

GUIDANCE FOR RECOMMENDING SKIN CANCER SURGERY SERVICES DURING THE CORONAVIRUS PANDEMIC

This is a very fluid situation and guidance may change

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.

INTRODUCTION

The challenge now facing the NHS as it begins the second phase of its response to the outbreak is to maintain the capacity to provide high quality services for patients with COVID-19, whilst increasing other urgent clinical services and important routine diagnostics and planned surgery. The situation remains in flux and Trusts will be at different stages of re-starting services according to their local capacity. You should update yourself with the latest government and Trust resources to keep abreast of this constantly changing situation.

A key objective in executing these plans must be to minimise the transmission of COVID-19 infection within hospitals, also referred to as hospital-onset infection or nosocomial transmission.

Patients should only be required to attend hospital where clinically necessary – maximise all opportunities for remote and multi-professional virtual consultations.

Each dermatology department and their clinical staff will need to apply judgement based on local circumstances, and resources to prioritise those patients needing face to face consultations.

This guidance is intended to aid in the development of a consensus approach regarding regional and local approaches to treatment. The rate of restoration of dermatology services will vary between departments. Due to reduced capacity within departments and the necessary precautions to protect staff and patients, the throughput of surgery patients will be reduced; this has been flagged at national level. It has been understood that there will be an accruing backlog of patients who require surgery for skin cancer, particularly BCCs, and that this will in some circumstances lead to increasing morbidity and more complex procedures.

Please read this alongside the publication 'Operating framework for urgent and planned services in hospital settings during COVID-19'.¹

Following this advice is essential for your own safety, to protect your patients and family, and to allow you to continue to treat patients during this crisis.

Consider the possibility of COVID-19 infection in every patient, follow national guidelines, and apply common sense to at-risk clinical environments.

TELEDERMATOLOGY

Where appropriate, hospitals and dermatology teams should continue to aim to deliver virtual clinics for outpatient appointments for the duration of the COVID-19 outbreak to support infection control. Virtual clinics provide a direct contact to a named surgeon by video link, email or telephone.

All routine clinics/minor operations should continue to triage new referrals and review patients for high-risk skin lesions with life-threatening outcomes. These patients should be booked directly into a surgical list, where possible.

Please see the BAD guidance for the management dermatology patients remotely <http://www.bad.org.uk/healthcareprofessionals/covid-19/remote-dermatology-guidance>.

Telephone reviews for all follow-up outpatients who do not need urgent and active treatment should be the first approach. Face-to-face post-operative review should only be carried out if this is required based on clinical need, and it should only be carried out once unless clinically indicated.

PRE-OPERATIVE PATHWAY

Each department will have worked with their own hospital and infection control teams to establish an appropriate and safe approach for patients undergoing skin surgery. Local interpretation of measures will vary.

The recently published operating framework¹ states the following:

- **Elective admissions (including day surgery)**. Patients should isolate for 14 days prior to admission along with members of their household. As and when feasible, this should be supplemented with a pre-admission test* (conducted a maximum of 72 hours in advance), allowing patients who test negative to be admitted with IPC and PPE requirements that are appropriate for someone whose confirmed COVID status is negative.
- **Other day interventions**. Testing and isolation to be determined locally, based on patient and procedural risk.

Many dermatology departments have their own dedicated outpatient theatres or procedural rooms, when 'Other day interventions' would apply. Some departments will use day case theatres.

Consider having patients wear a face mask during any procedure, where possible.

All symptomatic and suspected COVID-19 patients who require surgical treatment should be treated in a designated COVID-19 area within the hospital.

For 'Other day interventions', this is a list of examples of screening proposed by different dermatology departments in the UK:

- No self-isolation pre-surgery. Screening questionnaire at 72 hours pre-surgery and on day of procedure with temperature check (<37.8 °C), no swabbing.
- No self-isolation pre-surgery. As above, with COVID-19 testing 48 hours pre-surgery for central facial lesions. Aiming to do pre-appointment COVID-19 swab for all 2-week wait cases on the central face.
- Non-vulnerable *not* day case – temperature check and questionnaire on day of procedure. Non-vulnerable day case – self-isolation 7 days, swab day 7 and day 3, and questionnaire and temperature check on day of procedure. Vulnerable – same as day case.
- For Mohs cases:
 - Self-isolation for 14 days pre-surgery, screening questionnaire a few days pre-surgery and on the day of surgery, plus temperature check. Aiming to swab 3 days pre-surgery.
 - No pre-surgery self-isolation, no swab, screening questionnaire before listing for procedure, temperature check on arrival.

REINTRODUCING SURGICAL LISTS

As services are re-introduced, the skin cancer MDT and their surgical teams will need to review and prioritise patients alongside overall capacity. High-risk skin cancer patients (levels 4, 5 and 6 care) should remain the main priority. All decisions must be clearly communicated with patients.

- A gradual reinstatement of elective surgeries is recommended over the coming weeks, assessing capacity and feasibility at each stage.

The following is recommended:

- **Melanomas and squamous cell carcinomas**. Where possible, these time-critical lesions should be seen and treated on the same day to minimise visits to the hospital.
- **Wide local excision**. Reintroduction of WLE for melanoma patients on waiting lists.
- **T0 lesions**. Reintroduction of the surgical management of melanoma *in situ* patients on waiting lists.
- **SLNB** should be discussed with eligible patients, where appropriate. Each centre will restart delivering this at different rates depending on local surgical policy and availability of clean sites. Risks of delay versus wide local excision without SLNB must be discussed fully with the patient to enable an informed decision.
- **Basal cell carcinoma**. During the lockdown period the majority of Trusts deferred BCC surgery. The management of these surgical cases should be actively planned.
 - Prioritise high-risk or symptomatic cases.
 - For low-risk lesions, identify and plan to treat those patients < 70 years old with no risk factors/co-morbidities, followed by those patients > 70 years old or with risk factors/co-morbidities.
- **Shielded/extremely vulnerable patients**. Trusts should produce a local policy on how to safely screen and operate on these patients.

- **Radiotherapy.** Patients who have opted for radiotherapy are re-assessed to ensure this remains the better/safer option (N.B. radiotherapy will result in multiple visits to hospital which increases the risk of infection).
- **Communication** with high-risk patients waiting for a surgical appointment should be undertaken, covering the pros and cons of the procedure and whether they wish to go ahead during the pandemic. Alternative solutions and treatments for their care should be organised, where possible.

PROVISION OF MOHS SURGERY

It is recommended that Mohs services should initially prioritise patients with periocular tumours on their waiting list. If services start before the relaxation of lockdown for patients aged >70 years old with other high-risk factors for COVID-19, then patients aged <70 years old should be treated first.

Major post-resection reconstruction cases should be discussed carefully at the MDT preoperatively if a significant central facial reconstruction (i.e. particularly with reconstruction of the alar rim/lips) is likely.

There is a difference nationally in the reintroduction of the technical aspect of Mohs surgery, the BAD and BSDS are seeking clarification on this through the Royal College of Pathologists.

INFECTION PREVENTION

As the pandemic continues to affect NHS services, it is important for all dermatology teams to remain vigilant, with appropriate infection control practices, and ensure they have access to the right PPE.

This is a novel virus and we are in the early stages of understanding its infective risk. Currently, the screening test are not 100% sensitive. It is also likely that there will be variation in prognostic risk between operators, determined by their specific risk profile. It is reported that asymptomatic patients may be capable of transmitting the virus. Many units operate in outpatient facilities without lamina flow or smoke extraction. The case mix on each operating list will be variable, including operations on the central face. Operators will frequently be working within close proximity of a patient's face for over 40 minutes. The screening pathway may not include 14-day self-isolation or preoperative swab. For these reasons, the BAD and BSDS would advocate the use of FFP3 or FFP2 (N95) masks to ensure the safety of patients & staff when operating. We also recommend the use of smoke extractors in all operating facilities to maximise safety.

The PHE PPE summary [table](#) is also available.

REFERENCES

1. Operating framework for urgent and planned services in hospital settings during COVID-19 www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/05/Operating-framework-for-urgent-and-planned-services-within-hospitals.pdf