Protecting “covid protected” cancer hubs
Many patients still face risks from nosocomial transmissions from asymptomatic healthcare workers and patients

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With covid-19 disrupting global healthcare services, people affected by life threatening conditions such as cancer have faced substantial treatment delays or modifications. In the pandemic’s early days, with much unknown, this caution was understandable. For cancer, emerging data from small retrospective cohorts suggested a higher rate of serious complications or death following infection, particularly in late stage metastatic disease.1,4

This has caused widespread anxiety, with many facing difficult conversations with their clinical teams, often through unfamiliar platforms, as new national treatment guidelines are interpreted into personal care plans to appropriately balance risks.

These delays to treatment, coupled with a large drop in diagnostic referrals from a population understandably reluctant to seek help for suspicious symptoms, have raised concerns of a “post-pandemic surge” in non-covid associated mortality, as early stage, curable cancers progress to inoperable disease, or spread beyond the primary site.5

To try to prevent this, there has been a rapid effort to reconfigure services in order to safely treat patients with new or existing diagnoses of cancer. In the UK, this has led to the establishment of “covid protected” cancer hubs where, after centralised triage to prioritise patients based on clinical need, patients are screened up to 48 hours before admission for surgery at “clean” sites, including those in the private sector.6 Institutes in other countries have taken similar approaches.7

Such efforts are vital to reinstate safe care. Yet worries remain about the risks patients still face from nosocomial transmissions from asymptomatic healthcare workers and other patients.6,9 Are our “protected” sites adequately protected?

Protecting the hubs
Emerging evidence suggests SARS-CoV-2 transmissions can occur in the pre-symptomatic or asymptomatic phase of infection.8,9 Evidence suggests substantial asymptomatic covid-19 carriage and transmission with a significant proportion of healthcare workers carrying the virus pre- or asymptptomatically.10-17

For truly “covid protected” cancer treatment, it will be essential to regularly screen asymptomatic staff in cancer hubs. Unfortunately, despite progress, many countries, including the US, are still not testing widely, frequently, or quickly enough—either in protected areas, or more broadly—to adequately prevent patients from infection during treatment.18-19 The UK secretary of state for health’s announcement on 6 May that all medical staff are to be tested weekly is important in this regard, and will become more so as lockdown measures are relaxed further.20 However, with so much focus on capacity, turnaround time has been neglected. Reliable UK data on this measure are lacking, and challenges to developing a rapid and accessible testing pipeline have not been sufficiently tackled. Indeed, in April 2020, UK testing capacity exceeded the number of tests performed by twofold or more, pointing to major unsolved hurdles in logistics.21 Anecdotally, we’ve heard that turnaround times for healthcare worker testing can sometimes be upward of three days.

In the UK, overcoming barriers to rapid, routine staff and patient testing in all protected cancer treatment areas will be essential for the restoration of safe cancer care.

Several opportunities present themselves. Self-swabbing and saliva approaches, rather than nurse led nasopharyngeal (NP) swabbing, could rapidly accelerate testing, with emerging suggestions that the former may be even more sensitive than NP swabs.22 Turnaround times would be boosted further by rapid, high throughput testing or next generation assays.23-26

Distinct IT systems, with limited interoperability, delay the ability of widespread testing to be implemented and results to be readily disseminated and acted upon, particularly for testing in the community. Local IT solutions are required, modelled to the needs of the community and healthcare system each laboratory serves.

Taken together, such developments could enable twice weekly hospital testing of all staff and patients cost effectively, safely, and rapidly.
Beyond the hubs

Testing, however, needs to expand beyond cancer hubs. A diagnosis of cancer is, like many serious conditions, accompanied by a need for access to a range of secondary care services. Simply protecting patients on wards before and during surgery is not enough to fully protect them from covid-19. We cannot just view them as “cancer” patients who need “cancer” services.

This means rigorous, frequent (arguably twice weekly) testing of all healthcare workers working in proximity to patients, not just those working in “protected” areas—clearly an enormous task, requiring rapid organisational change. Naturally, as lockdown loosens, all patient admissions, both elective and emergency, will also need to be screened. To bring all this about, we must be flexible in the thresholds we set for evidence, particularly the need for stringent health economic evaluations, which almost seem absurd when the wider economic indicators are so catastrophic.

The benefits of getting this right would extend far beyond cancer care, greatly minimising risks for all patients, regardless of their condition. Effective covid-19 therapies are still lacking, and a vaccine may be years away. In their absence, the coronavirus’s main enemies are, currently, social distancing and protective equipment. They must also include widespread testing, with aggressive contact tracing and quarantining, and truly covid protected hospital environments. Time is the virus’s greatest friend. We must not delay.

Commissioned, not peer reviewed

Competing interests: HS a member of the National Cancer Research Institute Commissioned, not peer reviewed

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