The authors’ reply re: the role of teleconsultation in the management of suspected skin malignancy in plastic surgery during COVID-19 outbreak: a single centre experience

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Title:
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Dear Sir,

Thank you for your comments with regards to our letter (1).

The decision to deviate from the planned operative procedure on the day was made by the operating surgeon. The operating surgeon was not blinded to the participant allocation method (teleclinic vs face to face) as that would imply that they would not have full access to the patient clinic letter, which would result in suboptimal clinical practice. However, the operating surgeon was blind to study participation. Whilst all patients were nominally under the care of a single consultant, the patients are randomly assigned to an operating surgeon from a departmental group of over 40 surgeons, largely outside of the nominated consultant team. In contrast to potential eccentricities of hand surgery practice, skin cancer surgery is protocol driven with surgical excision margins determined primarily based on clinical diagnosis. This largely eliminates flexibility in surgeon preference for surgical procedure with decision to change planned operative procedure determined primarily by clinical diagnosis on direct examination, thus conduct bias is unlikely a significant issue.

The higher proportion of patients with squamous cell carcinoma (SCC)/melanoma we report for teleclinic (during pandemic) compared to the face-to-face clinic (pre-pandemic) (35% vs 6.7%) does indeed reflect service disruption secondary to Covid-19, with the overall number and relative proportions of each skin cancer type change before and during the pandemic having been presented in the letter (table 1). Andrew et al report a total 68.61% decrease in skin cancer diagnoses during the COVID pandemic (2). We observed a lower proportion of BCCs during compared with pre-COVID pandemic, which indicates slowly growing lesions
were less likely to present to, or be referred by, GPs during the pandemic. One of the key objectives of this study was to determine whether the teleclinic was safe and ensure that those cancers with potential to metastasise (ie melanoma, SCC) were triaged correctly and not incorrectly listed on a non-urgent pathway from the teleclinic visit.

The incidence of skin cancer increases with age and the age of our cohort reflects this. We included all patients referred avoiding any selection bias. Our teleclinic required simply the use of telephone only, relying primarily on patient verbal description for skin lesion assessment, with photographs only when available. We observed universal competence in using telephone and demonstrated that without the need for visual interaction and video conferencing the teleclinic remains accurate, accessible and independent of technological literacy. Where photographs were available the diagnostic accuracy in teleclinic was slightly, but not significantly higher (66.7%) than those without photographs (58.3%). The use of telephone alone allows service to be maintained for those shielding during the pandemic, with potential benefit for increasing participation particularly for elderly and other clinically vulnerable groups, who would be reluctant or fearful of attending face to face consultation during the pandemic. For these patients the teleclinic service minimised hospital attendances and permits safe one-stop treatment of skin cancers.

The nature of skin cancer and hand surgery is very different. Whilst hand surgeons and therapists may be satisfied and continue with virtual follow up after the pandemic (3), the key importance in follow up for patients with skin cancer is the need to check for signs of recurrence and lymphadenopathy, requiring direct examination and palpation of lymph
node basins. We would be concerned to adopt virtual follow up for those patients due to concerns of missing early signs of disease recurrence and/or metastasis.

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**References**:

