fragmented and poor-quality care, as well as a worse patient outcome. Although little research has been done on the psychological effects of COVID-19 on cancer patients, it is possible that this pandemic will increase population's vulnerability, even though a Cancer patient who are supported by a health care team that includes psychologists have a higher quality of life, according to a new study [8].

Various questions still are not answered in these circumstances:

- Is it necessary to conduct routine screening programmes on a regular basis?
- What should a covid-19 infected patient's care? Is it better to start immunotherapy or chemotherapy before or after a cycle of chemotherapy?
- What kind of policies needs to be implemented in each and Every country should contribute to the oncology section.
- How immunocompromised people with comorbidities (such as cancer) who live in high-virus-infection areas be treated?

DISCUSSION

Articles referred from PubMed, Web of Science, med RXiv and Cochrane were studied that Data on the incidence and death of cancer patients was supplied with COVID-19 infection. Eligibility criteria established/considered for the study are as follows,

- Confirmed clinically and laboratory diagnosed cancer patients with COVID-19.
- Study that contained statistics of cases and death of cancer and non-cancer patients.
- Language was limited to English [9].

In a study, Meta-analysis was carried out to know about the risk ratios, pooled incidences. 95% confidence interval using random effect model. To demonstrate the likely source of hetrologeneity between trials, a Meta regression was used [10].

Performing a risk analysis in every patient assessment appears like an affordable choice during this COVID-19 pandemic, especially where the in terms of recurrences in cancer patients, an oncological intervention may have a potential benefit or Overall survival is so low that the danger of death from COVID-19 infection is not worth it [11].

The main reason for the cutbacks was to restrict patient visits to a bare minimum and maintain social distance. Taking these safeguards is recommended in many published guidelines and suggestions for dealing with cancer patients during this outbreak [12]. Mandy of the authors' recommendations were based on their best judgement and throughout the current pandemic, anecdotal experience, as well as accounts from frontline oncologists or people who have previously dealt with infectious epidemics like Middle East respiratory syndrome and severe acute respiratory syndrome. However, because there were various aspects that were unknown. About the epidemic and In addition to the intrinsic diversity of cancer patients and health-care systems, how it might influence a certain country or even an individual institution is unknown many arbitrary decisions were made. More research on the influence of these decisions on patient care is needed in the future to assist establish an evidence-based approach. And outcomes are needed [13]. Other causes for limiting the amount of care offered, such as staff shortages, PPE shortages, and a lack of access to pharmaceuticals, should be explored in the future to avoid or at least mitigate their impact.

Patients receiving neoadjuvant/adjuvant therapy should be continuing their treatment and if it's possible receive longer interval gap between cycles and longer treatments, but should be avoid weekly infusions, taking into account each patient's individual drug regimen.

For patients with advanced disease, it must be established on a case-by-case basis, based on the link between health risks and benefits, if continuous therapies should be postponed or discontinued for that period of time, similar to the well-known "drug holiday." As a result, patients have a high probability of surviving COVID-19 but subsequently putting their lives in danger due to a lack of effective cancer care. Patients are concerned not only about the risk of infection, but also about the potential that a health system overburdened with COVID-19 patients will fail to treat them. In this case, patients' ability to manage with the condition may be impaired, demanding additional medical assistance [14].

Due to their comorbidities, elderly cancer patients should receive special treatment. As the pandemic progresses, we're learning new things and modifying some of our old habits, which is beneficial to oncology and health-care systems in general. What we can be confident of is that a new normal of health care, including oncology, will develop following the pandemic. This new normal will include more distant care, care closer to home, and increased use of technology in care delivery, research, education, and business management [4,15].

A case fatality rate of 28 percent was found in a single institution study from New York City, which was more than four times the rate for the entire city and more than double, the rate of cancer-free controls from the same institution. Similarly, despite the fact that the percentage of instances that resulted in death (11.4 percent) was significantly low as compared to our group, a multi-institutional Chinese investigation found that cancer cases had a higher death rate [5,16].

CONCLUSION

The authors, as ASCO specialists, campaigned for increased awareness and education on hand hygiene, infection management, COVID-19 signs and symptoms, and high-risk exposure. They recommended considering each patient's condition should be properly assessed before active intervention, elective surgery postponement, or chemo with a low risk of progression is considered. According to current preliminary results,

immunosuppressive medications and management in COVID-19 patients with lung involvement should be closely monitored by all investigators, particularly in terms of the relationship between immunosuppression and the overall duration of the disease. The research helps to advance our understanding of cancer's effects and prognosis. We discovered that not only does having a history of cancer, having active cancer, and receiving systemic cancer therapy increase the risk of death from the corona virus, but that hospitalised individuals without cancer are more likely to have advanced corona infection, necessitating intubation, ICU admission, and ARDS. Finally, protection measures all the health workers and their family members are also important.

The lessons learned from this epidemic should be incorporated into the new health-care standard. Integrating cancer care into an institution's disaster preparedness plan can enhance patient outcomes in comparable situations. Taking good care of patients during pandemics or major disasters should be an important part of the cancer treatment process. These partnerships and initiatives should aim to address the worldwide cancer care gap, which is exacerbated by the pandemic and driven by discrepancies in resource availability. This can be accomplished by putting in place a multidimensional strategy that utilises technology or modern approaches to improve care across borders, and also within the same country.

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