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# Cancer care during and after the pandemic

## From ordeal to opportunity through innovation and cooperation

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The covid-19 pandemic has had a drastic effect on the entire cancer continuum through interruption, delays, and altered modes of screening, diagnosis, and treatment as well as follow-up and palliative care.<sup>1 2</sup>

Some countries responded swiftly to the pandemic by introducing strong public health measures.<sup>3</sup> These countries experienced fewer infections and lower covid-19 mortality—in some cases (such as Vietnam) despite poor healthcare infrastructure, including cancer care. Even these countries had to reorganise their cancer services, but cancer care has been hardest hit in badly affected countries such as the US and the UK, with potentially greater effects on cancer outcomes.<sup>4</sup> Now we must focus efforts on the rapid recovery of services, using lessons from this adversity to improve and redesign care across the entire cancer continuum.<sup>2</sup>

### Restoring services

Firstly, screening, early detection, and diagnosis pathways must be reinstated and prioritised according to people's risk of both covid-19 and cancer. Primary care is central to the diagnosis of cancer but has to evolve and adapt to ensure that patients with symptoms are encouraged (and feel safe enough) to seek medical help and are assessed fully and in a timely manner. In embracing remote consulting, clinicians must be aware of communication challenges (for example, “missed cues”), lack of examination findings, and disparities in reaching disadvantaged groups.<sup>5 6</sup> Detailed history taking, traditionally thought to contribute 80% to diagnosis,<sup>7</sup> will be key, along with excellent communication skills.

The lockdown has led to a backlog of patients with symptoms needing urgent assessment. Existing services may not have capacity to manage these patients, even if they return to pre-pandemic levels. Close cooperation between primary care and specialty care workflows is essential, as is innovation, to prioritise and safely investigate patients at most risk.<sup>8</sup>

Innovations could include the use of triage tests for people with specific symptoms (for example, faecal immunochemical testing for lower gastrointestinal symptoms, the Cytosponge test,<sup>9</sup> for upper gastrointestinal symptoms, teledermatology for skin lesions) and increased use of risk assessment tools such as Qcancer.<sup>10</sup>

Secondly, the focus must be on safe delivery of treatment.<sup>2</sup> Known risks for poor outcomes from covid-19 have driven the development of guidelines and altered cancer treatment protocols (including adoption of routine covid-19 safety measures and screening).<sup>11 12</sup> As far as possible, acute cancer care

globally has strived to continue “as usual,” with greater use of telemedicine, the development of individualised approaches to care, and new policies, resources, and data sharing. Grassroots initiatives to create registries and resource repositories and to train cancer clinicians in telemedicine serve as tangible examples of global collaboration and innovation in the face of adversity.<sup>13 14</sup>

Care for people who have recovered after cancer treatment has been less of a priority but should not be neglected, especially given the serious effect of the pandemic on the mental wellbeing of patients and their caregivers,<sup>1 15</sup> including potential fears of cancer recurrence and sense of abandonment by the healthcare system. Similarly, palliative and end-of-life care has been limited, with face-to-face contact restricted.<sup>16</sup>

### Outreach, education, communication

Activating patient outreach and education must be a priority across the cancer continuum. Many people have not presented for cancer care or delayed care because of fear of healthcare interactions during the pandemic or misplaced beliefs that healthcare systems are shut to all but covid-19 patients.<sup>5</sup> Many have been socially isolated or unable to access care because of lockdowns, curfews, and border restrictions.<sup>17</sup>

Clear communication with patients about when and how to proceed with cancer treatment is needed, along with practical support, to ensure good understanding of the need to balance competing risks when treatment options and potential delays are considered.

Many of the strategies used to manage cancer care during the pandemic, such as remote consultations, are not new, and it is unfortunate that it took a pandemic to accelerate their adoption. It is critical that these innovations are not scaled down without examining their effect on patient outcomes (which may be both positive and negative) and equity of access.

Such evaluation should inform system redesign, with patient voices and good data at the centre. Conventional models of patient and public involvement need to become more nimble and integrated to ensure that patients' views are heard when rapid decisions need to be made.

The covid-19 pandemic has held up a mirror to the global state of cancer control, throwing new light on well known limitations in healthcare delivery and adding urgency to resolving them. The individual and collective response of clinicians and healthcare

systems to these challenges will be a lasting legacy of this pandemic.

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