COVID, Hepatitis, and Cancer

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Eighteen months ago, no one had heard of SARS CoV-2, the novel coronavirus that causes COVID-19. The medical community was charged with learning everything there is to know about this deadly disease. It was a process of reading everything, looking at studies, talking to colleagues and friends, and watching the news. Caring for people with COVID was a challenge, with little data on what worked and what didn't. Clinicians in the hospital watched thousands of patients die, unable to effectively slow down the disease process. Public health leaders were pressured to make recommendations based on little to no epidemiologic data, and the management of this pandemic at times proceeded in fits and starts. It was a chaotic time to be a clinician.

This issue of the *WMJ* contains several articles about COVID-19 infections in Wisconsin. As the pandemic starts to quiet, the academic medical community is catching up and writing about experiences over the last 15 months. We publish a group of papers in this issue about a rural community that organized a COVID testing site outside of the clinic in the early stages of the pandemic,[1] a hospital system that activated a hospital incident command system (HICS) in order to reorganize and prioritize resources due to the pandemic,[2] and a variety of clinical case reports about patients with unusual presentations of COVID-19. One paper from clinicians at the Medical College of Wisconsin (MCW) describes two cases of adolescent males who presented with COVID-related delirium that required long-term treatment with antipsychotic medications.[3] Another paper from MCW authors describes comorbidities associated with mortality in hospitalized patients with COVID.[4] This study of patients at Froedert Hospital found that heart disease was associated with increased mortality but obesity was not, which is counter to several other studies around the country.

Authors from the University of Wisconsin School of Medicine and Public Health (UWSMPH) did a retrospective chart review looking at patients who were admitted to the hospital with COVID who had an atypical presentation (ie, no fever or cough).[5] They found that patients with atypical presentations were more likely to be older, reside in long-term care facilities, and had more comorbidities but lower levels of inflammatory markers. These patients with atypical presentations also had a higher mortality rate.

Finally, Hau and colleagues describe a collaborative initiative aimed at documenting 2020 and healing their community through art via the "Healing Reflections" mural, a portion of which is featured on the cover of this issue.[6] All of these papers provide data about the myriad presentations and complications from coronavirus infection.

> "Knowledge comes from learning.
> Wisdom comes from living."
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> —*Anthony Douglas Williams*

We also include two papers and a commentary about hepatitis infection. In 2019, there were almost 2500 new cases of hepatitis C diagnosed in Wisconsin.[7] It is estimated that 70,000 people in Wisconsin are living with hepatitis C, but only about half know about the infection. One paper in this issue surveys primary care clinicians throughout Wisconsin and finds existing gaps in knowledge about treatment of hepatitis C.[8] The accompanying commentary by Tyska and Westergaard discusses hepatitis C as an epidemic that has a cure and advocates for increased screening for hepatitis C and expanded treatment in primary care. The other hepatitis paper looks at prevalence of hepatitis B and opportunity for education in a Hmong population in Milwaukee.[9] These papers were published online ahead of print in May to coincide viral hepatitis awareness month in the United States.

The third cluster of papers relates to cancer epidemiology and screening, as well as unique presentations. The paper by Pfau et al looks at colon cancer screening before

and after updated recommendations by the US Preventive Services Task Force.[10] Overall screening rates did not differ significantly, but the type of screenings did. It would be interesting to compare these rates to other national data. Decreased cancer screening has been a consequence of the COVID pandemic, with screening colonoscopies getting cancelled and patients being wary about interacting with the health care setting. In April 2020, numbers of colonoscopies decreased almost 80% compared to the previous year.[11] Procedures are increasing again, and it remains to be seen whether there will be excess deaths from cancer related to the pause in screening. Another paper looks at cancer incidence and epidemiology in North Dakota.[12] This group of researchers found different trends in cancer mortality based on county and sex. A third paper in this cluster describes a case of a 61-year-old man who presented with syncope and was diagnosed with renal cell carcinoma with metastases to the right ventricle and cervical lymph nodes.[13]

We hope that this issue contributes to the body of knowledge about COVID, cancer, and hepatitis. As we continue to weather the consequences of the pandemic, the medical community will work to transform new knowledge into wisdom that will allow all of us to recover and improve the quality of care we provide patients in the future.

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