REFERENCES

1. Society of Surgical Oncology. Resource for management options of melanoma during COVID-19. 2020. Accessed July 13, 2020. Available at: https://www.surgonc.org/wp-content/uploads/2020/03/Melanoma-Resource-during-COVID-19-3.23.20.pdf
2. National Comprehensive Cancer Network. Short term recommendations for cutaneous melanoma management during COVID-19 pandemic. Accessed July 13, 2020. Available at: https://www.nccn.org/covid-19/pdf/Melanoma.pdf
3. McKenna DB, Lee RJ, Prescott RJ, Doherty VR. The time from diagnostic excision biopsy to wide local excision for primary cutaneous malignant melanoma may not affect patient survival. *Br J Dermatol*. 2002;147:48-54.
4. Conic RZ, Cabrera CI, Khorana AA, Gastman BR. Determination of the impact of melanoma surgical timing on survival using the National Cancer Database. *J Am Acad Dermatol*. 2018;78:40-46.
5. Basnet A, Wang D, Sinha S, Sivapiragasam A. Effect of a delay in definitive surgery in melanoma on overall survival: a NCDB analysis. *J Clin Oncol*. 2018;36(15 suppl):e21586.

https://doi.org/10.1016/j.jaad.2020.07.078

Mycophenolate mofetil for the treatment of cutaneous lichen planus: A retrospective case series

To the Editor: Lichen planus is a debilitating, disfiguring condition that may involve cutaneous (CLP) or mucosal surfaces.[1] Although CLP is less chronic, generalized or recalcitrant local cases may require systemic treatment.[2] First-line systemic corticosteroids may be unfavorable because of their adverse effects and association with posttreatment relapse, and efficacy data for steroid-sparing alternatives remain scarce.[2] Mycophenolate mofetil (MMF) may be viable, but data are limited to 1 case report and 1 2-patient case series; all 3 patients (hypertrophic, bullous, and disseminated CLP) achieved remission without significant adverse effects.[3,4] We sought to ascertain MMF's safety and efficacy for CLP with a 10-patient retrospective case series.

Upon institutional review board approval, patients from a single institution who received MMF for generalized or recalcitrant local CLP between 2010 and 2019 were identified in the medical record. Patients with mucosal lichen planus, lichenoid drug eruptions, lichenoid dermatitis, or lichen planopilaris or those lost to follow-up were excluded.

Ten patients—mostly white (70%) and female (80%), with a mean age of 58 years, with hypertrophic (40%), papular (40%), and pigmentosus (20%) CLP—met the inclusion criteria (Tables I and II). MMF was initiated for generalized (70%) and recalcitrant local cases (30%), at daily doses ranging from 1000 to 3000 mg. Fifty percent of patients achieved improvement (2 mild, 2 significant, and 1 remission), mostly those with longer treatment durations (mean, 26.8 vs 7.9 months) and higher dosages (mean, 2200 vs 1200 mg). Most improvements were observed within 9 months—later than the mean onset of MMF's effects for atopic dermatitis (6.8 weeks).[5] The patient who achieved remission displayed markedly fewer lesions and less crusting and reported significant pain relief 16 months after starting MMF. Remission was achieved at 25 months and maintained for 17 months before switching to methotrexate (MTX) because of cost and gastrointestinal upset; she experienced painful flares during MMF tapering. Two patients who experienced significant improvement (markedly fewer lesions, less scaling, and drastic reductions in both pain and pruritus) also experienced flares when discontinuing MMF. Mild improvement (slightly fewer lesions, mild relief of pruritus) was observed in 2 patients, including 1 who experienced worsening pruritus when tapering. Thus, it appears that posttreatment relapse may be a potential concern with MMF therapy. Concomitant medications in patients who achieved improvement were mostly continuations of regimens initiated before MMF (80%) and included triamcinolone, clobetasol, prednisone, and cyclosporine.

First-line topical corticosteroids and topical calcineurin inhibitors failed for all patients before MMF was initiated. Three patients received prednisone, including 1 who improved and relapsed upon discontinuation. Acitretin caused intolerable fatigue, and phototherapy was not attempted. Although encouraging results have been reported with MTX, it had previously failed for 80% of patients who achieved improvement with MMF because of poor results or unbearable nausea, fatigue, and anorexia.[2] MMF was well tolerated; 1 patient experienced a herpes simplex virus infection, and 1 developed anemia. Common discontinuation reasons included lack of efficacy (20%), fatigue (20%), and cost (20%).

Although the variability in lesion locations, CLP subtypes, and concomitant medications precludes definitive conclusions, these results may provide insight into a CLP treatment option that lacks extensive study.

Matthew L. Hrin, BA,[a] Arjun M. Bashyam, BA,[a] William W. Huang, MD, MPH,[a] and Steven R. Feldman, MD, PhD[a,b,c,d]

From the Center for Dermatology Research, Department of Dermatology, Wake Forest School of Medicine, Winston-Salem, North Carolina[a]; Department of Pathology, Wake Forest School of

Table I. Individual patient characteristics and MMF regimen

Age, y/sex/race	CLP subtype	Disease distribution	CLP lesion location	Previous treatments	Maximum MMF dose, mg QD	MMF duration, months	Adjunctive medications	Outcome (months to achieve)	Adverse effects	Discontinuation reason
55/F/W	Hypertrophic LP*	Generalized	LE	Prednisone 20 mg QD, MTX 40 mg QW, clobetasol 0.05% BID	2500	42	Prednisone 15 mg QD	Remission (25)	HSV infection	GI upset, cost
63/M/B	Papular LP*	Local (recalcitrant)	UE, trunk	TAC 0.1% BID	2000	4	TAC 0.1% BID	Significant improvement (4)	Gout flare	Gout flare
73/M/W	Hypertrophic LP*	Generalized	UE, LE, trunk	MTX 15 mg QW, TAC 0.1% PRN	2000	19	TAC 0.1% PRN, clobetasol 0.05% BID	Significant improvement (9)	Fatigue	Fatigue
43/F/W	Papular LP	Generalized	UE, LE, trunk	Clobetasol 0.05% PRN, ILK,† MTX 10 mg QW	1500	14	Clobetasol 0.05% PRN	Mild improvement (4)	None	N/A
31/F/W	LP pigmentosus*	Generalized	Face, UE	Colchicine 1.2 QD, MTX 20 mg QW, desonide 0.05% QD, tacrolimus 0.1% QD	3000	55	Cyclosporine 300 mg QD	Mild improvement (1)	None	N/A
74/F/W	Papular LP*	Generalized	Bilateral LE	Clobetasol 0.05% PRN, ILK,† prednisone 400 mg pulse	1000	0.25	Clobetasol 0.05% PRN	No improvement	Tremor	Tremor
69/F/W	Papular LP	Local (recalcitrant)	Bilateral LE	TAC 0.1% BID	1000	31	Clobetasol 0.05% BID	No improvement	Anemia	Anemia
44/F/B	Hypertrophic LP	Local (recalcitrant)	Bilateral LE	TCS,† ILK 10 mg once	1500	2	ILK 10 mg once	No improvement	None	Lack of efficacy, cost, fear of adverse effects
79/F/W	Hypertrophic LP*	Generalized	UE, LE, trunk	Prednisone,† acitretin 10 mg QD, MTX 30 mg QW, betamethasone 0.05% BID	1500	2	Betamethasone 0.05% BID	No improvement	Malaise, arthralgia, fatigue, nausea	Malaise, arthralgia, fatigue, nausea
46/F/B	LP pigmentosus*	Generalized	UE, LE, trunk	MTX 15 mg QW, HCQ 200 mg BID, tacrolimus 0.1% BID	1000	4	Tacrolimus 0.1% BID	No improvement	None	Lack of efficacy

B, black; *BID,* twice daily; *CLP,* cutaneous lichen planus; *F,* female; *GI,* gastrointestinal; *HCQ,* hydroxychloroquine; *HSV,* herpes simplex virus; *ILK,* intralesional triamcinolone; *LE,* lower extremities; *LP,* lichen planus; *M,* male; *MMF,* mycophenolate mofetil; *MTX,* methotrexate; *N/A,* not applicable; *PRN,* as needed; *QD,* once daily; *QW,* once weekly; *TAC,* triamcinolone; *UE,* upper extremities; *W,* white.
*Biopsy proven.
†Details regarding treatment were not recorded.

Table II. Overview of patient characteristics and MMF regimen

Characteristic	Value, n (%) (N = 10)
Age at MMF initiation, y	
Mean (SD)	57.7 (16.2)
Median (range)	59 (31-79)
Sex	
Female	8 (80)
Male	2 (20)
Race	
Black	3 (30)
White	7 (70)
CLP subtype	
Hypertrophic lichen planus	4 (40)
Papular lichen planus	4 (40)
Lichen planus pigmentosus	2 (20)
Disease distribution	
Generalized	7 (70)
Local (recalcitrant)	3 (30)
Diagnosis	
Biopsy proven	7 (70)
Clinical	3 (30)
Body region affected*	
Lower extremities	8
Upper extremities	6
Trunk	5
Face	2
Previous treatments*	
Methotrexate	6
Clobetasol 0.05% ointment	3
Prednisone	3
Triamcinolone intralesional injection	3
Triamcinolone 0.1% ointment	3
Tacrolimus 0.1% ointment	2
Acitretin	1
Betamethasone 0.05% ointment	1
Colchicine	1
Desonide 0.05% ointment	1
Hydroxychloroquine	1
Unspecified topical corticosteroid	1
Maximum MMF dose, mg	
Mean	1700
Median (range)	1500 (1000-3000)
MMF duration, months	
Mean (range)	17.3 (0.25-55)
Outcome	
Remission	1 (10)
Significant improvement	2 (20)
Mild improvement	2 (20)
No improvement	5 (50)
Adjunctive medications*	
Clobetasol 0.05% ointment	4
Triamcinolone 0.1% ointment	2
Betamethasone 0.05% ointment	1
Cyclosporine	1
Prednisone	1
Tacrolimus 0.1% ointment	1
Triamcinolone intralesional injection	1

CLP, cutaneous lichen planus; *MMF,* mycophenolate mofetil; *SD,* standard deviation.
*Patients may fall into more than 1 category.

Medicine, Winston-Salem, North Carolina[b]*; Department of Social Sciences and Health Policy, Wake Forest School of Medicine, Winston-Salem, North Carolina*[c]*; and Department of Dermatology, University of Southern Denmark, Odense, Denmark.*[d]

Funding sources: None.

Disclosure: Dr Feldman has received research, speaking, and/or consulting support from a variety of companies, including Galderma, GlaxoSmithKline/Stiefel, Almirall, Leo Pharma, Boehringer Ingelheim, Mylan, Celgene, Pfizer, Valeant, AbbVie, Samsung, Janssen, Lilly, Menlo, Merck, Novartis, Regeneron, Sanofi, Novan, Qurient, National Biological Corporation, Caremark, Advance Medical, Sun Pharma, Suncare Research, Informa, UpToDate, and National Psoriasis Foundation; is the founder and majority owner of www.DrScore.com; and is the founder and part owner of Causa Research, a company dedicated to enhancing patients' adherence to treatment. Authors Hrin and Bashyam and Dr Huang have no conflicts of interest to declare.

IRB approval status: Reviewed and approved by Wake Forest University Health Sciences (IRB00065234).

Reprint requests: Matthew L. Hrin, BA, Department of Dermatology, Wake Forest School of Medicine, Medical Center Boulevard, Winston-Salem, NC 27157-1071

E-mail: mhrin@wakehealth.edu

REFERENCES

1. Le Cleach L, Chosidow O. Clinical practice. Lichen planus. *N Engl J Med*. 2012;366:723-732.
2. Thandar Y, Maharajh R, Haffejee F, Mosam A. Treatment of cutaneous lichen planus (part 2): a review of systemic therapies. *J Dermatolog Treat*. 2019;30:633-647.
3. Nousari HC, Goyal S, Anhalt GJ. Successful treatment of resistant hypertrophic and bullous lichen planus with mycophenolate mofetil. *Arch Dermatol*. 1999;135:1420-1421.
4. Frieling U, Bonsmann G, Schwarz T, Luger TA, Beissert S. Treatment of severe lichen planus with mycophenolate mofetil. *J Am Acad Dermatol*. 2003;49:1063-1066.

5. Phan K, Smith SD. Mycophenolate mofetil and atopic dermatitis: systematic review and meta-analysis. *J Dermatolog Treat*. 2020;31(8):810:814.

https://doi.org/10.1016/j.jaad.2020.08.090

Dermatologic surgery during the COVID-19 pandemic: Experience of a large academic center

To the Editor: The novel coronavirus disease 2019 (COVID-19) pandemic has required significant modifications to clinical practice.[1] In the hardest-hit areas, such as New York City, triaging of personnel and supplies, as well as prioritization of certain skin cancers, was required in dermatology practices. Although clinical judgment should be used to evaluate patients on a case-by-case basis, general guidelines from the National Comprehensive Cancer Network recommend postponing treatment for low-risk lesions by 3 months, except in cases in which "debilitating progression within 3 months" was estimated by the physician.[2,3] However, for certain skin cancers types, including invasive melanoma, Merkel cell carcinoma, and high-risk cutaneous squamous cell carcinoma, the decision to delay care is of higher risk.[2,3] Prior studies have reported that delays to treatment for stage 1 melanomas may increase the risk of poor prognosis and decrease overall survival.[4] Providers must also weigh the significant anxiety faced by patients who have received a diagnosis of skin cancer but are unable to receive definitive treatment. As such, for patients who require surgery during the pandemic via Mohs micrographic surgery or wide local excision, it is crucial that dermatology practices have protocols in place to provide necessary care while protecting patients and health care personnel from COVID-19. Our goal is to share our experience in practicing dermatologic surgery in the heart of the COVID-19 pandemic with an abundance of caution.

Dermatologic societies have created a living document to grade evidence regarding measures to minimize the transmission risk of COVID-19, covering topics including hand washing, personal protective equipment, risk of aerosolizing COVID-19, ventilation, and eye protection.[5] To add to this work, we summarize measures taken at New York Presbyterian—Weill Cornell Medicine, a large academic center greatly affected by the pandemic (Table I). We also summarize our approach to

Table I. Current coronavirus disease 2019 precautions taken at Weill Cornell dermatology

Visit	Location	Preventive measures taken
Preoperative	Televisit	Prioritizing surgical cases via telemedicine
		Patient taking a self-photograph to help identify surgical site
		Photographic instructions sent
		COVID-19 screening for symptoms and instructing patients to self-monitor and report any symptoms before surgery
		Since mid-June, presurgical COVID-19 PCR testing for surgical sites in mask zone or other high-risk situations
		24—72 h before surgery
		Ensure test turnover and result time appropriate
Operation day	In person	Screening for COVID-19
		Symptom screening and temperature check
		Waiting room avoidance
		Patients scheduled so that they can go directly to procedure rooms and remain in the room
		Visitors not allowed to be with the patient aside from special circumstances, including for minors and when there is a medical or legal necessity
		Operation precautions
		PPE for patient: provide patient with surgical mask
		PPE for provider: mask (N95 + surgical mask), goggles or face shield, hair and shoe covering, and gown
		Use of smoke evacuator during electrocautery
		Dissolvable sutures and cyanoacrylate for surgical closure to prevent need for additional visit
		Written and oral wound care instructions regarding wound care
		Sanitation steps (disinfecting room between patient encounters)
		Sanitary wipes to disinfect all room surfaces and any objects touched by patients

COVID-19, Coronavirus disease 2019; *PCR*, polymerase chain reaction; *PPE*, personal protective equipment.