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Editorial

Early oral cancer management during the COVID-19 period

This COVID-19 pandemic has raised urgent challenges in the provision of healthcare. To help guide clinicians during this time, several national and international articles have been published, including guidelines from professional groups, that relate to the management of head and neck cancer (HNC).^{1–5} HNC-related surgery has been affected by delays or cancellations, which have been influenced in part by the capacity of intensive care units (ICU).³ It was necessary to introduce changes in treatment rapidly, and these might have far-reaching consequences for the future provision of clinical care.

Immediate consequences of the pandemic have been the anxiety and uncertainty that have been felt by patients, carers, clinicians, and hospitals. There has been a need to reduce face-to-face contact, and this has had an impact not only on surgery itself, but also on the way outpatient consultations take place. In the past, the priorities for HNC treatment have been survival and cure. Functional deficits and health-related quality of life (HRQoL), although important, have been secondary to treatments that offer the best chance of a cure.⁶ During the pandemic, however, a new concern has arisen amongst everyone involved - that of the risk from COVID-19.⁷

It will be of value to reflect on the role of this risk in the shaping of oral cancer care, especially in patients with early-stage disease when disease-specific survival, postoperative dysfunction, and HRQoL are relatively good. There are aspects of disease management for which the lack of robust evidence results in uncertainty as to which approach is best, and equipoise is present. A patient's preference has an important role, with all those affected having to balance the risk from COVID-19 against the outcomes of their oral cancer. This will shape future protocols.

The standard of care for patients with oral squamous cell carcinoma (OSCC) is primary surgical resection with or without postoperative adjuvant therapy⁸ and, depending on the

nature of the defect, free-tissue transfer may be necessary. For the present (and at least in the medium term) during the treatment planning stage, clinicians will have to consider survival, morbidity, the need for tracheostomy (a high-risk procedure for the transmission of COVID-19), and available resources, including the number of hospital admissions and hospital stay. Patients who have free-flap reconstruction stay longer in hospital. It can be argued - taking into account the results of the COVIDSurg study² - that there is a measurable risk of COVID-19 transmission during the hospital stay, and a shorter stay with reduced healthcare contacts might reduce it. Free-flap reconstruction can have distinct advantages in terms of recovery. In addition to better function and a reduced risk of fistula and other complications, it can - by virtue of covering the resection defect - result in a rapid recovery, especially if there is no need for a tracheostomy.

Neck metastasis in OSCC is a major prognostic variable in overall survival. While there is a general consensus that patients with T3 and T4 N0 primary OSCC or clinically-evident nodal metastases should have neck dissection, little consensus exists for patients with early-stage OSCC (T1N0/T2N0) and clinically and radiologically node-negative necks.⁹ Sentinel node biopsy (SNB) is capable of detecting occult metastases in early oral cancer and is a safe technique for staging the clinically N0 neck,¹⁰ although a proportion of patients will require readmission for a completion neck dissection (CND). The SEND trial concluded that for early oral cancer, elective neck dissection (END) resulted in better disease-free survival than wait and watch,¹¹ and can be completed during one hospital admission. This is in contrast to those who require completion neck dissection following SNB.

Patients with early oral cancer are a heterogeneous group and this is often poorly reflected in the literature. Uncertainty arises because patients with larger tumours (when it has been decided that a free flap is not required) are likely to have

a survival advantage with surgical staging of the neck, and this can be an END or SNB. On the other hand, thin tumours might have a lower risk of occult metastasis and END may not be necessary, although sentinel lymph node biopsy (SLNB) might be preferable to wait and watch. There is always a risk of ipsilateral or contralateral failure irrespective of which approach is used. Rates are low and SLNB has an advantage, especially when tumours encroach on the midline or have unexpected patterns of drainage.

The concern about the added morbidity of CND compared with END is frequently raised. This is an important consideration and further investigation is warranted. In the current climate, SLNB has the disadvantage that when CND is indicated, two episodes of isolation, testing, and shielding may be required before the completion of surgery. These patient pathways differ from hospital to hospital and the impact of this will change over time. While the node-positive rates in the SEND trial for T1 and T2 cancers were 19.1% and 36.7%, respectively (with other trials of END and SLNB showing similar figures^{11,12}), it may be that advances in preoperative imaging could allow more node-positive patients to be identified during staging. Also, in the future it might be possible to improve the early detection of lymph node metastasis during follow up in the wait and watch group.

In early oral cancer it is difficult to make valid comparisons, and interpretation is fraught with difficulty in the absence of randomised trials. HRQoL is better in those who have laser resection with END than it is in those who have free flaps. However, this is likely to be because the tumours are different – that is, much larger in the free flap group – and of course the outcome is worse in those who also have postoperative radiotherapy (PORT).

The patient's perspective needs to be considered for every treatment option. Even well-informed patients can find it difficult to understand, in any meaningful way, the differences between SLNB, END, and watch and wait, and for most, the surgeon's preference and influence is the most important factor in decision making.

At this moment in time, for patients with clinically and radiographically staged N0 neck oral cancer, there is a rationale for the simplification of surgery with primary resection, the avoidance of tracheostomy, and careful consideration of the optimal treatment of the neck. There is, however, a trade-off based on uncertainty. Simplifying surgical management may shorten the hospital stay, reduce the burden on services, and enable the backlog of cases to be treated quickly, without having a detrimental effect on crude survival or disease-specific survival. Not only will reduced surgical interventions result in shortened waiting times for cancer patients, they might also free up surgical lists when capacity is limited, for important but less urgent cases. This trade-off would probably be something that would resonate with patients, given the unprecedented situation.

As COVID-19 will have an impact on surgical practice for the foreseeable future, any changes in practice need to be carefully audited. Balancing optimal cancer treatments with

the risk of COVID-19 is an inexact science based on incomplete evidence and an evolving knowledge base. The risk will vary with time and location as the prevalence of COVID-19 changes. Individual multidisciplinary teams may find at times that national guidance does not reflect the situation in their institution, and approaches to treatment need to be adaptable to account for this.

Finally, every cancer patient requires careful clinical follow up to check for treatment failure, to aid rehabilitation, and identify unmet needs.¹³ The COVID-19 crisis has resulted in reduced patient contact, and social distancing. Patient follow-up models will evolve, but patients still value the chance to discuss their concerns and seek reassurance. Technology will help shape the way consultations take place, but some patients will inevitably benefit from a face-to-face appointment. Although the prognosis for early oral cancer is good, one of their main concerns will be about recurrence, and the physical examination is very reassuring. Preoperative preparation and follow-up prompt lists have been developed and are in use in the UK.^{14,15} This model of care, resulting as a consequence of the COVID-19 pandemic, could support the foundation of a new more virtually based follow-up approach.

Conflict of interest

We have no conflicts of interest.

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