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DOI: 10.1111/jdv.17250

Position statement of the EADV Melanoma Task Force on recommendations for the management of cutaneous melanoma patients during COVID-19

Dear Editor,

This article prepared by the EADV Task Force on Melanoma aims at providing consensus-based recommendations on how to address the main challenges in management of patients with cutaneous melanoma during the COVID-19 pandemic.^{1,2}

- 1 In-person physical examinations remain irreplaceable for patients who have noticed new suspicious lesions or are referred by a clinician with a lesion suspicious for melanoma. For individuals who need periodical examinations due to increased melanoma risk, intervals between visits may be extended by a maximum of 2–3 months. For routine check-ups, the use of teledermatology is recommended. These efforts aim at limiting the risk of potential exposure to COVID-19.
- 2 Dermoscopy remains the gold standard for diagnosis of melanoma. Even though no transmission of COVID-19 via dermatoscopes has been reported, dermoscopy should be performed with careful disinfection between patients, to avoid the transmission of infectious agents, including bacteria, fungi and viruses. Epidemiological triage, proper hand hygiene and adequate personal protection equipment by physicians and patients are warranted.

- 3 Once a lesion is clinically suspicious of melanoma, an excisional biopsy with the intent to remove the whole clinically visible lesion should be performed as soon as possible. The timing of additional surgical procedures might require modification depending on the availability of operating rooms. A proposed approach after complete excision of primary melanoma during restrictions and limitations due to the pandemic is shown in Table 1.
- 4 In case of a COVID-19 lockdown, follow-up visits and imaging procedures may be postponed in asymptomatic patients with melanoma stage 0-IIA by up to 3 months. Teleconsultations with asymptomatic patients can help to foster the physician-patient relationship, reassure patients and strengthen compliance. Tumour-free, high-risk patients should continue to have physical and imaging examinations especially during the first 3 years after surgery of the primary tumour. All patients should be educated and encouraged to perform skin self-examination once per month.
- 5 Adjuvant melanoma treatment with approved drugs is recommended during the COVID-19 pandemic and should be initiated within the first 12 weeks after complete resection. PD-1 antibodies should be given using the longest approved treatment intervals: pembrolizumab 400 mg q6w and nivolumab 480 mg q4w.⁸ Targeted therapy allows for less frequent hospital visits, shorter time spent in the hospital/facility and telemedicine symptom checks. Yet, one needs to consider that the frequently occurring adverse event pyrexia might trigger false alarms in people and physicians unfamiliar with the safety profile of the dabrafenib + trametinib drug combination.

Table 1 Practical approach to melanoma surgery during the COVID-19 pandemic

Wide excision should be performed as soon as possible but within 3 months at the latest for both melanoma in situ and invasive melanoma ^{3,4}
Sentinel lymph node biopsy may be delayed by up to 3 months ^{5,6}
Therapeutic lymph node dissection should be limited to patients with clinically evident regional lymph node metastases ⁷
High surgical priority should be given to all invasive primary melanomas, resectable stage III melanomas and oligo-metastatic disease

Table 2 General recommendations for melanoma care at a glance

The COVID-19 pandemic mandates precautions to minimize the risk of infections, while ensuring most effective cancer care
Teledermatology is a valuable tool in times of lockdown and limitation of face-to-face visits
The initiation of adjuvant and therapeutic melanoma therapy should not be delayed during the COVID-19 pandemic
Treatment decisions require the consideration of individual risk factors and melanoma characteristics

- 6 Melanoma patients with unresectable or metastatic disease always require systemic therapy. Patients with active malignant diseases are at increased risk for a severe course of COVID-19 and thus need to be informed to strictly adhere to recommended safety and hygiene procedures (Table 2). Patients requiring targeted therapy, the combination of encorafenib and binimetinib (if available), should be considered over other BRAF and MEK inhibitors (lower rate of pyrexia). For the majority of patients requiring immunotherapy, it is recommended to start monotherapy with anti-PD-1 inhibitors due to their favourable safety profile.⁹ Some patients might still require treatment with the combination of anti-PD-1 and anti-CTLA-4 inhibitors. This includes patients with symptomatic and asymptomatic brain metastases, but also patients with elevated LDH levels, bulky disease, PD-L1 negativity, mucosal and acral melanoma.
- 7 Melanoma patients are at increased risk of a severe COVID-19 disease course and should receive priority access to SARS-CoV-2 vaccines. A panel of oncology and infectious disease experts agreed that the Pfizer/BioNTech and Moderna vaccines are safe and effective for the general population. To date, there is no evidence that these vaccines should not be safe for cancer patients.¹⁰

Funding source

The work was supported by the PROGRES Q28 (oncology) research programme awarded by the Charles University, Prague.

Conflict of interest

MA received honoraria and consulting fees from BMS, MSD and AbbVie. CP received honoraria and consulting fees from Novartis, BMS, MSD, Pelpharma, Sanofi, Roche, Iovance, Celgene, AbbVie and Galderma. Other authors reported no conflicts of interests.

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DOI: 10.1111/jdv.17252

Vaccination against SARS-CoV-2 and psoriasis: the three things every dermatologist should know

Dear Editor,

In this document, the three most important items that dermatologists should know about COVID-19 vaccines to be better prepared to the management of psoriatic patients are reported.