A Commentary on the Challenges of Telemedicine for Head and Neck Oncologic Patients during COVID-19

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Abstract

The COVID-19 pandemic is an unprecedented and historic event that presents unique challenges to patient care to medical providers worldwide. The pandemic and the ensuing rapid changes to medical practice have particularly affected head and neck cancer surgeons and their patients. In an effort to balance the needs of our patients with the risks to patient and staff safety, we have been tasked with finding alternatives to the traditional office visit. In this commentary, we discuss how telemedicine can be incorporated into the head and neck surgery practice, the challenges we have faced, and the dilemmas with which we have dealt in our efforts to fulfill the ongoing need for care of this unique patient population.
In just a few weeks, the COVID-19 pandemic has changed the practice of medicine and otolaryngology around the world, as priorities across health systems shift to accommodate a surge in COVID-19 patients. Otolaryngologists in particular are at elevated risk for occupational exposure and transmission of COVID-19. This is due to the high viral load in the nasopharynx and the aerosol-generating nature of many of the interventions we perform, resulting in high rates of infection amongst members of our specialty. As the risk inherent to our work becomes apparent, multiple societies including the American Academy of Otolaryngology and the American Head and Neck Society, have advised limiting patient care to “time sensitive and emergent problems” with a recommendation to consider telephone or video-based patient visits. This has ushered in an inexorable but necessary foray into telemedicine to connect with our patients as in-person office visits have significantly reduced, and in some places, have even come to a grinding halt.

For the head and neck specialist, this raises the question of how best to care for the head and neck cancer patient. Our head and neck surgery practice serves patients at all stages of the cancer care spectrum. This includes new patients awaiting an appointment, patients seeking second opinions, patients in the midst of treatment, and patients undergoing continued oncologic surveillance. Approximately one month ago, we began telemedicine visits for the first time.

Telemedicine is a disruptive process, especially when it must be adopted quickly out of necessity. There is little education in our field on how to best do a telemedicine visit. There are links to online materials and bulletins from our professional organizations outlining available products and medico-legal issues. There is telemedicine research, which in our field has been
largely limited to remote areas and specific subspecialties, and less commonly focused on the otolaryngology patient visit in general. In the case of head and neck, there is a handful of articles on provider-to-provider e-consultation or telemedicine to expedite the work up and oncologic intervention for a patient. Like many things at the moment, there is no guide on to how to best conduct oncologic surveillance over the phone or video. We are in uncharted waters.

Oncologic surveillance visits involve discussing new concerns and symptoms, reviewing imaging, performing a physical examination and often a flexible laryngoscopy examination. Following this, the patient is either provided reassurance that the cancer has not recurred or guidance for next steps in management. While many otorhinolaryngology diagnoses are amenable to review of patient history and objective data remotely, the traditional head and neck physical and endoscopic examination remains our workhorse. Multiple head and neck subsites are challenging, if not impossible, to see in the office let alone in a telemedicine visit, without the technology we have become accustomed to using. At the moment, it is also difficult to obtain imaging, as radiology offices are not scheduling elective scans. With any intervention, treatment, or imaging exam, we must weigh the risk of delaying with that of possible exposure and iatrogenic contraction of COVID-19, especially in light of the growing evidence that suggests cancer patients may have greater risk of severe disease and higher mortality rates.

There are no right answers, only difficult case-by-case decisions for which we have no precedent. Our practice has been to opt for video telemedicine visits through our institution-chosen platform whenever possible. Only patients with new acute complaints or concerning issues are seen in in the office. For patients who do not have any video capability, as is true for
many patients in our head and neck cancer population, we conduct a limited visit via phone call. Without our usual exam and surveillance options readily available, we have relied primarily on symptomatology and the subtleties of symptom change to guide our decisions. Despite these shortcomings, telemedicine at a minimum allows for at least some examination of a patient’s overall health or complaint that may assist the physician in triage. We have been challenged to develop methods to virtually educate patients and their families on symptom and physical exam changes that should prompt a discussion with their doctor. Over the last month, these telemedicine visits have continuously evolved as we, and our patients, together navigate this new space of digital health services and the challenges that accompany them.

There is no arguing that a telemedicine video-based visit is preferable to a phone call and most definitely to the alternative of “no visit” for the care of our head and neck cancer patients. Despite these challenges, we have heard how thankful our patients are to connect with their doctor during this time. We have also heard many patients echo the same concerns we have. Patients undergoing oncologic care are a unique subset of patients who often form very close, longitudinal relationships with their providers. They are reliant on us, every time, to tell them that they are disease free or to guide them through options for the next steps. Our virtual declaration of “no evidence of disease” is not as reassuring as when we examine, touch, and interact with our patients in the usual way. This emotional burden is borne not just by our patients, but by us as their physicians, too. Thus far, we have found that telemedicine both meets and yet falls short of our patients’ needs and our goals as providers. Is this all that we can do for our patients?
References


