The COVID-19 outbreak in dermatologic surgery: resetting clinical priorities

Editor

Emilia-Romagna was one of the Italian regions mostly affected by the COVID-19 pandemic, and lockdown measures were taken to slow the COVID-19 outbreak.[1,2,3] All routine activities in Modena hospitals were suspended; however, urgent procedures were still to be performed. Setting the priority of procedures in oncological dermatology in the COVID-19 era is challenging.[4,5,6]

We share our experience as a dermatological surgical unit at the Policlinico of Modena, highlighting the resetting of priorities and procedures, and the safety measures applied.

In 2019, 5483 surgical procedures were performed in our department: 482 inpatient, 836 day surgeries, and 4165

Figure 1 Reset of clinical priorities after the COVID-19 pandemic for dermatologic surgery planning. *SLB: sentinel node biopsy.

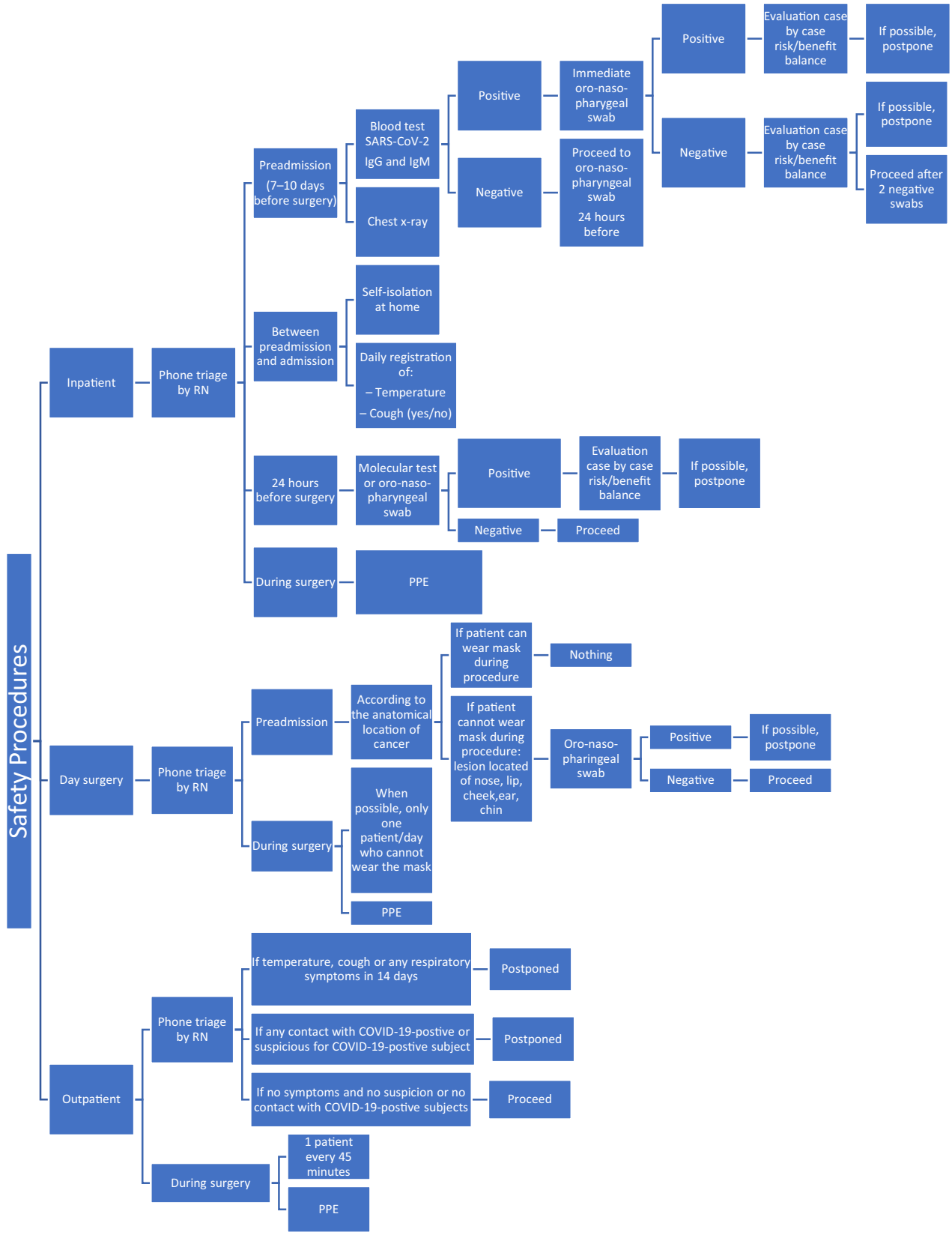

Figure 2 Preoperative and operative procedures for hospital admission (inpatient and outpatient). PPE: personal protection equipment.

outpatients. Weekly, our surgical activity consists of (i) four sessions of major surgery for inpatient with anaesthesiologic support, 3 three patients/session; (ii) four day-surgery sessions, four patients/session; (iii) 13 sessions of outpatient surgeries.

After lockdown (9 March 2020), dermatology departments were challenged to a sudden reorganization of surgical activity within 48 h. We had to perform only undelayable urgent interventions, leading to a new definition of priorities (Fig. 1). We limited our activity to potentially life-threatening or severe cancer types, such as melanocytic lesions suspicious of thick melanoma, histologically confirmed thick melanoma, histologically confirmed infiltrating high-risk squamous cell carcinoma (SCC) according to NCCN guidelines[7] and rapidly growing nodular lesions. All clinical charts were reviewed to assign these new priorities. We treated thick melanoma by performing both wide excision and sentinel node biopsy, while wide excision for already confirmed thin and *in situ* melanoma was deferred. Recently, different approaches were proposed regarding the possibility to postpone the node biopsy.[6,8,9]

Regarding SCC, the excision was performed in line with current guidelines while simple techniques, such as dermo-epidermal grafts, were selected for immediate reconstruction in order to shorten the hospitalization period. For *in situ* SCC and basal cell carcinoma (BCC), surgical treatment was postponed. Diagnostic incisional biopsies were restricted to severe diseases, such as suspicious blistering diseases or erythroderma.

Moreover, we set a new weekly plan of surgical sessions, consisting of (i) one session of major surgeries; (ii) two sessions of day surgeries; (iii) two sessions for outpatient surgeries; (iv) everyday, two urgent biopsies for in/outpatients.

All activities were performed wearing appropriate individual protective devices, such as FFP2 or FFP3 masks covered with a disposable surgical mask, protective eye-goggles or helmets, and overshoes in addition to the standard surgical equipment. Surgeons were requested to wear surgical equipment in a clean and safe area, different from the area they took off the equipment.

A strict triage procedure was applied before the admission of patients (Fig. 2). Consecutive surgical activities for outpatients were planned with a 45-min interval, to allow thorough cleaning of the operation room.

Dermatological surgery is considered a low-/medium-risk surgery. This also remains true in the current COVID-19 era, but only when the patient can safely wear a mask. For procedures on the face, we think that dermatological surgery should be considered as a high-risk procedure. Therefore, we suggest that independently from the type of anaesthesia used, it should be mandatory to wear high protection mask (FFP3) during surgery on the facial area. For body areas other than face, we suggest that FFP2 can be considered as an appropriate protection device.

We also believe that standardized consent forms should be prepared to inform patients of the inherent risk of getting infected from SARS-CoV-2 while they are in the hospital, in an effort to ensure transparency. Moreover, patients with dermatological conditions may feel abandoned, given the relocation of resources to address the pandemic emergency. It is therefore crucial to maintain proper communication with patients, ensuring that all urgent treatments continue to be delivered.

Conflicts of interest

None.

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