Skin Cancer Management Guidance in Response to COVID-19

The following guidance has been produced by the COVID-19 South East Cancer Cell, 30th March 2020

1 Key Points

- For use to determine access to services when capacity is limited
- Higher priority chemotherapy will have protected access to available capacity
- Priority is determined by the absolute benefit a therapy provides to patients receiving that therapy

2 Purpose of document

These recommendations have been drawn up to guide local services to manage their new and review skin cancer patients. These are not evidence based, but are a peer reviewed practical policy, to cope with the expected drastically reduced clinical and surgical facilities.

3 PPE

PERSONAL PROTECTIVE EQUIPMENT (From BAD Covid advice, see link http://www.bad.org.uk/shared/get-file.ashx?itemtype=document&id=6658)

• PPE may be in short supply, so the use of this should be discussed with local hospital infection teams, who may need to prioritise between different clinical areas when there are limited stocks.
• FFP3 masks, eye screens, aprons and gloves are essential for all close, face-to-face contacts with patients for examination and treatment.
• This will remain the case until the current trajectory of COVID-19 has flattened. To do otherwise is to be playing a very high-risk health lottery.
• For high-risk or known COVID-19 patients or invasive procedures, NHS England guidelines should be followed.
• The limited supplies of PPE mean that any patient who does not need to come to hospital should not.

4 GP referral to clinic

The emphasis is on the triage of the referral once received rather than putting off the referral. This is so that patients are logged in the system even if the decision is to defer treatment for now. Cancer cell are working on deferral codes and there will be central guidance on this to follow:
https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/cancer-alliance-information-on-managing-cancer-referrals-19-march-2020.pdf

Letter to go out with skin clinic appointment, stating

- New model of appointment and guidance regarding actions should they have symptoms of COVID-19 or live with someone who is self-isolating.
- Continue to take two week wait referrals.
- Requirement for a minimum dataset from referrer with accurate description of lesion and where possible a photograph attached. Patient could also take photo and send in if secure mechanism available.

4.1 Triage of Referrals

As of 24 March 2020, to support the government's in enforcing enforce a lock-down, all effort should be made to negate footfall into hospital or community dermatology units.

Patients at high risk of severe illness from Coronovirus:
Frail elderly patient (>70 years) and/or those at risk with significant comorbidities represent a significant risk of death from complication of Covid-19. Strict consideration should be given as to whether these patients should be seen in the clinic setting or their management deferred until the pandemic is over.

(*For latest PHE guidance on social distancing and vulnerable people see link below* - https://www.gov.uk/government/publications/covid-19-guidance-on-social-distancing-and-for-vulnerable-people/guidance-on-social-distancing-for-everyone-in-the-uk-and-protecting-older-people-and-vulnerable-adults)

Triage of patient referrals will take the following mechanism:

- Electronic referrals received by trust reviewed by a senior clinician involved in skin cancer care. Minimum dataset required from referrer. A photograph **should be** attached to this referral. If photograph **not attached** there should be a secure mechanism is which patients can be contacted and can send in a photograph of the lesion.

- By default, all direct patient interaction should be by a virtual clinic and NOT face-face.
- Screening of referrals WITH photographs and minimum can be put into 4 streams:

1) **Discharge if Clinically Benign** - write letter to patient with reassurance and attach information leaflet explaining benign nature of diagnosis. Information should contain information to seek further medical help if lesions were to change in the future. Copy letter to referral unit (e.g. GP).

2) **Treat with topical agents (eg: Premalignant lesion such as Actinic keratosis)-** consider treating topically (e.g Efudix). Either screening clinician to send prescription or to advise GP to send prescription with clear instructions on how to use and follow-up.

3) **Defer treatment until pandemic is over:** This should apply to all all clinical BCC's in anatomically non-critical areas**.** Letter to go to patient explaining diagnosis and future treatment plan. Referral logged to ensure they are followed up for treatment in future. Can consider topical agents as above (eg; in superficial BCC)

4) **Suspicious lesion requiring surgery** – If surgery is deemed best course action, booked directly (ie See and Treat) to a minor ops / theatre list for day case local anaesthetic procedure (ie: see and treat). Information leaflet to be attached to letter to go to patient explaining the surgery. Protocols for anti-coagulation and pacemakers to be assessed as per trust / unit guidelines.

- Screening of referrals **WITHOUT** photographs or minimum dataset:

  - Attempt to visualize the skin lesion through a virtual clinic. f the lesion can be diagnosed accurately then follow the procedure above.
  - If patient has no access to a virtual clinic, consider bringing patient to a see and treat minor operating session. Ensure information sent to patient that treatment will be delivered on same day. Protocols for anti-coagulation and pacemakers need to assessed as per trust guidelines and information is sent accordingly to patient.

5 Diagnostics

Diagnostics will take place in the following stepwise fashion:

1. Referral letter with minimum dataset and photograph
2. Virtual clinic
3. Excision biopsy of lesion and specimen sent for histological analysis

Communicate all results via telephone / virtual clinics / letter where possible

5.1 Management of the Primary Lesion

Where surgery is deemed absolutely necessary for diagnosis, the following rules must apply;

- Patients prescreened for symptoms of Covid –19 and advised to self-isolate if symptomatic
- Patients to be advised NOT to bring any relatives into the hospital with them
- Excision must be planned with a **CLEAR macroscopic margin** and in one sitting to avoiding multiple visits

- Excision should be planned with a clear macroscopic margin (for recommendations on margins see below). **DO NOT** perform diagnostic punch/shave/incisional biopsies, minimizing multiple visits to the hospital / unit.
- Excisions on limbs should be **strictly axial (longitudinal)**.
- Aim to primarily close the incision.
- Use **absorbable sutures** to avoid need for suture removal. GP practices are unlikely able to support wound care.
- For suspected melanomas where a delayed sentinel node biopsy may be required, do not use a flap based reconstruction during the primary resection.
- Large lesions in high risk functional or cosmetic place are more likely to require MDT input for resection. Referral to specialist surgical teams (eg: Oncoplastics / Maxfacs) should be made using the agreed pathways and **MUST** include photographs and the minimum dataset (mandatory).

Recommended margins are stated in sections below.

It is recognised that there could be an increased number of non-malignant lesions excised.

5.2 Primary surgery for a clinically indeterminate lesion

- Aim for a clinically clear margin of at least 5mm with primary closure using absorbable sutures.
- Consent patient appropriately of scar length and wound complications.

5.3 Primary surgery of a clinical melanoma

- If an in situ melanoma highly suspected, excise with a 5mm peripheral margin.
- If clinically an obvious melanoma on limbs, aim for a 1cm clinical peripheral margin. Aim to leave scar in longitudinal orientation on limbs. This may negate the need for a secondary WLE and can facilitate a delayed SNBx as lymphatic drainage of limbs is more predictable.
- If obvious melanoma on head & neck area or trunk there are 2 options.
    - If patient is of age group and co-morbidities that is suitable for SNB then aim for a 2mm surgical margin and discussion at SSMDT.
    - If patient is not suitable for SNB or does not wish to be considered for SNB then aim for a 1-2cm surgical margin.
- When deciding between 1 to 2 cm margin, aim for the largest margin that allows direct closure.
- The location of some lesions will require a skin graft or local flap even with a 1cm margin. Consider MDT involvement and referral to the specialist surgical team.
- All results should be discussed at SSMDT.

- Criteria for staging scans and surveillance scans should be discussed at the SSMDT and decided on a case by case basis.

5.4 Primary surgery of a clinical BCC

- **Only consider surgery** on lesions that are in high risk critical areas (near the eyes / nose / ears) or if bleeding / infected. Management of any other BCC's can be deferred.
- Aim for 4mm surgical excision margin where possible (exception around the face). Accept margins of >1mm peripheral and >1mm deep with histology for low risk subtype BCC's.
- Limited use of Mohs in current situation unless reconstruction can be offered on the same day. Do not perform slow Mohs
- Letter / Telephone / Virtual clinic follow-up where appropriate

5.5 Primary surgery of clinical SCC

- If clinically looks like a well/moderately differentiated SCC, excised with a 5mm clinical peripheral margin.
- If clinically looks like a poorly differentiated SCC, excised with 10mm clinical peripheral margin.
- Extra care needs to be given to the deep margin. Scalp lesions should be taken to periosteum and other lesions to fascia where applicable. This is to minimize incomplete excisions and need for adjuvant radiotherapy.
- There are draft BAD guidelines to reduce the necessity of follow-ups for many SCC's. Follow-up should be limited to high risk SCC (poorly differentiated or moderately differentiated with high risk features such as perineural / lymphovascular involvement)

5.6 Primary surgery of a clinical Merkel Cell Carcinoma

- Aim for peripheral 1cm margin on face and 2cm elsewhere. Deep margin to fascia.
  Will be discussed in MDT if adjuvant radiotherapy is appropriate. However, by excising with large margins, radiotherapy may be avoided is some cases or delayed.MDT to discuss f/u protocol and staging / surveillance scans

6 Secondary management of New Cancer Patients

6.1 Confirmed skin cancers requiring specialist MDT input

- This applies to diagnosis of skin cancer made by other centres either clinically or histologically

- Referral for specialist surgery or oncology should include a photograph (this may be the one send by GP or patient) and the agreed minimum dataset

- Virtual clinics to be setup where possible

- If surgery is considered, where possible consider booking patients straight onto a list. The patient to be sent written information on the procedure or via telemedicine consultation

- Theatre lists need to be identified and staffed with appropriate grade of surgeons. Flexibility given to the surgeon to perform required resection and reconstruction with a detailed consent and consultation on the day.

6.2 Secondary management of Melanoma

- Each regional MDT will have to assess its own capacity for delivering SNBx. It is recognised this can change over a short period.

- As of 24 March 2020, significant drop in capacity has mean that all SLNBx have been stopped.

- If surgical / nuclear medicine capacity starts changing in the near future, SLNBx can be reintroduced in a focused step-wise manner. This should be reviewed bythe regional SSMDT on a week-week basis.
    - 50% capacity: pT2b-pT3b *(This focuses the service on patients who are mostly likely to benefit from a SNBx).*
    - 75% capacity: pT2b-pT4b
    - Normal capacity: pT1b – pT4b *(as per standard protocols)*

- Head and neck and truncal primaries will have greater variability in their lymphatic drainage and delayed SNBx may not be appropriate and clinical monitoring of nodal basins should be discussed with patients.

- Consider resection of clinically node positive disease for local control only after SSMDT discussion and if no other treatment options (ie: systemic) available. Aim to carryout lymphadenectomies with minimal hospital stay.

- Patients should be advised that they will be phoned with the results and only seen if there are postoperative problems (eg: seroma). Patients with high risk sentinel node tumour burden, need to be carefully observed for recurrent nodal disease.

6.3 Management of recurrent disease

Management of recurrent disease should be discussed and decisions made on case-case basis. The following is guidance only.

Melanoma:

- Consider excising an isolated resectable recurrence with >5mm margin, where possible under local anaesthetic.

- Recurrent lesions causing significant morbidity should be prioritised (eg: fungating tumour, pain, involving critical structures)

- Resection of recurrent nodal disease should only be considered if there is a local control problem and no systemic therapy options.
- All decisions should be reviewed and clearly documented at the SSMDT.

Non-melanoma skin cancers

Decision for surgery will requires SSMDT input and should be decided on case-case basis. Consider deferring treatment for recurrent BCC's if safe to do so.

6.4 Pathology

Staffing of this service is likely to be affected too, therefore workload needs to be kept to a minimum. Local conditions will dictate the level of service available. Minimising work eg excision rather than biopsy then excision; highlighting urgent cases; defining local population to be offered SNBx; local policy on the need for double reporting of all cases.

7 Oncology

7.1 Adjuvant Treatment

It is anticipated that as the Covid-19 situation escalates, there may be a need to withhold all adjuvant treatment.

Adjuvant Radiotherapy (for non-melanoma skin cancers)

Decision for adjuvant radiotherapy should be made on a case-case basis at the SSMDT and clearly documented. Consideration should be given to length of treatment, number of fractions, risk of relapse and age/comorbidities of patient putting them at risk of adverse outcomes from Covid-19.

Adjuvant systemic therapy for melanoma

All decisions to give or deescalate adjuvant systemic therapy should be discussed on case-case basis and documented at SSMDT's. Please refer to local oncology guidelines.

7.2 Therapeutic Systemic Treatment

This should follow established practice with decisions documented at the SSMDT.

Please refer to local oncology / cancer center guidelines. Advice is due to be published on Melanoma Focus website (https://melanomafocus.com)

8 Follow-Up of Cancer Patients

All patients due for review should have their previous clinic letter assessed and offered the choice of a telephone consultation only or standard clinic follow up.

Routine review can be done by telephone. The NHS has provide useful information around information governance;

https://www.nhsx.nhs.uk/key-information-and-tools/information-governance-guidance).

Patients should be asked to assess: -

- The area around their primary scar
- The skin draining towards the appropriate nodal basin(s)
- The node basins themselves
- The presence of any other new lesions - photographed and emailed
- Whether they have any systemic symptoms

**** Avoid face-face consultation with Patients over 70 and/or with significant medical co-morbidity *****

9 MDT Meetings

It is acknowledged that local situations will vary and this will determine local practice. However, this should not be used to significantly deviate from current recognised high standards. The SSMDT should be used for advice. Attendance at the MDT meeting could be done remotely. Each local skin MDT and SSMDT should document how patients are managed and their outcomes for future management strategies.

10 Research Activity

It is recommended that all recruitment and screening to all clinical trials be suspended with immediate effect. No new trials should be opened.
The exceptions to this are:

- Research into COVID-19, or
- 'The experimental treatment is essential for serious, or life-threatening conditions, and in the opinion of the treating clinician, receiving treatment in the context of the clinical trial may be very significantly advantageous to the patient concerned compared with receiving standard of care treatment. These individual cases need to be discussed with and approved by the divisional research lead.

11 Workforce

The following should be used as a guide to change in practice. It is anticipated that this situation will change weekly and requires regular review at local level.

Assuming up to - 25% Capacity loss	A - 50% Capacity loss (estimated current situation)	B - 75% Capacity loss
Weekly Covid-19 Status Meeting	**As per 'Now' and to also to include:**	**As per 'Now' and 'A' and to also to include:**
2WW referrals and triaging Cancel routine OPD activity Routine follow-ups to be seen remotely Remote triaging patient with clinical photos and minimum dataset See and treat with high risk cases or those without clinical photography **Surgery:** See and treat where possible Avoid surgery to > 70 / high risk patients Primary excision to be done as per above protocols Focused SLNB (pT2b-3b) **Oncology:** **Follow current oncology guidelines**	Primary excisions only for SCC, Merkel cell and Melanoma excision (margins as described above) No excision for any BCC No SLNB Therapeutic lymphadenectomy for local control only and if no systemic therapy available. Adjuvant treatment to be decided on case-case basis via the SSMDT Excision of resectable recurrent disease if no systemic therapy options available and patient low risk or Covid-19 complications (to be decided on case-case basis via the SSMDT).	Primary excision of high risk SCC, melanoma and Merkel cell only (as daysurgery and under LA - see above) All other treatments to be deferred No adjuvant treatment. Only therapeutic systemic therapy.