

NCCP advice for Medical Professionals on the Management of patients with Suspected or Diagnosed Malignant Melanoma or Non-Melanoma Skin Cancer in response to the current novel coronavirus (COVID-19) pandemic

This document relates to patients who do not have COVID-19 or are not suspected of having COVID-19.

Current events surrounding the COVID-19 pandemic are challenging and all public health bodies are placing the safety of patients, staff and communities first in all decisions.

This is an evolving situation. This advice is based on current information, it is additional to the advice of the NPHET, the HSE and the DoH, and will be updated as necessary.

The NCCP acknowledges that each hospital is working under individual constraints, including staff and infrastructure, and as a result will implement this advice based on their own unique circumstances.

The purpose of this advice is to maximise the safety of patients and make the best use of HSE resources, while protecting staff from infection. It will also enable services to match the capacity for cancer care to patient needs if services become limited due to the COVID-19 pandemic.

Any clinician seeking to apply or consult these documents is expected to use independent medical judgement in the context of individual clinical circumstances to determine any patient's care or treatment.

1 NPHET, HSE and DoH advice

Hospitals will operate under the overarching advice of the National Public Health Emergency Team (NPHET), the HSE and the DoH. Information is available at:

- HSE HPSC - <https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/>
- HSE Coronavirus (COVID-19) - <https://www2.hse.ie/conditions/coronavirus/coronavirus.html>
- DoH Coronavirus (COVID-19) - <https://www.gov.ie/en/campaigns/c36c85-covid-19-coronavirus/>
- Ireland's National Action Plan in response to COVID-19 (Coronavirus) - <https://www.gov.ie/en/campaigns/c36c85-covid-19-coronavirus/>

2 Purpose

The purpose of this guidance document is to provide guidance to medical professionals on the management of patients with a suspected Skin Cancer (both Melanoma and Non-Melanoma Skin Cancer) referred to the;

- Pigmented Lesion Clinic
- Dermatology, Plastic Surgery or other Specialty Clinics

This document provides guidance to medical professional on the management of patients with Melanoma and non-melanoma skin cancer during the COVID-19 pandemic.

3 Patients referred with suspected melanoma or non-melanoma skin cancer

All referrals of suspected melanoma or non melanoma skin cancer will be accepted and assessed by a consultant.

4 Triage

All patient referrals will be triaged in the hospital and the triage category will be determined by a consultant. Patients will be triaged into four categories:

- Very urgent
- Urgent
- Soon
- Routine

This will be determined based on the clinical features outlined in the GP referral including: tumour dimensions, degree of ulceration, rapidity of growth, bleeding.

Other relevant considerations at this time will include age, immunosuppression, co-morbidities and anticoagulant medications

Photographic images in some cases will help with the accuracy of the triage.

Clarification may be sought with the GP regarding patient symptoms.

The GP will receive acknowledgment that the referral has been received and the patients are on a waiting list.

4.1 Patients triaged as being very urgent by the consultant

Patients triaged as being 'very urgent' by a consultant should be seen at the next available clinic and have a treatment plan formulated. The suspected tumour would be ideally excised or biopsied at the first visit on a "See and treat" basis, otherwise excised or biopsied in the next available surgical list under Local Anaesthetic (LA). This will be dependent on capacity and availability of clean facilities, ideally in a separate minor theatre setting, preferably not in a COVID-19 location.

4.2 Patients triaged as being urgent by the consultant

Patients triaged as being 'urgent' by the consultant should be seen and ideally treated as soon as possible on a "See & Treat" basis as above.

4.3 Patients triaged as being soon by the consultant

Patients triaged as being 'soon' by the consultant should be put on a priority clinic waiting list, which will be reviewed and seen as a priority after the COVID-19 crisis.

4.4 Patients triaged as being routine by the consultant

Patients triaged as being 'routine' by the consultant should be put on a routine waiting list.

5 Initial Management of Suspicious Skin Lesion

5.1 Suspected Melanoma

Pigmented lesions suspicious for malignant melanoma should be fully excised with a 2mm margin in most cases and closed directly in a separate minor theatre setting under local anaesthetic. Incisional biopsy may only be considered in very large/wide lesions.

5.2 Suspected Non-Melanoma Skin Cancer

Skin lesions suspicious for a more aggressive type of Non-Melanoma Skin Cancer, such as large SCCs or larger BCCs in difficult areas (such as the peri-orbital region), should be excised with a 6-8mm margin and closed directly or reconstructed with a local flap or skin graft in a separate minor theatre setting under local anaesthetic. Biopsy may be considered in very large tumours if not possible to excise (and reconstruct if required) under local anaesthetic when seen in the minor theatre setting.

6 Patients Diagnosed with Malignant Melanoma

All patients diagnosed with invasive malignant melanoma will be discussed at a MDM (Multi-Disciplinary Meeting).

6.1 Melanoma in Situ/Lentigo Maligna

In cases where the margins are not clear/incompletely excised, further excision should be delayed until the COVID-19 restrictions have eased.

6.2 Invasive Melanoma

Invasive melanoma which are completely excised and have clear margins which require wide local excision (WLE) may be delayed for up to 3 months in many patients. The timing of the WLE will largely depend on the need for and availability of Sentinel Node Biopsy, which will require specialised radiology and General Anaesthesia (GA). Staging scans may be considered for high risk patients based on availability.

6.3 Sentinel Lymph Node Biopsy

While desirable for staging purposes and usually carried out at the same time as WLE, Sentinel Lymph Node Biopsy (SLNBx) may be deferred in many cases until the COVID-19 crisis has passed. If radiology and appropriate theatre facilities are available but limited, priority should be given as follows :

1. Stage pT2b-3b (Intermediate depth , 1-2mm with ulceration or 2-4 mm no ulceration) melanoma patients or if high risk features (high mitotic rate, lymphovascular invasion, young age etc.) present.
2. Stage pT4a-b (>4mm depth)
3. Stage pT1b-pT2a (0.8 – 1mm depth or <0.8mm with ulceration)

If SLNBx is not available at all, patients can be given a choice of wide local excision (WLE) with direct closure with at most a 3mm margin followed by delayed SLNBx after the COVID-19 crisis has abated or when local restrictions lifted or a 10-20mm WLE margin carried out as appropriate and SLNBx not done later on. These decisions on WLE and SLNBx can be individualized for each patient and discussed at the MDM

6.4 Lymph Node Metastases

In patients who had a SLNBx which was positive for metastases, completion lymphadenectomy, can be deferred and close surveillance using ultrasound or other radiological techniques may be offered instead.

In patients who have clinically palpable nodes positive for melanoma metastases, patients should have radiological investigations for staging purposes. The options of surgery (lymphadenectomy) if isolated nodal disease only, or other (e.g. neoadjuvant) treatment can be discussed with oncology at the MDM and communicated thereafter to the patient in a virtual or normal clinic

6.5 In Transit Metastases

Patients who develop in-transit metastases which are not extensive can have them excised under local anaesthetic. Patients with multiple rapidly progressing in-transit metastases require discussion at the MDM as well as timely radiological assessment for regional/systemic metastases.

6.6 Systemic Metastases

Patients who develop systemic metastases require oncological input and radiological assessment.

Surgical resection should only be considered if a confirmed discrete melanoma metastasis is detected that is potentially resectable and likely to markedly improve the quality of life/symptoms of the patient, bearing in mind the reduced availability of theatre, anaesthesia and hospital beds which is likely to make this approach less likely during the COVID-19 crisis.

7 Patients Diagnosed with Non-Melanoma Skin Cancer

Most patients with Non-Melanoma Skin Cancers (NMSC) are slow-growing and have an excellent prognosis with relatively simple surgical excision and closure under local anaesthetic. Most patients

with NMSC are in the elderly age bracket and thus the management of their NMSC may best be delayed until the pandemic clears.

There are however exceptions to most NMSCs, such as rapidly growing and aggressive tumours especially in those who are significantly immunosuppressed (e.g. post organ transplantation). Pathological features of aggression include poorly differentiated squamous cell carcinoma, Merkel cell tumours and cutaneous sarcomas. These should be a priority for treatment as a delay in treatment of such higher risk and more aggressive tumours will have a significant detrimental effect on outcome. Careful risk benefit analysis should be emphasised in this patient population.

7.1 Patients with Basal Cell Cancer (BCC)

The majority of patients with BCCs should be informed of their diagnosis, excellent prognosis and the requirement for delay in their treatment during the COVID-19 pandemic. They should be informed of possible changes in their lesion which may occur during the delay (e.g. enlargement, crusting, bleeding) and advised to seek medical advice if there are rapid changes.

There may be rare exceptions that should be discussed at the multidisciplinary team meeting.

Incompletely excised BCCs can be referred for further surgery, Mohs micrographic surgery or radiotherapy which can be carried out after the COVID-19 crisis, but patients should be informed of the risk of more extensive surgery due to the delay in treatment.

7.2 Patients with Squamous Cell Cancer (SCC)

Similar to patients with BCCs, the majority of patients with SCCs have lesions which are non-aggressive, relatively minor and thus surgery or other treatments can be delayed. However, more advanced, symptomatic tumours may benefit from earlier intervention.

Early surgery should be carried out for T2 tumors (>2cm) and above or in a significant functional site, with reconstruction as required, under local anaesthetic if possible with a 6-10mm margin. Biopsy can be helpful in obtaining a definitive diagnosis and any high risk histological features identified (eg poorly differentiated, lymphovascular invasion (LVI) etc.). Radiological assessment may be required in some cases.

Incompletely excised SCCs, those with a close margin or with high risk features (poorly differentiated, perineural invasion, size >2cm, depth >6mm, high risk sites such as the ear) can be referred for further surgery and/or radiotherapy and should be discussed in the MDM.

Patients with local recurrence of their SCCs should be prioritised for early treatment, especially if symptomatic, fungating or with involvement of other structures. Such cases can be discussed at the MDM for consideration of surgery and/or radiotherapy.

7.3 Patients with Merkel Cell Cancer (MCC)

MCCs are aggressive tumours and treatment should not be delayed. All patients with MCC should be discussed at MDM and/or undergo wide excision and post operative radiotherapy should be considered. Radiological assessment is likely to be required.

7.4 Patients with Skin Sarcomas

There are a multitude of skin sarcomas (pleomorphic dermal sarcoma, atypical fibroxanthoma, dermatofibrosarcoma protruberans, leiomyosarcoma, angiosarcoma etc.) some of which behave more aggressively and can be difficult to diagnose without biopsy. Treatment should not be delayed. Early

wide local excision is usually required with discussion at the MDM for consideration of further radiological assessment and management such as further surgery and/or radiotherapy.

7.5 Patients with NMSC Lymph Node Metastases

Patients with nodal metastases require early radiological assessment and treatment. The options of surgery, radiotherapy or other modalities of treatment should be discussed at the MDM and with the patient.

Lymph node clearance usually offers the best chance of disease control but should be ideally carried out in a non-COVID-19 setting and with early discharge, with a drain in if required. If this is not possible, radiotherapy or other systemic treatments can be considered in conjunction with oncology.

8 Staff and capacity

Sufficient staff should be left in place to support melanoma and non melanoma skin cancer services.