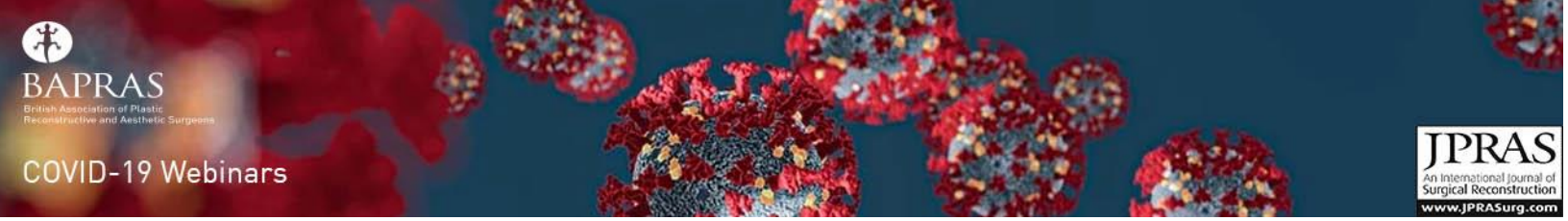


BAPRAS COVID-19 Webinar - Skin Cancer Care
28 May

Summary
As the main peak of COVID-19 is over we look at a sub- specialty, this of being of skin cancer.
This webinar brings together Plastic Surgeons and Dermatologists to consider the challenges to skin cancer care in the COVID era, look at ways to streamline and integrate care (including digital imaging and dual training).

Faculty
Mark Henley (BAPRAS President)
Marc Moncrieff (Professor, The University of East Anglia)
Jennifer Garioch (Consultant Dermatologist, Norfolk & Norwich University Hospital NHS Foundation Trust)
Rowan Pritchard-Jones (Consultant Plastic Surgeon & Medical Director St Helens & Knowsley NHS Trust)
Ben Aldridge (Consultant Plastic & Dermatological Surgeon, NHS Lothian/Lanarkshire)
James Heaney (Consultant Plastic Surgery, Castle Hill Hospital)
Dean Boyce (BAPRAS Education Committee Chair)
Andy Hart (JPRAS Editor)

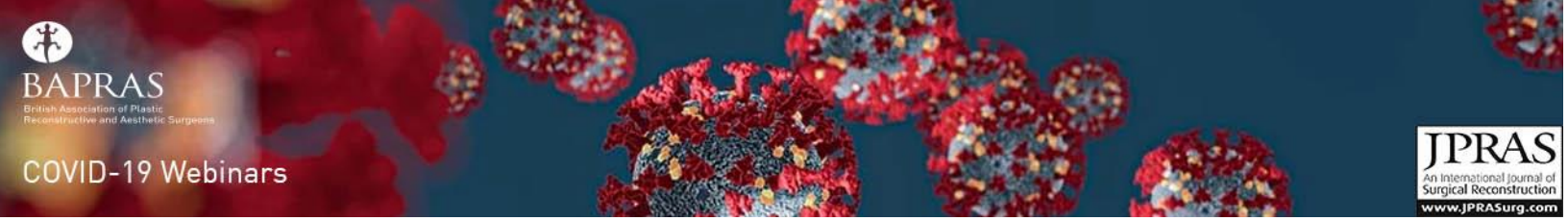
Speaker Presentations

Andy Hart – introduction
Link to presentation here

- Although the epidemic continues around the word, the number of new cases and deaths are starting to plateau globally and therefore the next phase will be to restart healthcare.
- Europe has seen mortality return to normal rates, therefore no excess mortality.
- Individuals have not presenting skin lesions when they should, need to educate that services are available and safe.

Jennifer Garioch: Dermatology - managing skin cancer in the COVID era
Link to presentation here

- Considerations for skin cancer treatment in the post - COVID era;
  - Are all BCC's required to be treated? Factors to consider, are they incidental and uncoincidental, significant and with morbid potential and diagnostic support.
- The frailty score used for more careful selection for patients for Mohs surgery.
- Lentigo Maligna is generally and probably better treated medically rather than surgically.



Marc Moncrieff: Plastic Surgery - managing melanoma in the COVID era
Link to presentation here

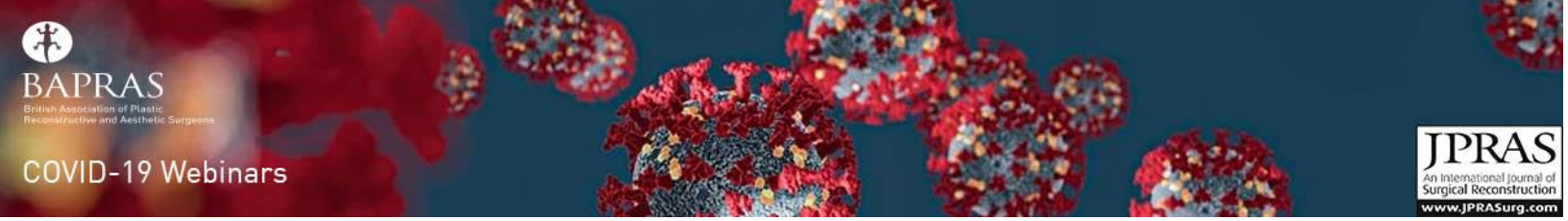
- Can we rationalise melanoma care in the COVID era?
  - Yes, we can particularly in the usual routine work carried out, suggestions are that there is wider excision, sentinel node biopsy and low risk (SN-ve) follow- up
- There would be no current change to Palpable Lymphadenopathy in the current NICE framework, no advice can be given in patient of COVID area as every centre has been affected differently, therefore judgment needs to be made on the local area on how to provide the service.
- Neoadjuvant therapy is nearly here for BRAFT mutant tumours.

Rowan Pritchard-Jones: national audit of non-melanoma skin cancer & a medical director's view on delivery skin cancer care in the COVID era
Link to presentation here

- National audit being led by trainees through Plasta and RSTN.
- Over 50 units signed up. There will be a chance to see impact on COVID and what has been done for patients through this audit.
- Having to manage skin cancer during a period of restoration during the end the first surge run at no more than 80% capacity and 2-metre distancing between beds means less capacity, a likely drop of 20%. Challenge of keeping occupancy down and adhering to distancing would be a big impact to elective surgery if there was second surge.
- Technology would be crucial for digital solutions, patients updating via photos and outpatient services.

James Heaney: bringing digital imaging into skin cancer care
Link to presentation here

- Digital progress in COVID era such as WhatsApp video trauma clinic, nurses WhatsApp viral dressing clinic, generic email and virtual and telephone consultations.
- NHS Digital published a useful statement on what and was not permitted.
- Digital has created innovative non -surgical pathways
- Challenges encountered were NHS is not historically technology friendly, reluctance to manage images in primary care, lack of uniformity and image size and storage can be challenging in legacy software.



Ben Aldridge: experience of dual training in Dermatology & Plastic Surgery
Link to presentation here

- Challenges are consent for one stop surgery, how you go about having not met someone before not very appropriate.
- Limitation of photo triage and dermatology, not being able to have full skin check.
- Only being able to check the incidental lesion and not the index lesion, majority of melanoma found in index lesion in the right environment via dermoscopy.

Mark Henley (BAPRAS President): commentary
Link to commentary here

Q&A
Link here