am fortunate to be able to say that both at my own institution and in the majority of other health care organizations throughout the United States, this did not occur. Both at the clinical provider level and at the hospital organization level, there has been understanding and acknowledgment of the stress and anxiety that a delay in diagnosis or in treatment would create in patients with cancer. Hospitals quickly established surge plans and prioritized patient care, with cancer care given the highest priority in some cases. Multidisciplinary head and neck tumor boards have continued in a virtual world by using teleconferences and surgical and nonsurgical therapies have proceeded as planned. Patients have been offered standard-of-care therapies, including appropriate surgeries and formal flap reconstructions; robotic procedures, as needed; and chemotherapy or radiation therapy, when indicated. Minimizing hospital/outpatient exposure to the virus or further immunosuppression resulting from chemotherapy has been considered with great care.

I have watched with great pride as health care workers from my department (doctors, fellow/resident trainees, nurses, clinical/nonclinical staff) have continued to treat our patients despite concerns regarding greater-than-average risk of exposure in viral aerosol-generating procedures. Various position papers and safety guidelines continue to be published with respect to the adequate use of PPE, environmental safety within ambulatory and operative suites, sterilization procedures, and risk stratification of patient procedures. One must remember that this is all observational and expert opinion level evidence. At the most fundamental level, it comes down to the use of proper PPE (gowns, gloves, face shields, and properly fit-tested N-95 masks or powered air-purifying respirators). In essence, this is just a continuation of good universal precautions, which, unfortunately, many providers had become quite complacent about in years past. Antigen–antibody COVID-19 testing will continue to improve, but it is still lacking in high-level sensitivity and specificity. Despite this, at most institutions, it is standard practice to perform COVID-19 antigen testing in patients before they undergo head and neck surgical procedures. We, as health care providers, must

ensure the safety of ourselves, our staff, and our families, but we should remember that we have the mandate to treat our patients and to understand that the job comes with some personal risk. It was not long ago that other communicable diseases, such as HIV/AIDS, hepatitis C, and tuberculosis, did not have effective therapies and the same risks and rules applied.

The COVID-19 pandemic has forced our economy into recession, which has affected all areas of society, including health care. A significant portion of both hospital and dental school revenue, including that of any oral-maxillofacial surgery unit, is generated from operative procedures. The ability to evaluate and perform operative procedures on patients with head and neck cancer has helped serve the dual purpose of providing essential care and maintaining the revenue of and the purpose for OMS departments within their respective health systems.

Unfortunately, the COVID-19 pandemic is far from over, and patients with new or recurrent head and neck cancers will continue to need care. Until a vaccine or an effective antiviral treatment regimen is developed, we, as oral health care providers, will need to encourage our patients to continue undergoing routine oral cancer screening examinations, adhere to the recommended practices to decrease the risk of severe acute respiratory syndrome coronavirus 2 transmission, and advocate passionately for the treatment of our patients with head and neck cancer.

*Joshua E. Lubek, DDS, MD, FACS, Section Editor  
Oral and Maxillofacial Surgery Section, Oral Surgery  
Oral Medicine Oral Pathology Oral Radiology*

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