

Management of patients with melanoma and non-melanoma skin cancers in the coronavirus disease 2019 era

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The recent coronavirus disease 2019 (COVID-19) pandemic has completely disrupted hospital and outpatient activities.^[1-2] It has been reorganized to allow a lower inflow of patients, to reduce non-urgent out-patient visits and to concentrate public health forces in the fight against the COVID-19 outbreak. In this reorganization, dermatology departments have also adapted their activities suspending routine patient visits and providing only urgent surgical removal, urgent visits, consultations, and oncological examinations.

Moreover, this particular situation has led dermatology to address new challenges, concerning medical oncological therapies for melanoma patients, management of individuals on topical treatments for non-melanoma skin cancers (NMSC), follow-up of patients with advanced melanoma and advanced NMSC. Certainly, delay in diagnosis and consequently treatment of both NMSC and melanoma is expected to rise in the coming months, as concerned also for other solid tumors.^[3] This is the first major problem in dermatological diagnostics, which has always been committed to making a diagnosis as early as possible, especially with the help of dermoscopic examination.

A possible solution to limit at the one hand, unnecessary access to the hospital and on the other hand, prevent lesions progression towards advanced cancers, is screening through telematic systems (teledermatology) which can be implemented in order to triage the urgency of suspected lesions and plan access direct for intervention.

Teledermatology can be a valid tool if used correctly; it allows to make video calls with some categories of patients, for example, evaluation of psoriasis area severity index (PASI) during systemic therapies for psoriasis, first level

screening of keratinocytic or melanocytic lesions, evaluation of clinical manifestations of chronic diseases (for example, atopic dermatitis, bullous diseases). In addition, some consultations can also be performed through calls, especially to continue the follow-up of some patients who necessarily need to be followed up in hospital such as melanoma patients. In this sense, videodermoscopy is very effective at this time because it allows to evaluate skin lesions without face too close to the patient but keeping the appropriate distances; in fact, the images are shown on a screen and this allows a precise evaluation without the need to get too close to the patient's face, especially for facial lesions.

While our efforts are aimed at continuing to strive for early diagnosis, we must also continue to effectively treat patients with actinic keratosis (AK) and other epithelial cancers (KCs).^[4] As it is known, AKs are more frequent in the elderly population who is considered at high risk of infection, and more severe and life-threatening complications associated with the infection. For example, at our dermatological clinic, about 900 patients per year are treated with photodynamic therapy (PDT) for skin cancers and the majority is older than 60 years. During the lock down, all topical treatments including PDT for AKs, Bowen disease (BD), superficial basal cell carcinomas (BCCs), and field of cancerization (FC) have been temporarily suspended. Only in selected patients, alternative treatments such as 5-fluorouracil 0.5%/salicylic acid 10% solution, imiquimod 5% cream and imiquimod 3.75% cream may be used. While for the above-mentioned cancers with very low risk for progression,^[5] treatment has been largely suspended, oncologic surgeries for melanoma, high risk BCCs and rapidly growing squamous cell carcinomas are guaranteed. Thereby histology, location and tumor size are important criteria to assess the urgency of the intervention. Only for small BCCs (<0.5 cm),

Access this article online

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DOI:
10.1097/CM9.0000000000000930

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Chinese Medical Journal 2020;133(17)

Received: 20-04-2020 Edited by: Li-Shao Guo

surgery is postponed unless lesions are considered locally aggressive or when located at very high-risk H-areas of the face (palpebra, lip, eye).^[6]

Wide re-excisions, if necessary, are performed for invasive melanomas, while currently suspected melanoma *in situ* is immediately excised with 5 mm margins.

For surgery we recommend therefore: (1) postponing surgeries of low risk cancers and inform the patients to contact the clinic in case of any recent changes; (2) for surgeries that cannot be postponed, schedule appointments with sufficient time between two sessions in order to avoid long waiting time in the waiting room; (3) patients should wear the surgical mask during the entire stay in the hospital; (4) it would be desirable to test patients via swab before extensive surgeries requiring hospitalization or frequent access for wound dressing; (5) where possible, switch to medical therapies with topical drugs and perform controls by telematic consultation.

With regard to systemic treatments, patients already on treatment should contact their oncologist or treating specialist before suspending independently the treatment in case of flu-like symptoms. For patients requiring systemic treatment, ideally a swab before treatment and polymerase chain reaction should be performed. Up to date there are no clear contra-indications against treatment start, however, some treatments such as immunotherapy may induce side effects that may be very difficult to differentiate from COVID-19 such as pneumonia and colitis. For this reason, if possible, targeted treatment as oral treatment should be preferred.

Regarding locally advanced BCCs, currently two drugs (vismodegib and sonidegib) inhibiting the Hedgehog (HHI) pathways are available. Again, there is no clear contra-indication against the treatment start with regard to COVID-19. Follow up of treatment success can be managed by teledermatology using high resolution images of patients. In contrast to immune-therapies, side effects of HHI are less confounding with clinical symptoms of COVID-19 and can be managed by progressive dose reduction or treatment pauses.^[7-8] Up to date it is unclear whether targeted treatments such as BRAF/MEK inhibitors and HHI or immunotherapies may negatively influence the course in the case of COVID-19 patients. Most current recommendations, however, suggest suspension of the treatment until healing of the infection.^[9]

Slightly different is the management of invasive squamous cell carcinoma. In all cases, given the risk of metastasis, surgical removal is mandatory for newly diagnosed cases or for fast growing nodule/plaque. For patients on follow-up, if treatments can be postponed (*eg*, 6-monthly ultrasound), postponement can be considered, but in all cases, it is necessary to discuss it with dermatologists and not to abandon the planned medical and radiological follow-up programs.

Last but not least, the biggest challenge at the moment remains the follow-up of melanocytic skin lesions as well as medical and surgical treatment of melanoma.

In the case of atypical melanocytic lesions, fast growing or rapidly changing in shape and color lesions, it is essential that patients have easy access to the dermatology departments. Initial screening can be performed electronically and this would limit access to the hospital for banal lesions such as seborrheic keratoses. In this sense, teledermatology and general practitioners can help to effectively filter out the lesions that need further investigation, including the use of ABCDE rule. Patients in follow-up for previous melanoma should be contacted by phone or email to remind them of their appointments and to invite them not to abandon the follow-up.

With regard to patients suffering from metastatic melanoma undergoing immunotherapy or target therapy, it is essential that they do not suspend treatment and to this purpose telephone or email consultation can help to increase therapeutic compliance.

However, for this category of patients, there are no evidences or strong specific recommendations on how to proceed. Based on our clinical experience and some recommendations of Italian Association of Medical Oncology (AIOM)^[10] and European Society of Medical Oncology (ESMO),^[11] we suggest to evaluate each single patient appropriately and in case of symptomatic individuals with impaired respiratory function, postponement of therapy can be considered as a valid alternative, even for short periods such as 2 to 6 weeks or until clinical improvement.

Conflicts of interest

None.

References

1. Conforti C, Cannavò SP, Jafferany M, Dianzani C, Di Meo N, Lotti T, *et al*. Coronavirus disease 2019 (COVID-19): facts and controversies. *Dermatol Ther* 2020;e13366. doi: 10.1111/dth.13366.
2. Conforti C, Giuffrida R, Dianzani C, Di Meo N, Zalaudek I. COVID-19 and psoriasis: Is it time to limit treatment with immunosuppressants? A call for action. *Dermatol Ther* 2020. published ahead of print. doi: 10.1111/dth.13298.
3. Schrag D, Hershman DL, Basch E. Oncology practice during the COVID-19 pandemic. *JAMA*; published ahead of print. doi: 10.1001/jama.2020.6236.
4. Conforti C, Beninati E, Dianzani C. Are actinic keratoses really squamous cell cancer? How do we know if they would become malignant? *Clin Dermatol* 2018;36:430–432. doi: 10.1016/j.clindermatol.2017.08.013.
5. Conforti C, Paolini F, Venuti A, Dianzani C, Zalaudek I. The detection rate of human papillomavirus in well-differentiated squamous cell carcinoma and keratoacanthoma: is there new evidence for a viral pathogenesis of keratoacanthoma? *Br J Dermatol* 2019;181:1309–1311. doi: 10.1111/bjd.18212.
6. Puig S, Berrocal A. Management of high-risk and advanced basal cell carcinoma. *Clin Transl Oncol* 2015;17:497–503. doi: 10.1007/s12094-014-1272-9.
7. Woltsche N, Pichler N, Wolf I, Di Meo N, Zalaudek I. Managing adverse effects by dose reduction during routine treatment of locally advanced basal cell carcinoma with the hedgehog inhibitor vismodegib: a single centre experience. *J Eur Acad Dermatol Venereol* 2019;33:e144–e145. doi: 10.1111/jdv.15367.
8. Villani A, Fabbrocini G, Costa C, Scalvenzi M. Patients with advanced basal cell carcinomas in treatment with sonic hedgehog inhibitors during the coronavirus disease 2019 (COVID-19) period:

- management and adherence to treatment. *J Am Acad Dermatol* 2020. published ahead of print. doi: 10.1016/j.jaad.2020.03.057.
9. Conforti C, Giuffrida R, Di Meo N, Zalaudek I. Management of advanced melanoma in the COVID-19 era. *Dermatol Ther* 2020; published ahead of print. doi:10.1111/dth.13444.
 10. AIOM, Rischio infettivo da Coronavirus Covid-19: indicazioni per l'oncologia. Available from: https://www.aiom.it/wp-content/uploads/2020/03/20200313_COVID-19_indicazioni_AIOM-CIPOMO-COMU.pdf.
 11. ESMO, Cancer patient management during the covid-19 pandemic. Available from: <https://www.esmo.org/guidelines/cancer-patient-management-during-the-covid-19-pandemic?hit=ehp>.
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- How to cite this article:** Conforti C, di Meo N, Giuffrida R, Zalaudek I. Management of patients with melanoma and non-melanoma skin cancers in the coronavirus disease 2019 era. *Chin Med J* 2020;133:2017–2019. doi: 10.1097/CM9.0000000000000930