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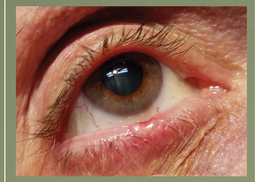
The Impact of Covid-19 on the progression and management of periocular Basal Cell Carcinomas

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Introduction

- BCCs are the commonest non-melanoma skin malignancies[1]
- 20% of all BCCs appear in the periocular region[1]
- COVID 19 has impacted all sectors of healthcare including cancer surgery



Purpose

To identify if the surgical delay caused by Covid-19 had an impact on the per-operative size of lesions and the choice of reconstruction performed in patients with periocular BCCs

Methods

- Elective surgery was stepped down between March and June 2020 at UHCW
- Data was collected for the period July 2020- April 2021 once elective surgery re-commenced (and the equivalent period a year before)
- Data collected included measurements of lesion at listing, the procedure the patient was listed for, the size of the lesion at the time of surgery and the type of surgery performed
- For the purpose of our calculation we assumed that the fixation process causes the histology specimen to shrink by 25%.
- Taking into account the shrinkage and the 3 mm margin used surgically, a value of 4.5mm (2.25 from each side) was deducted from the recorded histology measurement to obtain comparable per-operative measurements at the time of excision.

References

1. Furdova A, Kapitanova K, Kollarova A, Sekac J. Periocular basal cell carcinoma - clinical perspectives. *Oncol Rev*. 2020;14(1):420. Published 2020 Apr 30. doi:10.4081/oncol.2020.420
2. http://www.bopss.co.uk/news/covid-19-prioritisation/
3. Der Sarkissian SA, Kim L, Veness M, Yiasemides E, Sebaratnam DF. Recommendations on dermatologic surgery during the COVID-19 pandemic. *J Am Acad Dermatol*. 2020;83(1):e29-e30. doi:10.1016/j.jaad.2020.04.034

Results

- 25 patients with BCCs were operated on between July'20 and April'21.
- 6 patients did not have the lesion size recorded at the clinic visit and data from 19 patients was analysed
- The average increase in the size of the lesion between pre and per op was 70mm^2 (as compared to 18mm^2 for a comparative time period one year prior). Analysis using the paired T test proved that the growth in the lesion while awaiting surgery was statistically significant both pre and post Covid. The difference was more significant post covid (p value 0.005) than pre Covid (p value 0.04)
- In the post COVID cohort, 2 patients listed for direct closure had a Tenzels and Hughes flap respectively. Of 3 patients listed for flaps and graft, 2 were reconstructed by direct closure and 1 was allowed to heal by Laissez faire due to the patients' ill health. The remainder of the patients went on to have the same procedure as that at listing
- Pre COVID, 2 patients had less invasive procedures than planned, with the remainder having the same surgery they were listed for
- The longest wait for surgery was 12 months, but the average time from listing to surgery was 5 months (as compared to 3 months in a comparative time period one year prior)

Discussion

- Literature suggests that for BCC's, operations can be safely delayed up to 3 months[2] and in some cases up to 6 months[3]
- Our longest wait was 12 months with a mean wait of 5 months.
- Although we noted statistically significant growth in the lesions, we conclude from our data that the delay caused by the pandemic, beyond 3 months, only had a small impact on the surgical outcomes for patients with BCC's and we suggest that cases can be risk stratified based on the size of lesion at presentation and histological subtype from diagnostic biopsies.