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Research Letter

Urologists During the COVID-19 Pandemic: What Can Be Learned in Terms of Social Interaction, Visibility, and Social Distance

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We read with great interest the recent series of papers published in *European Urology* related to current uro-oncology practice during the COVID-19 pandemic. The papers report that doctors are doing their best for the patients, with minimal delays in the diagnosis and treatment of urogenital neoplasms [1,2]. This involves what we can call *social interaction*, *visibility*, and *social distance*. These three items, as discussed below, concern clinicians, urologists, and patients.

Consider, as an example of a clinician and typical activity, a urologist and their interaction with a patient with prostate cancer. In this context, *social interaction* refers to the fact that the urologist deals with the patient from diagnosis to treatment, and all the steps in between. They have an active role and co-participate with the patient in the diagnostic and therapeutic processes. The patient is not only informed but is also always and constantly part of the discussion and decisions. The urologist's role is not only the mechanical process of removing the prostate in the surgical theater while the patient is asleep. Should the urologist be simply involved in a single step of the process, such as performing the prostate biopsies at the request of the family doctor, they lose what we can call *visibility* as a consequence of the lack of social interaction.

The papers related to COVID-19 published in *European Urology* help readers to understand how clinicians can retain social interaction and visibility while maintaining social distance in these difficult times when dealing with patients whose treatment cannot be postponed [1,2].

The traditional role of a pathologist does not always involve a high level of social interaction and visibility, as addressed in a recent article by some members of our group [3]. The background for this contribution was a paper published in the same journal by Harrold et al. [4], who pointed out that the waning interest in pathology among

medical students led to a negative impact on the level of visibility and social interaction of pathologists. Our paper, the aim of which was to reverse this trend, was submitted and accepted for publication months before any hint of the current COVID-19 pandemic. When the article was published, our group suddenly felt that it might have appeared at the wrong time.

Pathologists face the risk of being marginalized because they do not have clinical experience or a role in the diagnostic and therapeutic processes related to COVID-19. At a time of global reductions in clinical activity, they risk being confined to “processing and reporting specimens that did not really deserve to be examined histologically”, as mentioned at the end of our paper [3]. This represents a real threat to visibility and social interaction because of the COVID-19 pandemic.

This consideration prompted our transnational group of closely collaborating urologists to think about the actual risk of not remaining visible for lack of social interaction. We discussed how to continue to be an integral part of the clinical processes still in place, and how the current experience might influence our future approach to pathology after the pandemic is resolved.

Equipment we all have readily available in our offices and laboratories can have a particular value in maintaining, if not increasing, the level of social interaction and visibility while following the rules for social distance when closely collaborating with clinicians in the diagnostic identification of patients with high-grade urothelial carcinoma, advanced kidney cancer, testicular cancer, or penile cancer who need to be prioritized for treatment [2].

A microscope with a digital camera, a computer with webcam, a TV monitor, an internet connection, and a slide scanner are pieces of equipment we can exploit for sharing images and consulting, teaching, and communicating with

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Fig. 1 – A pathologist uses a multiple-head microscope with a digital camera and a TV screen showing an image of prostate cancer. The equipment is associated with a computer and a monitor showing a remote participant discussing the case. The audience is composed of a resident sitting at a distance from the microscope.

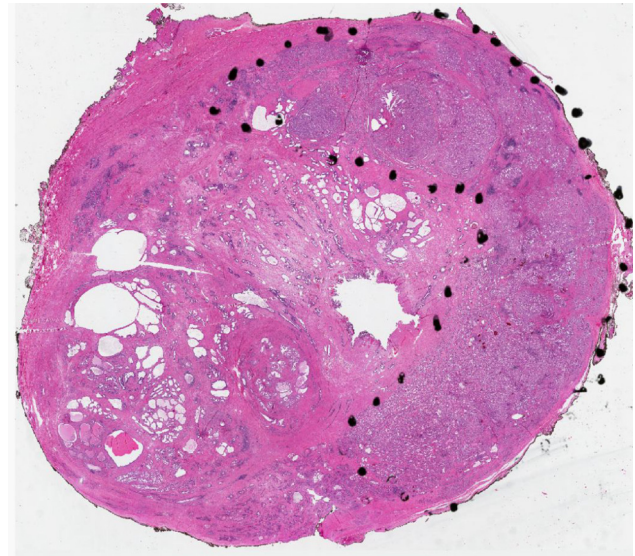


Fig. 2 – Whole-mount section of a radical prostatectomy specimen. The tumor is outlined with black dots. The virtual slide scanned at 20× can be downloaded from https://drive.google.com/file/d/1GK7ph9DV39nTXcSIM9KfoZ_tcRHtI9q/view?usp=sharing.

79 clinicians and patients in real time. To some extent these
80 goals can also be achieved via so-called smart working from
81 home. There are basically two ways we can use routinely to
82 meet these goals.

83 The first is a microscope with a digital camera. The
84 images are shown on a wide TV screen. A computer with a
85 webcam can be added for remote viewing using software
86 that is freely available on the internet. This set-up is
87 basically what we now use for intradepartmental consulta-
88 tion (Fig. 1).

89 The second is based on virtual slides obtained with a
90 digital scanner. Modern equipment can also scan whole-
91 mount sections (Fig. 2) [5]. Virtual slides are shared among
92 the group (members are located not only in Italy but also in
93 Portugal, Spain, and the USA) or sent over the internet to
94 other colleagues, with no limits as far as institution and
95 country are concerned. For instance, Google Drive can be
96 used to send a virtual slide via a link for downloading
97 images, as in the caption for Figure 2. The procedure is
98 simple and fast, considering that the size of a virtual whole-
99 mount section can be in the range of gigabytes. The viewing
100 and image analysis software can be downloaded from the
101 internet free of charge.

102 This means that the histological features of both glass
103 slides and virtual slides are shared and their content
104 discussed with pathology colleagues for both consultation
105 and teaching purposes. The same systems are also used to
106 discuss cases with clinicians and even with patients. This

107 approach fulfils the basic requirement of social distance
108 while maintaining social interaction and visibility.

109 The question is whether we, as pathologists, will return
110 to the routine we followed before the pandemic. It is
111 difficult to foresee. However, considering that we are
112 rapidly moving into an era of global digitalization, most of
113 our future activities may well be based on what we are
114 currently doing during the COVID-19 pandemic.

115 This is in line with the conclusions of Porpiglia et al. [6] in
116 their paper on traditional and virtual congress meetings.
117 They foresee that “By the end of the COVID-19 emergency,
118 we will enjoy a new reality in which technology and
119 sociality go together in order to offer a more engaging and
120 adaptable scientific congress experience, allowing more
121 flexible and dynamic use of content, modulated to the needs
122 of each attendee.”

123 Finally, in this time of the COVID-19 pandemic,
124 uropathologists can learn a lot from clinicians in terms of
125 social interaction, visibility, and social distancing. Similarly,
126 clinicians can learn from uropathologists not only through a
127 process of interaction [7] but also, above all, by working in a
128 tighter way than we have defined in the past: together we
129 can do it better [8]. And, as mentioned, the patient is always
130 an integral part.

131 **Conflicts of interest:** The authors have nothing to disclose.

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