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Dermatologic surgery during the COVID-19 pandemic: Experience of a large academic center



To the Editor: The novel coronavirus disease 2019 (COVID-19) pandemic has required significant modifications to clinical practice.¹ In the hardest-hit areas, such as New York City, triaging of personnel and supplies, as well as prioritization of certain skin cancers, was required in dermatology practices. Although clinical judgment should be used to evaluate patients on a case-by-case basis, general guidelines from the National Comprehensive Cancer Network recommend postponing treatment for low-risk lesions by 3 months, except in cases in which “debilitating progression within 3 months” was estimated by the physician.^{2,3} However, for certain skin cancers types, including invasive melanoma, Merkel cell carcinoma, and high-risk cutaneous squamous cell carcinoma, the decision to delay care is of higher

risk.^{2,3} Prior studies have reported that delays to treatment for stage 1 melanomas may increase the risk of poor prognosis and decrease overall survival.⁴ Providers must also weigh the significant anxiety faced by patients who have received a diagnosis of skin cancer but are unable to receive definitive treatment. As such, for patients who require surgery during the pandemic via Mohs micrographic surgery or wide local excision, it is crucial that dermatology practices have protocols in place to provide necessary care while protecting patients and health care personnel from COVID-19. Our goal is to share our experience in practicing dermatologic surgery in the heart of the COVID-19 pandemic with an abundance of caution.

Dermatologic societies have created a living document to grade evidence regarding measures to minimize the transmission risk of COVID-19, covering topics including hand washing, personal protective equipment, risk of aerosolizing COVID-19, ventilation, and eye protection.⁵ To add to this work, we summarize measures taken at New York Presbyterian–Weill Cornell Medicine, a large academic center greatly affected by the pandemic (Table 1). We also summarize our approach to

Table 1. Current coronavirus disease 2019 precautions taken at Weill Cornell dermatology

Visit	Location	Preventive measures taken
Preoperative	Televisit	Prioritizing surgical cases via telemedicine Patient taking a self-photograph to help identify surgical site Photographic instructions sent COVID-19 screening for symptoms and instructing patients to self-monitor and report any symptoms before surgery Since mid-June, presurgical COVID-19 PCR testing for surgical sites in mask zone or other high-risk situations 24–72 h before surgery Ensure test turnover and result time appropriate
Operation day	In person	Screening for COVID-19 Symptom screening and temperature check Waiting room avoidance Patients scheduled so that they can go directly to procedure rooms and remain in the room Visitors not allowed to be with the patient aside from special circumstances, including for minors and when there is a medical or legal necessity Operation precautions PPE for patient: provide patient with surgical mask PPE for provider: mask (N95 + surgical mask), goggles or face shield, hair and shoe covering, and gown Use of smoke evacuator during electrocautery Dissolvable sutures and cyanoacrylate for surgical closure to prevent need for additional visit Written and oral wound care instructions regarding wound care Sanitation steps (disinfecting room between patient encounters) Sanitary wipes to disinfect all room surfaces and any objects touched by patients

COVID-19, Coronavirus disease 2019; PCR, polymerase chain reaction; PPE, personal protective equipment.

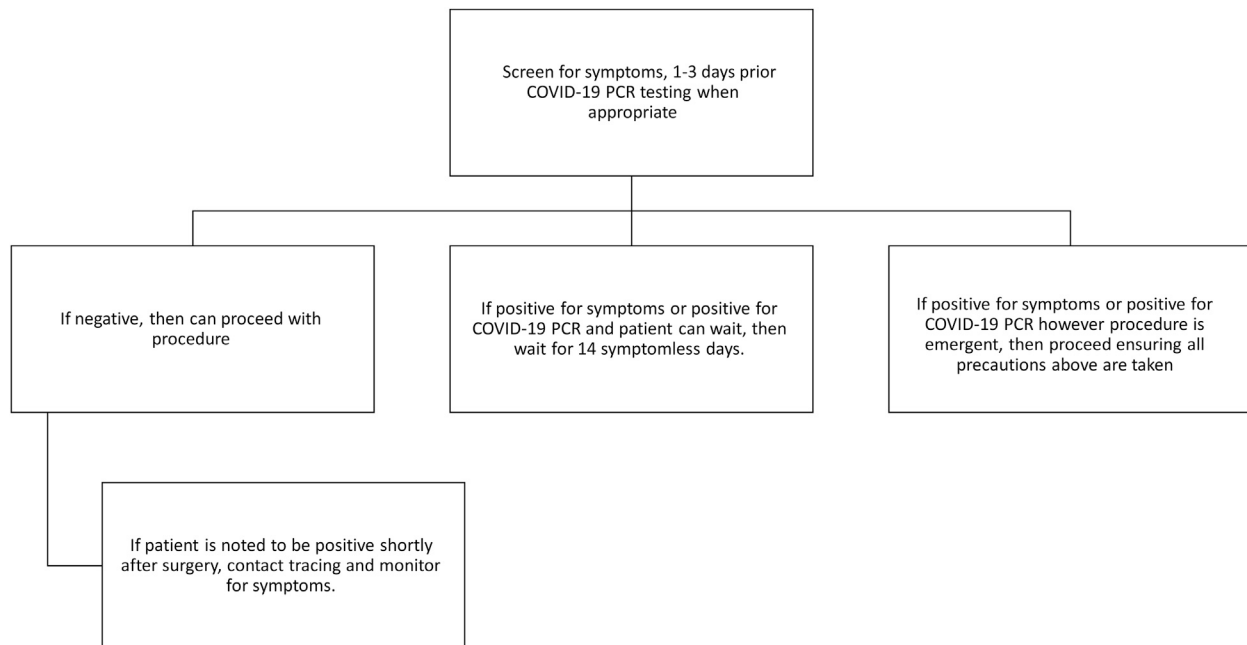


Fig 1. Current protocol regarding handling coronavirus disease 2019—positive patients.

handling COVID-19—positive patients who require care (Fig 1). From March 1, 2020, to July 14, 2020, 235 nonmelanoma skin cancers and 27 melanoma excisions were performed at Weill Cornell Dermatology. With our measures, there has been no known transmission of COVID-19 associated with dermatologic surgery, even when COVID-19—positive patients were treated.

With regional variability in the prevalence of COVID-19, personal protective equipment shortages, and hospital policies, we acknowledge the complexity of this issue and that our solution may not be a one-size-fits-all solution. We appreciate that alternative methods for transmission prevention, including a “pod system” in which staff work in small, unchanging groups to limit the number of exposures, may be a better option for other facilities or regions. We also appreciate that in some situations, practices have to temporarily pause surgeries. We foresee COVID-19 to be a long-term issue, particularly in New York City, where there has been a secondary increase in cases. Given the lack of proven treatments or vaccines for COVID-19, the paucity of information on practice standards for dermatologic surgery, and concerns about how delays can affect patients, we hope that sharing our experience will add to the body of information and may enable other practices to continue to serve their patients during this difficult situation.

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Conflicts of interest

None disclosed.

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The impact of the COVID-19 pandemic on the presentation status of newly diagnosed melanoma: A single institution experience



To the Editor: The COVID-19 pandemic has had a significant impact on cancer care.¹ Some have projected up to a 10% increase in mortality for specific malignancies due to delays in care caused by the COVID-19 pandemic, but the pandemic's impact on melanoma has yet to be defined.^{2,3} Delays in diagnosis could result in thicker melanomas at presentation and profound effects on patient outcomes. This study evaluates the presentation status of melanoma lesions before and after a period of

Table I. Patient and tumor characteristics of all melanomas examined by dermatopathology and oncologic surgery from June 15 to August 15, 2019 and June 15 to August 15, 2020

	Pre-COVID-19 N = 172 (52.9%)	COVID-19 N = 153 (47.1%)	P value
Age (median, IQR)	68 (16.5)	68 (18)	.518
<50 y	24 (14.0)	23 (15.0)	
50-59 y	22 (12.8)	30 (19.6)	
60-69 y	48 (27.9)	38 (24.8)	
70-79 y	56 (32.6)	43 (28.1)	
≥80 y	22 (12.8)	19 (12.4)	
Sex			.757
Male	96 (55.8)	88 (57.5)	
Female	76 (44.2)	65 (42.5)	
Race			.257
White	138 (80.2)	116 (75.8)	
Black	2 (1.2)	0 (0.0)	
Asian	0 (0.0)	1 (0.7)	
Unknown	32 (18.6)	36 (23.5)	
Immune compromise	1 (0.6)	4 (2.6)	.137
Tumor depth (median, IQR)	0.5 (0.7)	0.6 (0.9)	.171

Continued

Table I. Cont'd

	Pre-COVID-19 N = 172 (52.9%)	COVID-19 N = 153 (47.1%)	P value
pT staging group			.900
1/2	147 (85.5)	130 (85.0)	
3/4	25 (14.5)	23 (15.0)	
Clark level			.880
Level II	57 (33.1)	47 (30.7)	
Level III	52 (30.2)	41 (26.8)	
Level IV	56 (32.6)	58 (37.9)	
Level V	4 (2.3)	4 (2.6)	
Unknown	3 (1.7)	3 (2.0)	
Lymphovascular invasion	6 (3.5)	4 (2.6)	.092
Unknown	5 (2.9)	0 (0.0)	
Ulceration	14 (8.1)	22 (14.4)	.165
Unknown	3 (1.7)	4 (2.6)	
Tumor-infiltrating lymphocytes			.537
Brisk	18 (10.5)	14 (9.2)	
Nonbrisk	92 (53.5)	88 (57.5)	
Unknown	28 (16.3)	17 (11.1)	
Vertical growth	114 (66.3)	98 (64.1)	.673
Unknown	8 (4.7)	5 (3.3)	
Regression	48 (27.9)	32 (20.9)	.162
Unknown	4 (2.3)	8 (5.2)	
Satellitosis	0 (0.0)	6 (3.9)	.001*
Unknown	5 (2.9)	14 (9.2)	
Perineural invasion	3 (1.7)	4 (2.6)	.080
Unknown	8 (4.7)	1 (0.7)	
Mitotic count			.240
None	97 (56.4)	79 (51.6)	
≤1	33 (19.2)	24 (15.7)	
>1	42 (24.4)	50 (32.7)	
Residual tumor	50 (29.1)	47 (30.7)	.691
Unknown	58 (33.7)	56 (36.6)	
Source			.587
Dermatopathology only	104 (60.5)	97 (63.4)	
Surgery	68 (39.5)	56 (36.6)	

IQR, Interquartile range.

*Indicates significance.

pandemic restrictions, which limited dermatologic evaluation to define the pandemic's impact on melanoma care.

Patients referred to the University of Pennsylvania's Dermatopathology Department for pathologic slide review and/or Division of Endocrine and Oncologic Surgery (handling most of the institutional resection volume) for definitive resection of nonmetastatic primary melanomas were identified from a 2-month period after clinical resurgence at our institution (June 15-August 15, 2020; the COVID-19 era cohort) and a corresponding period in the pre-COVID-19 era (June