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Heterogeneity of reports about the impact of the COVID-19 pandemic on melanoma diagnosis

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Linked Article: Sangers TE *et al.* Br J Dermatol 2022; **187**:196–202.

In this issue of the *BJD*, Sangers and coauthors report on the impact of the COVID-19 pandemic on new diagnoses of melanoma and cutaneous squamous cell carcinoma (cSCC) in the Netherlands.[1] Due to the COVID-19 pandemic, many planned medical activities have been postponed, therefore a diagnostic delay and the loss of some cancer diagnoses is an expected eventuality. Several studies have evaluated the impact of the COVID-19 pandemic on skin cancer diagnoses, but most of them are single-centre studies and the total number of cases is much lower than those in the Dutch study.[1]

The results of Sangers *et al.* showed only a minor shift towards unfavourable melanoma tumour stages during the first lockdown, and no clinically relevant impact for cSCC tumour characteristics. However, this is not surprising given the scenario depicted in Figure S1 of Sangers' report: in 2020, in the Netherlands, they only needed two to three additional weeks to reach the cumulative number of melanoma diagnoses observed during 2019, in the prepandemic period. Therefore, the mean diagnostic delay seems to be minimal, and with scarce effects on Breslow thickness. In Rome, Italy, this picture was radically different.[2] Figure 1 shows that melanoma diagnoses nearly stopped as soon as the lockdown was instituted, and in 2020 it took approximately eight more weeks to reach the same number of melanoma diagnoses observed in the same period in 2019. Still, in Italy, other reports are quite consistent in observing a significant delay of new melanoma diagnoses during 2020,[3] and even in 2021 there does not yet appear to have been a real return to prepandemic everyday life.[4]

Reductions of new melanoma and/or cSCC diagnoses have also been observed in Spain[5] and Chile.[6] A large Canadian study showed a reduction of most cases of cancer during the COVID-19 pandemic especially for melanoma and cervical, endocrinological and prostate cancers.[7] Contrasting results have been observed in two studies conducted in England,[8,9] while in Belgium[10] no particular variations in skin cancer diagnosis have been observed during the COVID-19 pandemic.

The results of the Dutch study, and such wide variations between countries, should be interpreted by taking into consideration the possible different intermixing of a number of factors, among which are: (i) the strictness and effectiveness of the lockdown; (ii) the severity of the restrictions for access to hospitals and other healthcare structures; (iii) the impact, both practical and emotional, on individuals and collectively of the first wave of the pandemic; (iv) shifting of

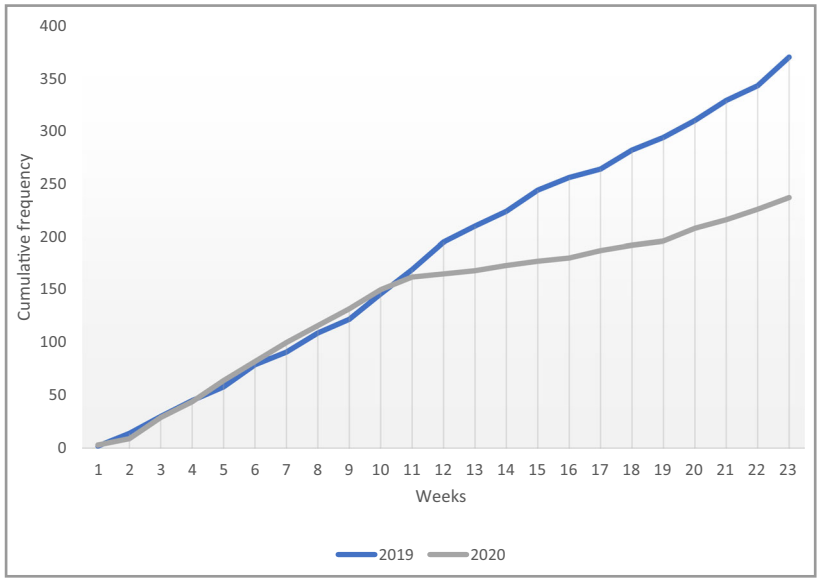

Figure 1 Cumulative number of melanoma diagnoses registered in the first 23 weeks of the years 2019 and 2020 at the Dermatological Research Hospital IDI-IRCCS, Rome, Italy.

healthcare resources to emergency COVID-19 care; (v) general levels of healthcare organization and availability of resources and (vi) cultural differences in melanoma and cancer awareness.

It is difficult to obtain valid estimates of the joint effects of such complex factors, but it is plausible that they may explain, methodological issues notwithstanding, the observed discrepancies among studies. However, the report by Sangers and colleagues highlights, once more, the importance of national disease databases and cancer registries for epidemiological, public health and health policy purposes.

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Clinical practice guidelines for psoriasis: which ones are the best?

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In this issue of the *BJD*, Yen *et al.* provide a summary of the available guidelines for the management of psoriasis.[1] The authors did a comprehensive search and selection process to identify 33 guidelines published globally since 2015. Furthermore, the authors assessed the quality of the guidelines, applying three different approaches for that purpose: the AGREE II tool, Lenzer's red flags and the Institute of Medicine criteria. Although a high number of guidelines were evaluated, only the EuroGuiDerm study[2] was considered to be of high quality according to the three approaches. However, considering only the assessments using AGREE II,[3] which is the only validated tool for this purpose,[4] four additional guidelines can also be considered of high quality: two British,[5,6] one French[7] and one German.[8]

These findings suggest that most of the recommendations implemented in many contexts on patients with psoriasis come from guideline development processes that did not meet the expected standards. Moreover, according to the AGREE II tool assessments, most of the identified limitations in the guidelines were related to critical elements in the development process. Firstly, many guidelines failed in considering patients' values and preferences. Seeking what patients prefer and value about their disease management is key for understanding the acceptability of interventions and the expectations regarding their health. Failing to consider these values puts the recommendations at risk of not being followed by patients or allows the implementation of recommendations to impact outcomes that are not important for patients.

Another limitation found in the guidelines was their poor applicability. To be considered applicable, guidelines: (i) need to describe the expected barriers to the recommendations and provide information on how to address them (e.g. how to address barriers of access to the biological therapy); (ii) should provide tools and/or advice for facilitating the implementation and provide monitoring and/or auditing criteria (e.g. indicators); and (iii) should consider the resource implications of implementing their recommendations. Most of the psoriasis guidelines failed to consider these resource implications. These guidelines consider expensive treatments, and interventions should not be recommended without considering their costs and the barriers for their implementation. Depending on the healthcare system, this limitation may reduce adherence to treatments or increase healthcare inequalities, as expensive treatments would only be available for patients who can afford them.