

CLINICAL GUIDANCE FOR THE MANAGEMENT OF SKIN CANCER PATIENTS DURING THE CORONAVIRUS PANDEMIC

This is a very fluid situation and guidance may change over the next days. This guidance is derived from that made by the British Association of Oral and Maxillofacial Surgeons.

As doctors we all have general responsibilities in relation to coronavirus and for these we should seek and act on national and local guidelines. We also have a specific responsibility to ensure that essential surgical care continues with the minimum burden on the NHS. We may also need to work outside our specific areas of training and expertise and the General Medical Council has already indicated its support for this in the exceptional circumstances we may face: <https://www.gmc-uk.org/news/news-archive/howwe-will-continue-to-regulate-in-light-of-novel-coronavirus>. Skin cancer services may not seem to be in the frontline with coronavirus but we do have a key role to play and this must be planned and remain safe for staff and our patients.

In the event of disruption to skin cancer services clinicians may also need to prioritise treatment for those most in need (Level 4, 5 and 6 care). It is important that all decisions taken are done so with multidisciplinary team (MDT) input and clearly communicated with patients.

Skin cancer services should ensure the following guidance is implemented:

- Consider cancelling all elective surgeries.
- Consider deferring all surgical excisions of BCC, including Mohs micrographic surgery, for 3-6 months, with exceptions for highly-symptomatic lesions. Highly symptomatic lesions and those with potential for significant rapid growth could be considered for surgery.
- Consider deferring many surgical excisions of SCCs, such as SCC *in situ* and small, well differentiated SCCs. Prioritise the following lesions: Rapidly-enlarging tumours, poorly-differentiated tumours, perineural tumours, ulcerated and symptomatic lesions; lesions in patients with significant risk factors (while balancing the risk of COVID-19 complications for these high-risk patients).
- Consider deferring treatment of melanoma *in situ* for 2-3 months.
- Consider deferring wide local excision of completely excised stage T0 and T1a melanoma in patients who had an initial diagnostic excision biopsy
- The NCCN has recommended deferral of treatment of T0 and T1A lesions for up to 3 months, depending on clinical and histological features such as adequacy of biopsy sample and margin positivity.

PERSONAL PROTECTIVE EQUIPMENT – PPE

- PPE may be in short supply, so the use of this should be discussed with local hospital infection teams, who may need to prioritise between different clinical areas when there are limited stocks.
- FFP3 masks, eye screens, aprons and gloves are essential for all close, face-to-face contacts with patients for examination and treatment.
- This will remain the case until the current trajectory of COVID-19 has flattened. To do otherwise is to be playing a very high-risk health lottery.
- For high-risk or known COVID-19 patients or invasive procedures, NHS England guidelines should be followed.
- The limited supplies of PPE mean that any patient who does not need to come to hospital should not.

This is why we must **Avoid, Restrict** and **Abbreviate**.

AVOID

Avoid clinics:

- All routine clinics/minor operations should be cancelled. This requires triaging of new and review patients for life- or limb-threatening conditions, an active decision based on priorities and recording this in the notes.
- Use teledermatology to triage 2-week wait referrals and book patients directly to surgery where possible. Please see [COVID-19: Clinical guidelines for the management of dermatology patients remotely](#).
- Ensure that booking slots and clinic templates are adjusted to protect 2-week wait and urgent slots.

Avoid contact:

- Telephone reviews for all follow-up outpatients who do not need urgent and active treatment should be the first approach.
- Patients should only come to the hospital for urgent assessment and treatment – emergency care and time-limited conditions.

Avoid surgery:

- Especially non-urgent surgery as much as possible but particularly where aerosols are generated.

RESTRICT

Restrict the number of visits:

- For patients who must be seen – cancer, emergencies, urgent time-limited conditions – the patient pathway should be “*see, treat and discharge*”, where possible. The number of visits must be kept to a minimum.

Restrict the generation of aerosols:

- Body fluids contain virus particles. The avoidance or minimisation of aerosols is of importance to reduce the transmission of COVID-19 to healthcare staff.

Restrict staff numbers:

- So that skeleton staff is available on site with a second tier available to cover for sickness, isolation and tiredness.

ABBREVIATE

The length of contact determines the length of potential exposure of healthcare workers. All clinical episodes and surgery should be as brief as possible.

Abbreviate waiting times:

- Patients should not wait for treatment in waiting rooms. They should be treated promptly.
- Provision for vulnerable groups (elderly and comorbid patients who DO need care) should be made to maintain social distancing.

Abbreviate treatment:

- Undertake the most efficient, short-duration intervention.