Do little things cast great shadows?

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During the risky period of the outbreak of the new type of coronavirus (COVID-19) in Wuhan city, which subsequently became a pandemic, a doctor from the neurology department called me. She wanted to know what would be the best for one of her patients whose daughter was undergoing radiotherapy (RT) in oncology - to continue or postpone it. The 50-year-old woman who had completed chemotherapy after surgery due to locally advanced breast cancer had just started adjuvant RT. The patient's mother was 94 years old and had been diagnosed with Alzheimer's disease approximately a year ago, who was at high-risk for COVID-19. The mother of the patient was brought to the emergency room because of loss of consciousness; she started to cry after regaining consciousness and could not be calmed in any way. For a long time, the mother and her daughter had lived together. During RT, my patient had taken her mother out of the house and placed her close to a relative. The mother had anxiety attacks in the form of unrest and crying as a result of being thrown out of the house. The mother was diagnosed with psychogenic nonepileptic attack, and sedative medication had to be used.

Nearly one and a half months after March 11, 2020, Turkey announced its first case of COVID-19. I was preoccupied with thinking about my breast cancer patient who had to go to the hospital every day for 5 weeks for RT, and the neurologist, in turn, was preoccupied with thinking about his elderly patient whose home environment had changed and who had a serious anxiety disorder. With communication technologies and the use of smartphones, information on the number of new cases (3.7 million) and deaths (256,000), was available to everyone.[1] Across the world, there were people suddenly collapsing in the streets in Wuhan, China; there were bags filled with corpses on the floor in New York's Manhattan Hospital; patients who could not find a place in intensive care units in Italy; Spain was in dire need of help from NATO; and the British prime minister, Boris Johnson, being taken to the intensive care unit - an unprecedented pandemic was being experienced right before everyone's eyes.

Both oncology patients and elderly neurology patients are included in the high-risk group for COVID-19, making it a common problem for both divisions. Should we protect our patients and carry out their treatment amidst this pandemic? Because COVID-19 polyclinics were usually given priority, our request for personal protective equipment (PPE) for our patients and ourselves was not given immediate consideration, thus leaving us struggling to provide adequate PPE and an appropriate place for patients. Just when we were going to say that non-COVID-19 patients needed treatment too, our words stuck in our throats. Sudden decisions were made to close most outpatient clinics, and COVID-19 patients were the only ones being cared for, with no consideration given to the oncology patients undergoing treatment. As in the case for most of us, both patients and doctors were confronted by a pandemic for the first time in their lives. The only thing we could do was to fight the infection. Oncology patients were treated with a multidisciplinary approach. The fact that geriatric patients were most vulnerable in times of natural disaster and crisis was being discussed.[2] Moreover, the fact that most of the deaths due to COVID-19 were elderly, who, in addition, had underlying comorbid diseases, was yet another reason for giving more consideration to this population. Patients with neurological issues are monitored in outpatient clinics every 4–5 months and are recommended to walk and socialize every day to improve their emotional and mental states.[2] However, in Turkey, a curfew had been imposed very early in the course of this pandemic for these patients aged 65 years and above. Thus, as a small but very effective measure in the fight against the epidemic, the number of hospitalizations were reduced, and the collapse of the health system was prevented by reducing the patient burden.

Can RT be omitted for patients with breast cancer because of this pandemic? Moreover, having to work in a COVID-19 outpatient clinic made us potential carriers of infection for these vulnerable patient groups. The bimodal treatment approach, including both surgery and RT, was found to be associated with significantly better progression-free survival.[3] Le Scodan *et al*.[4] stated that local treatment for oncology patients is an independent prognostic factor in the overall survival in patients receiving/not receiving local treatment, the majority of which include RT. Then, should we omit rather than delay? In many retrospective analyses, the potential adverse effects on the regional recurrence rates were higher when adjuvant RT is postponed after chemotherapy.[5] In addition, a statistical decrease in disease-specific survival was found in patients with locally advanced breast cancer who received RT at least 60 days after surgery.[5] Should the multidisciplinary

oncology councils have continued to function during the pandemic? In their study, Bydder *et al*. found that the survival of patients who were discussed by multidisciplinary means for 1 year improved (82% vs. 57%).[6] Similarly, it was reported that the survival of patients with esophageal cancer treated through multidisciplinary teamwork improved significantly (5-year survival, 52% vs. 10%).[7] It is known that the survival of patients managed by a multidisciplinary team improves.

What do oncologists and neurologists need to do, right now? To quote Theodore Roosevelt, *"Do what you can, with what you have, where you are."*[8] Without becoming desperate and with common lessons for the whole world, we need to lend an ear to Sufi poet, Mevlana Jalaluddin Rumi, a 13th century mystic poet, who told us: *"There is hope after despair and many suns after darkness."*[9]

As a result, despite all the precautions taken, in cases of neurological patients with neurocognitive inhibition or dementia, negligence may occur when we set hygiene rules or issue prohibitions and rules for social isolation. Special follow-up and evaluation strategies should be developed for these patient groups, and caregivers must be informed of them, for example, a home exercise program, fever tracking, the use of surgical masks, and personal hygiene rules.[2] Where oncology patients are in question, the waiting time for RT should be reasonably short, considering the specific risk factors for each patient. The treatment should be decided by multidisciplinary discussion online and in line with the treatment guidelines to avoid delays in the provision of RT.

A Swedish proverb says: "*Worry often gives a small thing a big shadow*."[10] Similarly, perhaps we cannot do all this, even in this period; however, it is not the magnification of a minor worry, to focus on this very small group of patients when compared to the scope of this huge epidemic that is currently taking the world by storm. When the pandemic ends and the dust settles, we will see the real size of the shadow it leaves on these patients followed up over the long term.

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Conflicts of interest

There are no conflicts of interest.

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