BPG Statement Regarding Phototherapy Services During Corona Virus Pandemic

As part of the acute response to preparation for the predicted impact of the SARS-CoV-2 coronavirus pandemic, elective services were largely put on hold and all attention and resources have been redirected to dealing with the demands of COVID-19. This has included virtually all elective dermatology care, with most dermatology departments now only seeing urgent potentially life-impacting cases and dealing with other patients with skin conditions remotely. This has impacted majorly on phototherapy services, with departments either having stopped offering phototherapy completely or offering a greatly reduced urgent skeleton phototherapy service. As time passes and the acute demand on staff and resources for COVID-19 work settles, we need to look at how we can gradually start reintroducing services in order to ensure that patients with non-COVID-19 diseases do not remain at a disadvantage in terms of ensuring optimal effective and safe care.

Phototherapy is an essential core dermatology service and effective and controlled use of phototherapy can ensure that some patients will either not end up requiring immunosuppressants or will not need to be admitted for acute flares of disease. Thus, it is appropriate to cautiously increase phototherapy services post-lockdown, with core principles and factors considered:

1. All patients should be triaged for risk of severe COVID-19 disease and for the urgency of need for phototherapy ie. case-by-case risk/benefit assessment – with respect to risk factors for severe COVID-19 disease and what the alternatives would be for skin management if phototherapy was not used (and what their risks would be). Patients should be counselled accordingly taking this risk assessment into account.
2. If phototherapy capacity is limited then priority should be given to those with severe skin disease urgently requiring treatment.
3. All patients should be screened for COVID-19 symptoms and temperature checked pre-entry to the department/phototherapy unit and only those without suspected COVID-19 should be allowed to proceed. Where possible testing should be undertaken to confirm negative status before commencing phototherapy and this should be repeated in the event of symptoms developing in themselves or family and this will hopefully be increasingly feasible with availability of testing.
4. Plan adequate spacing of appointments for social distancing and minimise waiting times. We do not have evidence on which to base the optimal frequency of appointments, which has to be decided by individual units, but in general 30 minutes between appointments per cubicle (with times staggered) may be appropriate for whole-body UVB and PUVA.
5. Timing of appointments needs also to allow for cleaning of contact parts of equipment between patients.
6. Aim for patients to be in the department for as short a time as possible (Including, patients should be switched from topical PUVA to oral PUVA unless contraindicated).
7. Attempt to minimise treatment numbers and duration of courses. This may mean increased use of PUVA relative to UVB.
8. Review the need for using an MED-based start dose – could a test area or fixed start dose regimen be used – although caution as if doses are too low then patients may need longer courses.
9. Review opening times and staffing of unit – which days of the week open, opening hours & weekend opening to consider re. spacing of patients and appointments.
10. Ensure staff are provided with and wearing appropriate personal protective equipment as per local policies (eg. mask/gloves/apron/visor).
11. Advise patients to wear masks whilst attending and waiting.

12. Consider introducing and where possible increasing the use of home phototherapy.
13. Consider whether self-administered phototherapy is an option to help with social distancing – cleaning between treatments & staffing need thought.
14. Do not treat patients with definite or possible COVID-19 and do not treat patients who have had COVID-19 until resolution of fever and, where possible, two consecutive sets of swabs at >24h interval. Where testing is not yet readily available then three weeks after resolution of fever may be an appropriate time to start treatment.
15. In regions that offer phototherapy in many locations, phototherapy may currently be more centralised but to reduce patient travelling peripheral centres should plan to restart phototherapy when possible.

This general information and advice is based on the best evidence available currently, but is likely to vary as further information and practices evolve. Additionally, individual units may be subject to other local NHS Trust/Healthboard guidance. Thus, this should be used as a general guide but should be kept under regular review.

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On behalf of the BPG Committee

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