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## 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.*

Please note that any BAD advice and guidance produced as a result of COVID-19 would still require authorisation by Trusts which indemnify members. Most will be guided by available evidence and responsible medical opinion, and that any deviation from standard practice needs to be documented clearly and the reasons stated.

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, depending on clinical and histological features such as adequacy of biopsy sample and margin positivity.

#### **PERSONAL PROTECTIVE EQUIPMENT – PPE**

- Refer to updated Public Health England guidance on PPE (secondary care settings) [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/877728/T1\\_Recommended\\_PPE\\_for\\_healthcare\\_workers\\_by\\_secondary\\_care\\_clinical\\_context\\_poster.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/877728/T1_Recommended_PPE_for_healthcare_workers_by_secondary_care_clinical_context_poster.pdf)
- The limited supplies of PPE mean that any patient who does not need to come to hospital should not.
- All surgical patients should be treated as potentially COVID-19 positive.
- For any potentially aerosol-generating surgical procedure, FFP3 masks, eye screens, full sleeve, disposable fluid-repellent surgical gowns and gloves should be worn by all practitioners present during the procedure.
- Smoke extractor systems are the most effective way to minimise risk, as standard surgical masks are not sufficient to act as the primary method of particle filtration.
- Only the absolute minimum number of healthcare professionals required for the procedure should be present.
- In the absence of FFP3 masks, and where there is significant risk in not performing the surgery (e.g. high-risk SCC, melanoma and Merkel cell carcinoma) and where the patient is asymptomatic, risk can be reduced by using bipolar diathermy rather than hyfrecation, using a smoke extractor and wearing surgical masks preferably with an integral Perspex visor.
- For high-risk or known COVID-19 patients or invasive procedures, NHS England guidelines should be followed.
- 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.

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 the BAD guidance for the management of

dermatology patients remotely <http://www.bad.org.uk/healthcare-professionals/covid-19/remote-dermatology-guidance>.

- 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.