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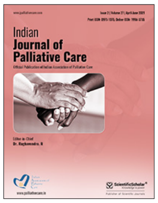

Original Article

COVID-19 – Initial Lockdown: Implications on Cancer Treatment among Palliative Care Outpatients

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ABSTRACT

Objectives: The pandemic and the lockdown has challenged palliative care patients especially those on palliative oncological treatments. This study aims to understand the effect of COVID-19 and initial lockdown on palliative oncological treatments among palliative care patients.

Materials and Methods: A retrospective chart review of patients who attended the palliative care outpatient clinic, between 21 April and 12 May 2020, was done. Sociodemographic and palliative oncological treatment details were reviewed.

Results: Of the 107 patients included, 53.7% were between 40 and 60 years of age, and 58.3% were women. A large proportion (63%) was unemployed and 40.2% had to rent vehicles for hospital travel. During this period, palliative oncological treatment was interrupted or deferred in 20% and 3.5%, respectively. During this period, homecare services were also affected in about 12.2% of our patients.

Conclusion: The COVID-19 pandemic and the lockdown have affected the palliative oncological treatment of palliative care outpatients with cancer. The implications of interrupted and deferred treatment on patient outcomes would be seen in the months and years to follow. Palliative care teams should enhance patient and caregiver support and promote non-abandonment and continuum of care during such unprecedented times.

Keywords: COVID-19, Pandemic, Palliative care, Oncological treatment

INTRODUCTION

COVID-19 caused by the novel severe acute respiratory syndrome coronavirus-2 was declared a pandemic and cause of international concern by the World Health Organization on 11 March 2020.[1] The numbers have spiralled up since the first case was reported on 30 January 2020. As of 19 August 2020, according to the Ministry of Health and Family Welfare, Government of India statistics, there have been 20,96,664 cases of COVID-19, and 53,866 have died of this disease in India.[2] This pandemic has stretched the healthcare system to the seams due to its unique nature and magnitude. It has caused and amplified untold suffering due to its ripple effect on the healthcare system as it has reset priorities and redefined limits.

The lockdown in India caused difficulties to cancer patients in accessing and continuing treatment. Since the emergence of the COVID-19 infection in India, the oncology and the palliative care team within our institution has been actively encouraging patients to continue oncological treatment nearer home as mortality from COVID-19 is higher among cancer patients.[3]

The impact among individuals receiving palliative care is far reaching; affecting oncological treatment, quality of life, and survival. For most cancer patients, this pandemic is a grave concern as disruption, deferral, and downscaling of treatment will increase the risk of cancer progression and hospital visits thus posing the risk of contracting COVID-19 not only for themselves but also their family members.[4] The unpredictable nature of the pandemic and the ambiguity of cancer treatment unsettled the equilibrium of patients and the families' ability to tolerate uncertainty. The measures taken to mitigate and contain COVID-19 such as the sudden lockdown, social distancing has heightened the suffering of our patients by adding to their distress, fear, anxiety, socioeconomic instability, and compounding uncertainty at the end of life.[5,6] Palliative care services support patients and caregivers through relief of suffering, difficult/complex

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decision-making, handling concerns with downscaling or deferring oncological treatment, and managing uncertainty at the end of life. Effective palliative and end-of-life care are essential and vital, even during these times when health systems are stretched.[7]

We have attempted to understand the impact of the COVID-19 pandemic on palliative oncological treatment among palliative care outpatients.

MATERIALS AND METHODS

A retrospective chart review of patients who attended the palliative care outpatient clinic during the period 21 April–12 May 2020 was done. Sociodemographic details and changes in oncological treatment were reviewed. Descriptive statistics (n, mean and median) were calculated for the continuous data and the percentage for the categorical data. This study has been reviewed and granted permission by the Institutional Review Board (IRB Min. No. 13120).

RESULTS

A total of 107 patients were seen in the palliative care outpatient clinic during the specified period. This included both new (41.7%) and review (58.3%) patients, both who came in person (80.6%) and as a proxy (19.4%). A large group of patients (57%) seen in the palliative care outpatient clinic belonged to the age group of 40–60 years (mean 55.4 years; median 55 years; range 27–82 years). The relevant sociodemographic details of the patients are provided in [Table 1]. The majority of the patients (63%) were unemployed/housewives and 50.5% had education only up to 5th grade. Although most patients (66.7%) came from within Tamil Nadu, 33.3% came from other states/other countries. A large proportion of patients 46.3% had to travel >40 km to access the hospital and 40.2% had to spend for transport to the hospital.

Gynaecological cancers were the most common diagnosis among these patients (25.2%), closely followed by head and neck (19.6%) and gastrointestinal cancers (14%). Among these patients, 45.4% were on oncological treatment. Treatment interruption and deferment due to the pandemic occurred in 20% and 3.5%, respectively. Nearly half of the patients (47.7%) had comorbidities and 23.5% reported difficulty in access to medications for their comorbidities. Among these patients, 37% were on oral morphine. During the lockdown, homecare services were completely stopped and among our patients, about 12.2% had an interruption of the services. Details of their oncological diagnosis, treatment changes, and palliative care needs are listed in [Table 2].

DISCUSSION

This short retrospective review of charts was done to understand the early impact of lockdown and the COVID-19 pandemic among our palliative care patients, so they can be supported appropriately. Of the 107 patients, there was a good spread of patients across different age groups, with the majority within the 40–60 years group. In our series, females marginally outnumbered males (53.7%), while data from another tertiary comprehensive cancer centre in India (23 March–3 May 2020) showed that the majority who attended the pain and palliative care service were male (67.1%).[8] Gynaecological cancers were the most common (25.2%) among this group of patients, while during a similar period, data from another tertiary comprehensive cancer centre report head-and-neck malignancy as the most common (48.7%).[8] Patients with head-and-neck cancers in our series contributed to 19.6%.

Nearly one-third of our patients were from other states and this challenged ongoing cancer treatment, this was

Table 1: Sociodemographic details of palliative care outpatients.

Variable	Percentage (n)
Age (years)	
20–40	17.6 (19)
40–60	53.7 (57)
>60	28.7 (31)
Gender	
Male	41.7 (45)
Female	58.3 (62)
Visit to outpatient clinic	
New	41.7 (45)
Review	58.3 (62)
Hospital visit	
With patient	80.6 (86)
Proxy	19.4 (21)
Occupation	
Private	12.2 (13)
Government	6.5 (7)
Daily wages	16.8 (18)
Unemployed/housewife	62.6 (67)
Student	1.9 (2)
Type of family*	
Nuclear	57.1 (60)
Joint	42.9 (45)
Education	
Up to 5th class	50.5 (54)
6–12th class	34.6 (37)
Graduate and above	14.9 (16)
Home town	
Tamil Nadu	66.7 (71)
Other states in India	25.0 (27)
Outside India	8.3 (9)
Distance from hospital (km)	
<40	53.7 (57)
40–100	15.7 (17)
>100	30.6 (33)
Mode of transport	
Rented vehicle (auto/car)	40.2 (43)
Own vehicle (two-wheeler/car)	41.1 (44)
Others (by foot, etc.)	18.7 (20)

*Missing data in 2- type of family details not available

Table 2: Details of oncological diagnosis, treatment and palliative care needs.

Variable	Percentage (n)
Diagnosis	
Gynaecological	25.2 (27)
Head and neck	19.6 (21)
GIT	14.0 (15)
Hepatobiliary	12.2 (13)
Lung	10.3 (11)
Genitourinary	7.5 (8)
Breast	3.7 (4)
Others	7.5 (8)
Comorbid illness	
Yes	47.7 (51)
No	52.3 (56)
Difficulty in medication access (if comorbid illness, *n*=51)	
Yes	23.5 (12)
No	76.5 (39)
On oncological treatment	
Yes	45.4 (50)
No	54.6 (57)
Treatment interruption (*n*=50)	
Yes	38 (19) (in 20% due to COVID-19)
No	62 (31)
Treatment deferred due to COVID-19 (*n*=57)	
Yes	3.5 (2)
No	96.5 (55)
On oral morphine	
Yes	37.4 (40)
No	62.6 (67)
Need for home care*	
Yes	13.0 (13)
No	87.0 (87)

*Missing data in seven

much higher than that reported from another tertiary comprehensive cancer centre in India (21.6%).[8] The sudden lockdown and the pandemic posed added difficulty to patients on cancer treatment. With challenges in returning home mounting, the urge to pursue cancer treatment was pressing; patients and families were forced to make undesirable decisions due to the lockdown and pandemic.

Cancer treatment has faced many constraints during this pandemic, primarily because individuals undergoing active cancer treatment with chemotherapy or radiotherapy were at heightened risk of severe illness from COVID-19.[9] Recommendations from different bodies including the American Society of Clinical Oncology and European Society of Medical Oncologists have suggested that treatment be deferred if the risk outweighed the benefit in the context of the pandemic.[10,11] A conceptual framework to guide prioritisation of cancer treatment has been proposed by Hanna *et al.*[12] Elective surgeries and palliative chemoradiation are being deferred due to COVID19. Hypofractionated irradiation and conversion of intravenous to oral systemic regimens are considered to reduce the number of clinic visits and the associated risks. These require shared decision-making with individual patients balancing the risk of contracting COVID-19 due to compromised immunity, frequent hospital visits, and complications with treatment. In this group of patients, deferring treatment will bring in added distress in the form of uncertainty, anxiety, fear, and physical suffering.[13]

A case series from one of the tertiary hospitals of India reports that six of the 10 cancer patients had postponement of their surgery/chemotherapy and radiotherapy during this pandemic.[14] In our series, treatment interruption and deferment primarily due to the pandemic occurred in 20% and 3.5%, respectively. We need to keep in mind these data are quite early in the course of the pandemic. The majority of oncologists on a survey looking at the impact of the COVID-19 pandemic on oncological decision-making reported that they use less chemotherapy, immune checkpoint inhibitors, and steroids. Most stated that while radical treatment and first-line metastatic disease treatment were less affected, they were hesitant to offer second- or third-line therapies in metastatic disease.[15] Situations in which the risk of COVID-19 infection outweighs the expected cancer-related outcome, oncology, and palliative care teams should support shared decision-making discussing potential risks and benefits thus empowering patients and caregivers to decide.[16]

Nearly 37% of our patients were on oral morphine as compared to 34.2% who were on opioids from another tertiary comprehensive cancer centre in India.

The palliative care team supports the psychosocial needs of the patient, but these needs are likely to be more complex during this period when the scope of some oncological treatment is a challenge and brings a sense of hopelessness. Such situations call for palliative care teams to be there to listen, acknowledge, support, and put in systems to ensure non-abandonment and continuum of care can go a long way in communicating that we are with them and for them.[17] Telemedicine consultations both video and audio consultations have helped to reach out to patients both far and near at the desired frequency.[18,19]

Regular follow-up by calling up patients and families to assess their needs and offer direction and support can ensure some continuum of care. Provision of an adequate supply of medications and coordinating with local regional palliative care centres to ensure the ongoing supply of essential medicines, especially at such times, were efforts we made to further reduce the suffering of many of our patients.

Interdisciplinary coordination, good communication, and support from palliative care teams for patients and families are crucial during these times.[17]

This study has few limitations; retrospective chart review was done over a short period of time with limited numbers. Being a retrospective study, an in-depth understanding of the patient and carer distress due to the inability to pursue palliative oncological treatment is limited. The findings of this study cannot be generalised to all cancer patients and refer to only a subgroup of cancer patients receiving concurrent palliative care.

The added distress in patients and caregivers due to interruptions and deferral of palliative oncological treatment due to the pandemic or lockdown should be considered and addressed by palliative care teams.

CONCLUSION

Palliative care patients are a vulnerable group and the changes with ongoing palliative oncological treatment are evident during the COVID-19 pandemic and lockdown. Understanding this added distress is important for palliative care teams to support such patients effectively.

Collaboration with different palliative care centres across the country should be exploited at times as these to minimise patient movement and enhance access to care.

Declaration of patient consent

Patient's consent not required as there are no patients in this study.

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Conflicts of interest

There are no conflicts of interest.

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