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EDITORIAL

**Adapting Head and Neck Cancer Management in
the Time of COVID-19****Hisham Mehanna, PhD, FRCS (ORL),* Maura Gillison, MD, PhD,†
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“We are living in unprecedented times.” How many times have we heard that in the last 3 months? Indeed, it almost does not register anymore. We are fortunate that few of us have experienced war in recent times. For those of us who have, however, 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 behaviors, 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 postoperative 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

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outcomes, and by accepting delays that we would not normally countenance. Other patients are recommended radiation therapy instead of surgery. 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 as a result of the reasons noted above. Yet at the same time, they have had to cope with considerable reductions in staff owing to COVID-19 infection or self-isolation. Many services in regions considered hot spots for COVID-19 have therefore had to reconsider the standard risk–benefit ratio with which we are normally comfortable. They have had to consider hypofractionation radiation therapy regimens to shorten treatment durations, reduce visits and exposure to hospitals, and increase patient throughput. In addition, many have weighed the benefit of concomitant chemotherapy against the significant increase in acute toxicity, potential complications and associated hospital admissions, and the need for more intensive monitoring. As a result, some have opted for the omission of concomitant chemotherapy in the curative setting.

submitted work. H.M. is a National Institute for Health Research senior investigator. The views expressed in this article are those of the author(s) and not necessarily those of the National Institute for Health Research or the Department of Health and Social Care.

As a result 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 COVID-19 patients tolerate radiation therapy in a way similar to non-COVID patients? Is immunotherapy protective or a risk factor for COVID-19 infection and severity? Does immunosuppression associated with head and neck cancer and its therapy affect COVID-19 outcomes? Does COVID-19 infection increase the risk of complications of surgery? What is the best tracheostomy technique to reduce aerosol generation? Are remote follow-up consultations or no consultations at all safe for patients with head and neck cancer? Who should be prioritized for treatment in the setting of severe shortages of capacity? Should a highly curable patient be prioritized over a palliative patient with symptoms?

As never before, we have become acutely aware (and appreciative) of the critical role that research has in guiding our daily practice. Yet we have had to suspend many research activities. How do we try to maintain ongoing research, given the necessity of halting clinical trial enrollment to preserve resources and to comply with physical distancing? How do we make up for lost opportunities from the closure of laboratories doing critical correlative science?

We have been collectively exposed to stresses that we may have never encountered before. Many of us have had to care for patients outside our own specialties. Some of us have had to learn to do venesection or use the stethoscope again after many decades. And we have all reached out for the physiology book or the online tutorial on the respiratory system and blood gases.

We have also learned that some of us, especially in otorhinolaryngology, dentistry, maxillofacial surgery, and ophthalmology, appear to be at even higher risk of COVID-19 infection and occasionally death, presumably due to high viral loads in the upper airways and regular exposure to aerosol-generating procedures, such as nasal endoscopy, dental procedures, tracheostomy, and upper-airway surgery. Severe curtailment of these procedures has now been instituted in many centers.

Our physician–patient relationships are also being strained. How do we balance the need to provide the best possible care with restrictions on access to personal protection equipment, operative theaters, and intensive care? How do we best balance accurate assessments of toxicities with travel and exposure risks to our patients with face-to-face visits? How do we seamlessly transfer care from major referral centers to local community oncologists and reassure patients this will not affect outcomes?

Furthermore, some of us have had to make very difficult decisions on who will be ventilated and who will not. These are decisions that we are used to in our normal clinical practice in oncology, but not at such frequency or scale or for noncancer indications.

These are unprecedented psychological stressors. We need to ensure that working practices allow for downtime and recovery so that we do not burn out. And like no time before, we need to be able to support and care for our fellow clinicians and colleagues. Petty disagreements, dysfunctional working relationships, and unhelpful specialty territorial boundaries have no place in these unprecedented times.

An important way of reducing the stress of uncertainty and unfamiliarity in clinical practice has been the rapid development of guidance by different professional bodies. Their availability has been very welcome to the overstretched, overstressed clinicians working on the front line. However, due to lack of time, resources, and available evidence, these guidelines are usually developed by local or national bodies and are based on small group expert opinion.

In this issue, a new international guideline for the treatment of patients with head and neck cancer by radiation therapy during the COVID-19 pandemic¹ is published. The authors completed 3 rounds of a Delphi consensus process that involved 30 radiation oncology experts from around the world, including China and Southeast Asia, who have had to deal with the virus the longest. The resulting guidance, endorsed by the American Society for Radiation Oncology, the European Society for Radiotherapy and Oncology, and the Head and Neck Cancer International Group, makes available the considered consensus advice of this international group of experts. The approach used by this guideline has several strengths: the qualitative scientific methodology, the involvement of experts from across the globe, and the consideration of 2 different pandemic scenarios—early risk mitigation and severely reduced resources. Remarkably, the whole process was undertaken in under 2 weeks, a testament to the efforts and commitment of the authors and an example to us all of what can be achieved.

Additional international efforts are underway. Using the same methodology, an international consensus guideline is currently being developed for surgery by the Head and Neck International Group. Other efforts are underway to prospectively collect, collate, and rapidly publish data relevant to decision-making for patients with head and neck cancer so we can address with data the questions raised above.

As with all such guidelines, these of course need to be interpreted and implemented locally; conditions differ from region to region, country to country, and hospital to hospital. Even in the same hospital, the situation is changing on a weekly and sometimes daily basis.

But now is the time to rally our extraordinary worldwide community of head and neck cancer practitioners. Together, we can get through this crisis with thoughtful guidelines such as these. Never has there been more need than in these unprecedented times.

Stay well.

Reference

1. Thomson DJ, Palma D, Guckenberger M, et al. Practice recommendations for risk-adapted head and neck cancer radiotherapy during the

COVID-19 pandemic: An ASTRO-ESTRO consensus statement. *Int J Radiat Oncol Biol Phys*, in press.

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