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Perspectives on the recommendations for skin cancer management during the COVID-19 pandemic



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The National Comprehensive Cancer Network and American College of Mohs Surgery have released guidelines for managing cancer during the human severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) pandemic. The detailed National Comprehensive Cancer Network and American College of Mohs Surgery recommendations are available online (<https://www.nccn.org/covid-19/default.aspx> and <https://www.mohscollege.org/>), and here we provide our perspective.¹

Clinical judgment should be exercised on a case-by-case basis while interpreting the general guidelines. All efforts should be directed toward minimizing unnecessary exposures to patients and staff. Excisional biopsies with narrow margins to completely remove all suspicious lesions, including melanoma, Merkel cell carcinoma, and others, should be attempted to minimize travel and to allow for delays in definitive treatment, if necessary.

We divide skin cancers into low-, intermediate-, and high-risk categories to guide treatment decisions. The low-risk category includes basal cell carcinoma, cutaneous squamous cell carcinoma (cSCC) in situ, and cSCC without high-risk factors (≥ 2 cm in diameter, poorly differentiated histologically, perineural invasion ≥ 0.1 mm, or invasion beyond subcutaneous fat),² melanoma in situ, and indolent cutaneous lymphomas. For this category,

Abbreviations used:

cSCC:	cutaneous squamous cell carcinoma
SARS-CoV-2:	severe acute respiratory syndrome coronavirus 2

elective therapies, operations, and radiation may be postponed for at least 3 months. Again, clinical judgment on a case-by-case basis weighing individual risks for the patient, including risks of serious complications and death from COVID-19, should be exercised.

For the intermediate-risk category (T1 melanomas with clear margins after biopsy, T1 melanomas without a clear margin, assuming most of the tumor was removed, and T1b melanomas), wide local excisions should be performed, and sentinel lymph node biopsies should be reviewed on a case-by-case basis and may be postponed.

Therapy-related travel for the high-risk category (high-risk cSCC, invasive, thick and ulcerated melanoma, Merkel cell carcinoma, tumors with aggressive histology or in sensitive areas) must be weighed against each patient's risks. For rapidly growing cSCC, particularly of the head and neck (eyes, ears, lips, mouth) and symptomatic lesions, more immediate treatment may be considered. Mohs micrographic surgery may be used for high-risk squamous

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cell carcinoma and rare cancers, including undifferentiated pleomorphic sarcoma and adnexal tumors with concern for rapidly developing metastasis.

To minimize surgical team exposure, the least complex reconstruction to preserve function should be considered. Operating room use should be avoided to conserve resources and minimize potential SARS-CoV-2 exposures. For basal cell carcinoma in sites where delay may compromise preservation of function, neoadjuvant therapy with hedgehog inhibitors may be considered until definitive management can be safely achieved.

Infusion therapies, including in the adjuvant setting for melanoma, pose serious risks due to necessity of infusion center visits. Immunotherapy conceivably confers additional risk due to deleterious immune activation resulting from SARS-CoV-2. The National Comprehensive Cancer Network

resources propose alternative immunotherapy regimens (see complete guidelines for reference).

Telemedicine visits should be prioritized, limiting in-person visits for biopsies of highly suspicious lesions and for in-office therapies for the highest-risk cancers. This pandemic presents evolving challenges, and we must continue to provide optimal treatment for our patients while preventing global spread of the disease and preserving resources.

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