

LETTER

Dermatologic surgery in the COVID-19 era: Observations and practical suggestions

Dear Editor,

The pandemic spread of the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection has dramatically impacted the health care services worldwide. As of 28 April 2020, more than 200 000 confirmed cases of coronavirus disease (COVID-19) have been registered and over 27 000 deaths occurred in Italy.¹ It is also worth remarking that reported cases may not include all positive COVID-19 individuals and the cumulative incidence of the disease may be much higher.² In this scenario, recent extensive measures to reduce person-to-person transmission have been rapidly implemented, requiring a complex reorganization of the work and environment in the hospital setting.

As health care workers (HCWs), we have the responsibility to implement measures with the aim to limit the spread of SARS-CoV-2, providing, at the same time, the essential medical and surgical care to our patients.

In the specific context of dermatologic surgery, the choice to defer planned surgical patients may help to decrease the SARS-CoV-2 risk transmission, even if this approach needs to be well-thought-out since it may lead to disease progression and increasing tumor burden.^{3,4} Firstly, we need to prioritize treatment for most urgent patients, selected by checking clinical history in medical chart. We revise clinical and dermoscopic images of the target lesions and when in doubt we contact patients, asking for additional information or scheduling them for an update check at the hospital (Table 1). If clinical-dermoscopic examination is indicative for melanoma or for a highly suspicious melanocytic lesion, then surgical excision must be performed promptly, in accordance with the availability of operating rooms and anesthesiologists (Figure 1). Accounting for non-melanocytic skin cancers (NMSCs) and focusing in particular on suspicious low-risk basal cell carcinomas (BCCs) (trunk and extremities' lesions, well-defined borders, primary lesions, nodular or superficial histologic subtypes, and no perineural involvement in a previous incisional biopsy),⁵ we recommend to defer treatment by 4 to 6 months, since these tumors have a slow-growing behavior not influencing the prognosis outcome; high-risk BCCs (head and neck lesions, poorly defined borders, recurrent lesions, BCC in immunosuppressed patients or grown on the site of prior radiation therapy, aggressive histologic subtypes or perineural involvement in a previous incisional biopsy) should be excised, since a deferring may lead to significant morbidity and disfigurement. In the management of suspicious squamous cell carcinomas (SCCs), surgical excision should be scheduled for ulcerated and symptomatic lesions, rapidly enlarging tumors, lesions occurring in patients with significant risk factors (immunosuppression, site of prior radiotherapy, or chronic inflammatory process) and head and

neck lesions, while it seems reasonable to postpone by 4 to 6 months radical excision for low-risk SCCs (primary, well-differentiated lesions, with well-defined borders, located on the trunk or extremities).⁵

Having accurately selected lesions to excise, it is important to stagger appointments in order to minimize the number of patients attending waiting room together. All patients should undergo contactless body temperature scanning before getting into the clinic (body temperature must be <37.5°C) and complete a specific form declaring to have had no flu-like symptoms neither contact with COVID-19-positive individuals in the last 2 weeks. Furthermore, patients need to wear surgical face mask and gloves and keep them during the surgical procedure whenever possible. It is mandatory for HCWs to wear surgical face mask, eye screen, apron and gloves; FFP2 masks are essential for all cases of close, face-to-face contact with patients, such as surgical procedures performed on the head and neck area.

TABLE 1 Recommendations regarding dermatological surgery during COVID-19

Target lesion (suspicious diagnosis determined with clinic-dermoscopic examination)	Procedure
Melanoma or highly suspicious melanocytic lesion	Surgical excision
Low-risk BCCs ^a	Defer surgical excision by 4 to 6 months
High-risk BCCs ^b	Surgical excision
Low-risk SCCs ^c	Defer surgical excision by 4 to 6 months
High-risk SCCs ^d	Surgical excision
Benign lesions	Defer surgical excision by 4 to 6 months

Abbreviations: BCC, basal cell carcinoma; SCC, squamous cell carcinoma.
^aLow-risk BCCs: trunk and extremities' lesions, well-defined borders, primary lesions, nodular or superficial histologic subtypes, and no perineural involvement in a previous incisional biopsy.
^bHigh-risk BCCs: head and neck lesions, poorly defined borders, recurrent lesions, BCC in immunosuppressed patients or grown on site of prior radiation therapy, aggressive histologic subtypes, or perineural involvement in a previous incisional biopsy.
^cLow-risk SCCs: primary, well-differentiated lesions, with well-defined borders, located on the trunk or extremities.
^dLow-risk SCC ulcerated and symptomatic lesions, rapidly enlarging tumors, lesions occurring in patients with significant risk factors (immunosuppression, site of prior radiotherapy, or chronic inflammatory process) and head and neck lesions.

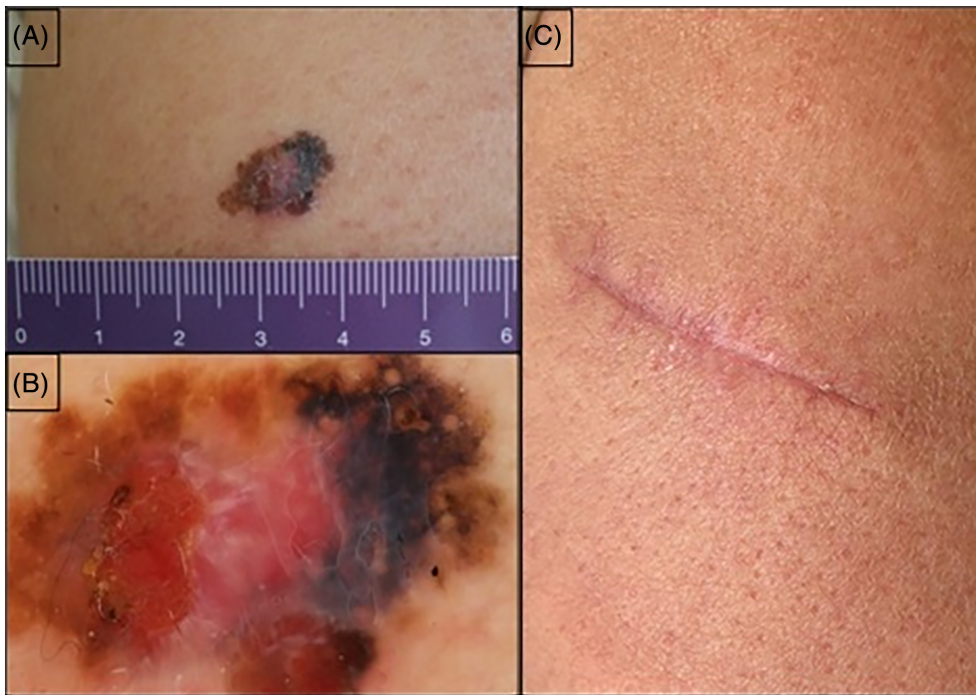


FIGURE 1 Female patient of 60 years of age with ulcerated pigmented nodular lesion (17 mm × 9 mm) showing irregular borders and multiple colors, located on the extensor surface of the right arm (A). Dermoscopic examination showed a multicomponent pattern, with atypical pigment network, shiny white streaks, milky red areas, peppering, and blue whitish veil (B). Clinical-dermoscopic examination was highly suspected for melanoma, patient underwent surgical excision (C), and histological examination showed melanoma 1.1 mm Breslow thickness

These general recommendations on dermatologic surgery might be subjected to further modifications according to the evolutions of the COVID-19 pandemic in order to ensure safety of both HCWs and patients.

ACKNOWLEDGMENTS


The authors wish to thank the nurses and all the health care workers of the Fondazione Policlinico Universitario Agostino Gemelli IRCCS for the valuable care of patients during pandemic spread of the novel coronavirus.

AUTHOR CONTRIBUTIONS

A.P. and P.S. had full access to all of the data in the study and took the responsibility for the integrity of the data and the accuracy of the data analysis, and also contributed to the concept and design of the study. All authors contributed to acquisition, analysis, and interpretation of data. A.P., P.S., and S.C. contributed to the drafting of the manuscript.

CONFLICT OF INTERESTS

Alfredo Piccerillo, Barbara Fossati, and Simone Cappilli have no conflict of interest to report. Pietro Sollena reports personal fees for presentations during dermatologic meetings from Leo-Pharma, Novartis, Pierre Fabre, Sanofi and Almirall, outside the submitted work.

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