

Management of a Head and Neck Oncological Department During Covid-19 Pandemia

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1. Editorial

The recent outbreak of SARS-CoV-2 has assumed worldwide proportion. Due to the high virulence and a delay in the application of containment measures in order to avoid social contacts, the so-called “Coronavirus” has sickened about 2000000 people all over the world, causing around 120000 deaths. Italy is the first country in the world for infections and deaths. The high rate of hospital and intensive care unit (ICU) admission provoked a serious congestion over hospitals and extreme lockdown measures has been taken by Italian and European government to strengthen the health system to avoid a national collapse.

On the other hand, cancer is a life-threatening disease that should be treated without delay to avoid a prejudicial outcome to patients.

Oncological patient are more fragile than not oncological patient due to immunosuppression caused by the malignancy and anticancer treatments, such as chemotherapy or surgery. Therefore these patients might be at increased risk of SARS-CoV-2 with poorer prognosis.

The organization of an oncological center is challenging even in a standard setting due to a multi-disciplinary approach. The treatment of a single patient should be discussed by disease management team (DMT) to produce shared strategies of treatment. During pandemic, DMT meetings, attended by surgeons, medical oncologists, radiotherapists, radiologists, pathologists and other specialists, have strong limitations. First of all is not allowed to hold a meeting with some specialists, patient and relatives in the same room due to the social distancing, but it is possible only discuss via social media or video-conference. A referring doctor should collect data from the patient such history, imaging, lab data and histological examination and, above all, videorecording of the clinical examination to share with the others member of the group the best treatment taking into consideration firstly guidelines as well current limitation in delivery treatment. Some hospital for example could not operate due to environmental presence of virus and constant need of sanitize the operating room or could not use radiotherapy due to some more difficulties in travel and accommodation for the patients living too far.

Traditional, standard of care treatments should be observed wherever reasonable. Deviation from the traditional standard of care may be appropriate or necessary in light of the current, extraordinary circumstances. These decisions are likely to be highly patient and institution specific and is recommended to share decision-making with the patient [1].

In this out of ordinary setting the main goal should be ensure the safety of staff and patient together.

2. Staff Management

The medical staff must attempt to protect all the fragile patients from the infection and itself at the same time. Firstly clinical staff should be educated in order to minimize the risk exposure to infection wearing the correct personal protection equipment (PPE) [2].

Human-to human spread occurs through respiratory secretions so healthcare personnel that manage patients with disease of the aero digestive tract are the most susceptible healthcare workers to became infected (risk ratio of 2.13).

Up to date there is no evidence-based guideline on the use of PPE.

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In fact, hospitals could be equipped with different types of gloves, masks, gowns and shoe covers, generating confusion before dressing. Furthermore, in the worst-case scenario, PPE shortage for improper use could threaten health workers beyond the already high risk of infection. UK, Canadian, Hong Kong and Italian guidelines, recently released for medical procedure in COVID-19 positive patients, slightly differ from the WHO document on rational use of PPE, suggesting a higher protection level. The rationale of covering should be a multilayer donning and doffing in order to minimize the possibility of contamination and regenerate reusable PPE, cap and shoe covers are considered necessary for safely dressing as double nitrile gloves and disposable gown where available.

A separate discussion is reserved for the mask: FFP3 (Europe) or N99 (US) masks must be preferred than any other option. In case of FFP3 mask lacking, FFP2 or N95 masks can be used, covered by surgical mask [3].

3. Patient Management

Over the last years, there has been a significant improvement in the survival rate of patients with critical head and neck cancer directly correlated to stage at initial presentation.

During the COVID-19 lockdown could be very difficult for the patients to be addressed to correct diagnostic workup, above all due to difficulty to meet general practitioner involved in pandemia.

In this setting the social media and telemedicine for counselling is very important either for early diagnosis or correct follow-up. Even with some limitations, this alternative could help people to rule out lesions and realize when refer to hospital is necessary.

As a general guideline for scheduling, cases are deferred when performed for prophylactic intent, benign diseases, conditions unlikely to be adversely affected by an 8-12-week surgical delay.

In order to decrease the number of people entering the hospital, the outpatients should be divided in three groups:

Urgent: need to be seen in 72 hours (head and neck oncological patients could have serious symptoms even fatal, like acute dyspnea or massive bleeding.)

Intermediate: could be rescheduled after a short delay up 2-4 weeks

Routine follow-up: should be rescheduled later in the future because treated a long time ago and without new symptoms.

All patient should scheduled an appointment in order to avoid a crowded waiting room.

All patients were screened before entering the hospital at a nurse

checkpoint with a checklist that included clinical and epidemiologic criteria and temperature measurement by an infrared thermometer.

All clinical examination should be done with adequate PPI. Flexible naso-pharyngo-laryngoscopies should be limited but necessary. When performed, they are recorded for shared review to eliminate duplicate exposure risk.

4. Surgical Patient

Ideally, where testing is readily and rapidly available, SARS-CoV-2 testing should be performed on all patients with mucosal lesions prior to HNS evaluation, and/or, at the least, 1 day prior to the planned surgery.

In case of positive swabs no surgery should be done but life-saving procedures as tracheotomy and massive bleeding control. In this case is preferred the use of a separated

An OR with a negative pressure environment is ideal to reduce dissemination of the virus. A high frequency of air changes reduces viral load within the OR [4].

5. Post-OP Patient

Through a telemedicine platform the patient could sent notifications about post-operative rehabilitations and recovery and the medical staff could check post-op care.

For the follow-up, online surveillance or by telephone is preferred to reduce population flow and cross-infection. For patient with relatively slow progression or scheduled for 1 year follow-up, the appointment should be postponed. During the follow-up, medical staff is in a balance of both anticancer and antiepidemic responsibilities [5].

6. Conclusion

It is very rare for head and neck surgery departments in cancer hospital to face sudden epidemic situations, such SARS-CoV-2.

The aim of the staff management plan was to minimize staff exposure to infection, educate them about the crisis, improve their *modus operandi*, specifying their roles and responsibilities reducing their anxiety and stress.

Sharing of correct information about virus transmission and availability of personal protection contribute to boost staff's confidence.

All the effort must be focused on overcome the virus and at the same time on keep curing cancer patients.

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