Wednesday 25th March 2020

Advice for managing BCC & SCC patients during Coronavirus pandemic

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

They should be read in conjunction with other current NHS cancer service guidance (https://www.england.nhs.uk/coronavirus/cancer/), in particular the 'Clinical guide for the management of essential cancer surgery for adults during the coronavirus pandemic' (https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0239-Specialty-guide-Essential-Cancer-surgery-and-coronavirus-v1-70420.pdf).

Diagnosis of suspected BCC/SCC

Current diagnostic pathways should be followed, with the referral providing a clear history of the lesion and good photograph and dermoscopic image if available (see appendix 1) This will be reviewed by the dermatologist/plastic surgeon and advice given on the basis of the photograph. Patients should be aware of the suspected diagnosis.

Where possible, remote consultations should take place instead of face-to-face.

Suspected BCC

The patient should be informed of the diagnosis and any requirement for delay to treatment due to current restrictions. They should be informed of changes they may see in the oncoming months (phases of bleeding, crusting, slight growth). They should seek medical advice if there are rapid changes (indicating possible SCC/other).

Patients may be listed directly for surgery in biopsy-proven or highly suspicious cases, or booked for face-to-face consultation in uncertain cases, both to be at a future time when services allow.

Urgent BCC

These will be rare. For cases that are urgent (eg impending ocular invasion, functional impairment, uncontrolled bleeding), list directly for surgery if possible or arrange face-to-face assessment if necessary.

Suspected SCC

If an SCC is suspected, please inform your patient at this stage that they may be sent directly for surgery to remove the lesion (following decision from the hospital) and that they then may be phoned with the results at a later date (either malignant or benign) once the pathology has been analysed.

As services become increasingly restricted, patients should be triaged as per current cancer guidelines. 'Highly suspicious' SCCs may continue to have treatment, whilst those 'very low suspicion' may be temporised (consider follow-up consultation in approx 4 weeks to assess lesion).

Management of Primary BCCs and SCCs

Urgent BCCs should be excised with 4-6mm margin. Where this is not possible due to patient factors or the need for GA (either for excision or reconstruction), aim for maximal debulk and reconstruction under LA to temporise until services allow for definitive treatment.

In times of restricted services and need for social distancing where possible, Mohs micrographic surgery may not be available. Incompletely excised BCCs and those with indistinct margins can be referred for Mohs in the future. The patient should be informed of the risk of more extensive surgery due to any potential delay in treatment.

To aim for maximal chance of primary excision, SCCs should be excised with at least 6-8mm margin.

The excision could be provided by a local/regional MDT - MDT to advise. Lesions located in a significant functional or cosmetic site are more likely to require MDT input for resection, however on the basis of photographs, these patients could be listed straight for theatre (See & Tx). It is recognised that there could be an increased number of non-malignant lesions excised.

Reconstruction with a flap is preferable to a graft which may fail and necessitate prolonged hospital attendance for dressings. Consider glue/quilting absorbable sutures for grafts if used. Close all wounds with absorbable sutures where appropriate and provide patients with adequate dressings to allow them to carry out their own dressing change if appropriate. Provide patients with adequate analgesia and prescribe antibiotics for all ulcerated lesions.

Incomplete / close margin / high risk SCC excision

These should be discussed at MDT.

Risks of patients returning from isolation to hospital, vs watchful wait, vs radiotherapy should be discussed.

Consider timing of further treatment, consider delay until services are recovering and risk of patient infection/exposure are reducing, weighed against risks to patient from SCC.

SCC Recurrence/metastases

Recurrent nodal disease should be referred to the regional MDT for consideration of appropriate action, according to local resources and patient circumstances. A comprehensive history for potential systemic metastases should be taken with simple staging – USS if available, if CT imaging not available.

Lymph node dissections provide local control and should be considered as primary treatment when available. Patients can be considered for early discharge, the day of / after surgery, with a drain in.

If surgical theatres/services are unavailable, consider radiotherapy or Cemiplimab when available.

Recurrent lesions causing significant morbidity should be prioritised - Fungating tumour, pain, involvement of critical structure or delayed surgery would lead to loss of control at that site.

Outpatient follow-up

BCC

All patients due for review should have their previous clinic letter, operative notes and histology assessed. Face-to-face consultations should be converted to virtual / telephone consultations where appropriate. Otherwise they should be written to, providing information on diagnosis, scar management and any need for further management. They should have a contact number in case they have any queries.

SCCs

All patients due for review should have their previous clinic letter, operative notes and histology assessed.

Low risk SCC - should be written to +/- a telephone consultation.

High risk SCC - consider standard clinic follow up if services allow. Otherwise, conduct a telephone consultation.

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
-

Patients over 70 or with relevant medical co-morbidities should be seen only if they are expected to require surgical / medical intervention / they are unable to examine the above.

Wound Care

Patients should be given written wound care advice. All wounds should be closed with an absorbable suture and a dressing, which can be removed by the patient at 10-14 days. If the wound becomes red, painful, increasing discharge or smelly, then the patient should seek medical advice.

The Role of The MDT

MDTs are an essential part of cancer management. Attendance should therefore be reduced to enable the service to continue for as long as possible. Clinicians in attendance should be reduced to one surgeon, one dermatologist, one pathologist, one radiologist, one oncologist, one CNS, and an MDT coordinator. In the event that staffing is reduced to critical numbers, two clinicians (one could be a CNS) can run an MDT, one of the two ideally is familiar with the patient. The MDT proforma should be annotated with: 'Covid MDT' for future reference. The number of cases discussed should be reduced to limit the risks to the team. The role and membership of the MDT should be reviewed as the Covid situation evolves.

Conclusion

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.

Please ensure standards of note-keeping are maintained and keep close communication with clinic-booking and TCI teams, to optimize clinic and list efficiency. Pathways

should be in place to ensure patients are not 'lost in the system' during any delay phase for treatment.

As always, treatment planning and clinical decisions should be fully discussed with patients and any 'deviations from the norm' should be carefully explained – patients may not always be fully aware of local/national service restrictions, and should be given the opportunity to understand (and consent to) their planned treatment within allowable provision.

Finally as this is a unique situation, each local skin MDT and SSMDT should document how patients are managed and their outcomes as it may provide useful information for future management strategies.

Appendix 1 - Patient advice on photographing lesions

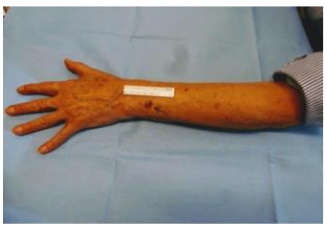
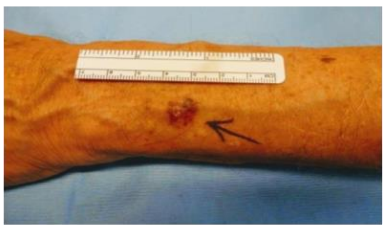
Patient advice on photographing lumps, bumps, moles or rashes

Preparation:

a. **Clearly expose the skin: remove make-up, fake-tan and ensure hair/ clothes not obscuring lesion**

b. **Ensure well lit: avoid shadows**

c. **Ideally mark the lesion with an arrow using a skin marker and add a ruler nearby (if you have one): label with a number if more than one**

VIEWS	1 OVERVIEW	2 CLOSE-UP
EXAMPLES		
AIM	Enables the doctor to identify the exact location (eg. Right or left hand, upper or lower back) and compare it to other lesions	Hopefully enables the doctor to make a diagnosis by naked-eye
TIPS	Entire limb, Head or back/chest should be visible	Lesion centrally located in the photo
	Check that the photos are in focus before sending	

Corona patient photography advice