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Letters

COMMENT & RESPONSE

Evidence Base for Health Care Strategies to Protect Vulnerable Patients During the COVID-19 Pandemic

To the Editor The Editorial by Hoerger and colleagues¹ published recently in *JAMA Oncology* outlined 10 health care strategies to support patients who are vulnerable during the COVID-19 pandemic. We agree that strategies for protection are needed, but these strategies should be evidence based, which the 10 recommendations are not.

Hoerger and colleagues¹ build on 3 previously suggested strategies: ventilation, filtration, and 2-way masking. Currently, to our knowledge, there are no randomized data on filtration systems in reducing COVID-19 transmission, although there are several randomized studies under way.^{2,3} Randomized data on the efficacy of masks are limited to 2 studies^{4,5} that either reported no benefit or were biased, making it difficult to determine whether the small benefit reported was real or confounded. Neither study tested N95 masks. Moreover, whether masks work for months or years on end has not been assessed. Other interventions—antibody testing, prophylactics, education, or treatments for post-COVID-19 condition—have yet to be tested to determine whether they have benefit.

The authors¹ may contend that there are no downsides to these strategies. Yet there are downsides. Patients with cancer spend a good deal of time and financial resources on medical treatment. Engaging in these suggested strategies would further add to their time burden for medical treatment—time that could be spent enriching their quality of life with family or other meaningful and enjoyable activities. This additional time burden could be justified, however, if an evidence-based approach supported that these strategies lead to better patient outcomes. Because no randomized studies have been conducted, the time may be spent in vain. The financial aspect is an additional downside. There have been substantial financial contributions to implement these strategies,¹ which means that

financial resources, which are limited, are being used to implement non-evidence-based strategies, when that money could have been used to conduct trials to generate evidence.

We should not be complacent to accept recommendations based on intuition or basic laboratory or observational data, or because they are “imaginative,” as it has been 3 years since the COVID-19 pandemic began. Rather, we should expect that recommendations are based on high-quality randomized clinical trial data with demonstrable efficacy.

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