

Letter to the Editor


Cite this article: Kumar A, Singh R, Munda PKS, Raina P, and Tudu R. (2020) The new normal in the oncology department in COVID-19 scenario. *Journal of Radiotherapy in Practice* 19: 405. doi: [10.1017/S1460396920000485](https://doi.org/10.1017/S1460396920000485)

Received: 16 May 2020
Revised: 19 May 2020
Accepted: 24 May 2020
First published online: 18 June 2020

Author for correspondence:

Rashmi Singh, Rajendra Institute of Medical Sciences, Oncology Block, Bariatu, Ranchi, Jharkhand 834009, India. Tel: 0651-2541533. Fax: 91-651-2540629. E-mail: rashmisingh.noor@gmail.com

The new normal in the oncology department in COVID-19 scenario

Anup Kumar, Rashmi Singh , Praveer Kumar Singh Munda, Payal Raina and Rajanigandha Tudu

Rajendra Institute of Medical Sciences, Oncology Block, Bariatu, Ranchi, Jharkhand 834009, India

The COVID-19 pandemic is an international public health emergency with a 4,347,935 total number of cases and 297,241 deaths worldwide.¹ We are highlighting the practice changes at our centre in the oncology department during the outbreak of COVID-19.

During this pandemic, the oncology department as a whole is also being affected; in India, the majority of centres are either closed or partially functioning. As reports of catching COVID-19 in health care workers have surfaced, while caring for patients having no symptoms or signs of COVID-19, thus leading to shut down of medical facility.

Cancer patients are at a higher risk of developing severe COVID-19 manifestations and have over three times a higher risk of death.² In the oncology setting, the following measures are being taken to reduce the risk of COVID-19 transmission to patients and healthcare workers. All patients needing consultation are sent to a COVID-19 screening centre for testing, this is a dedicated place and testing is mandatory for all patients attending health care settings. Real-time polymerase chain reaction (RT-PCR) testing for COVID-19 should be proposed for cancer patients as per institutional protocols. Also, general practice of hand hygiene, social distancing, the use of a face mask by all, and regular sanitization of work place should be emphasised. The wearing of personal protective equipment assists in safeguarding the health care worker undertaking surgical interventions and during the treatment of cancer patients attending for multiple fractions of radiotherapy.

Patients on cytotoxic chemotherapy are to follow the schedule as advised, judicious use of G-CSF/Peg-Filgrastim in the prescription, and taking a nutritious balanced diet along with maintaining oral care with lukewarm saline water gargles for 2–3 days following chemotherapy.

Patients already on oral hormone therapy, TK inhibitors, and cytotoxic chemotherapy medications can be prescribed to continue the treatment for 2–3 months where possible. Blood monitoring for those patients can be done in local labs close to their home. This further reduces the patient volume in the oncology setting.

During this tough time, surgery for some cancer patients has been deferred and some patients are being referred for neoadjuvant chemotherapy/radical chemo-radiotherapy instead. This will be the new normal for cancer patients until a vaccine against COVID-19 becomes available for all.

Patients treated with radiotherapy with a curative intent may need to attend the hospital for up to 6–7 weeks and those treated for palliative intent may need to attend the hospital for up to 1–3 weeks. During this pandemic, strategies have been developed to select patients for radiotherapy on a priority basis and where possible, treatment to be delayed for 4–6 weeks³ or to shorten the total treatment duration without compromising the overall treatment outcome. These strategies decrease the risk of COVID-19 infection for patients, the hospital staff, and other patients already on treatment.

To reduce the overall treatment times for patients attending for radiotherapy, we are moving from the conventional (1.8 Gy/#–2 Gy/#) to hypo-fractionation schedules for cases where this is feasible. As clinical trials in breast and prostate cancer have clearly shown a non-inferiority of clinical outcomes in using hypo-fractionation in the curative setting, these schedules are now in current practice. There are recent recommendations made by ASTRO-ESTRO for head and neck cancer hypo-fractionation schedules to ease this pandemic situation.³ For all palliative cases, we are using 1–5 fractions as per clinician discretion.⁴

References

1. WHO Dashboard as of 8:13pm CEST, 15 May 2020. (Google)
2. Liang W, Guan W, Chen R et al. Cancer patients in SARS-CoV-2 infection: a nationwide analysis in China. *Lancet Oncol* 2020; 21 (3): 335–337. doi: [10.1016/S1470-2045\(20\)30096-6](https://doi.org/10.1016/S1470-2045(20)30096-6).
3. Thomson DJ, Palma D, Guckenberger M et al. Practice recommendations for risk-adapted head and neck cancer radiation therapy during the COVID-19 pandemic: an ASTRO-ESTRO consensus statement [published online ahead of print, 2020 Apr 14]. *Int J Radiat Oncol Biol Phys* 2020; S0360–3016(20)31034–8. doi: [10.1016/j.ijrobp.2020.04.016](https://doi.org/10.1016/j.ijrobp.2020.04.016).
4. Hahn E, Livergant J, Millar BA, Ringash J, Wong R, Dawson LA, et al. Comments on the publication by Yerramilli et al. titled “Palliative Radiotherapy for Oncologic emergencies in the setting of COVID-19: Approaches to Balancing Risks and Benefits.” *Adv Radiat Oncol* 2020. doi: [10.1016/j.adro.2020.04.017](https://doi.org/10.1016/j.adro.2020.04.017).

© The Author(s), 2020. Published by Cambridge University Press. This is an Open Access article, distributed under the terms of the Creative Commons Attribution licence (<http://creativecommons.org/licenses/by/4.0/>), which permits unrestricted re-use, distribution, and reproduction in any medium, provided the original work is properly cited.