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Dermatology practices as vectors for COVID-19 transmission: a call for immediate cessation of non-emergent dermatolgy visits

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Title: Dermatology practices as vectors for COVID-19 transmission: a call for immediate cessation of non-emergent dermatology visits

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To the Editor: In late 2019, a novel coronavirus (2019-nCoV) emerged that triggered a devastating disease (COVID-19) that has spread throughout the world. In this issue of the *JAAD*, Lan et al. report on occupational dermatitis in health care workers managing COVID-19 patients.[1] While the authors make an important point, our specialty should be collectively addressing the urgent issues facing healthcare delivery in this rapidly changing environment.

Recent reports demonstrate that the COVID-19 pandemic is set for exponential growth in the United States. While COVID-19 has spread globally, the outbreak has been controlled in some countries (e.g. South Korea, Japan) versus rapidly escalated in other areas (e.g. Italy, Spain), largely based on public health measures that have blunted the peak number of cases.[2]

As dermatologists, the majority of our outpatient visits are non-emergent. Given our exposure to many individuals through high volume clinics and that asymptomatic carriers can shed viral particles for weeks before (or even without) symptoms, we feel it is prudent to immediately cancel all non-urgent visits indefinitely. Screening patients and cancelling appointments only for those with fevers is not sufficient as there is known asymptomatic viral transmission and a prolonged incubation period.[3] Indeed, fever was only present in 43.9% of 7736 patients at time of hospital admission with Covid-19 in a study of 552 hospitals in mainland China.[4] Emerging research also suggests that COVID-19 viral particles remain viable in aerosol for several hours and can survive several days on multiple surfaces.[5] In summary, we feel the following measures should be immediately implemented:

1. All elective outpatient visits cancelled with deferment for a teledermatology or face-to-face visit.

2. Only urgent outpatient visits should be conducted (including surgical procedures for invasive malignancies) or emergent inpatient consultations with proper personal protective equipment and an emphasis on social distancing.
3. Practitioners who fit high risk criteria of being age 60 or older, immunocompromised, or pregnant should be prohibited from evaluating patients.
4. Trainee exposure (residents/fellows) should be minimized and staggered to protect the health care workforce.

The last point is especially important given that there is minimal supply of ICU beds, ventilators, and practitioners at the front lines are at high risk for infection. With a limited supply of health care providers, dermatology residents and attendings may be called upon to treat COVID-19 patients similar to what is currently taking place in Italy.

These measures also apply to the broader medical community and other specialties. We call upon the American Medical Association to take measures to promote guidance for wider implementation of telemedicine platforms and to help smaller solo and group practices with loans and other forms of financial relief to keep practices afloat during this crisis.

Dermatology is a part of the broader medical community and it is time for our specialty to make important decisions that can save lives. By taking the above proactive measures we also spread a message to our communities about the seriousness of the crisis. Instead of being reactive, we urge dermatology departments and practices to show leadership. If not now, when?

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