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EDITORIAL

Infection Control in a Dermatology Office During a Coronavirus Epidemic: Let's get down to Specifics which includes the Auto Visitation

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An ongoing outbreak of coronavirus disease 2019 (COVID-19), started in December 2019. It was first identified in Wuhan, the capital of Hubei, China. As of February 26, 2020, 81,278 cases have been confirmed, including in all provinces of China and more than forty other countries. Of these, 11,569 cases were classified as serious. There have been 2,770 deaths attributable to the disease, including 55 outside mainland China, surpassing that of the 2003 SARS outbreak. The first confirmed case of the global outbreak in the United States was announced on January 21, 2020. As of February 24, 2020, the Centers for Disease Control and Prevention (CDC) has confirmed numerous cases of coronavirus in the United States, but none in Northwest Ohio, where I practice dermatology.

1. NEED FOR INFECTION CONTROL AND PREPAREDNESS IN INDIVIDUAL OFFICES

Heaven forbid, but if there is a coronavirus epidemic, all medical offices should institute measures in terms of infection control and preparedness. To do so, one should have designed a framework outlining the steps to be taken in that scenario. A well-constructed infection control preparedness plan will avoid otherwise early mistakes in treatment. In this editorial, I will outline the format that my dermatology office will follow if a COVID-19 outbreak occurs.

There are several caveats in anyone considering mirroring my response. First, as a dermatologist, I do not feel any responsibility in pursuit of diagnosing and treating the respiratory disease itself. Thus, primary care physicians and internists have a much broader mission with such an epidemic. In short, the identification and testing for COVID-19 is not within the realm of my intent with patients (I merely will address their skin problems and limit dissemination of possible respiratory disease).

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Secondly, I am on the first floor in a small office building in which I am the only medical tenant. I am the only physician in practice with no physician assistants or nurse practitioners. Thus, I can more easily control patient/medical personnel experiences, as well as access to and from the building.

Third, my office does not have any rooms with negative pressure airflow, in which air flows into the isolation room but not escape from the room, preventing contaminated air from escaping the room. My office will be treating all patients during this possible period of a COVID-19 with either cold/fever/runny nose/sore throat is contagious. Thus, my office will not try to differentiate between COVID-19, from the flu or any other respiratory disease. In an epidemic, unfortunately we will have to lump such patients as all having possibly the dreaded virus. As stated by the CDC, this virus can present with symptoms similar to the common cold, and it is best to isolate those who may be symptomatic and use respiratory precautions. along with standard, contact, and airborne precautions.

2. TWO PHASES OF PREPAREDNESS

I also would like to differentiate two phases of preparedness. The first is prior to any cases of COVID-19 being documented in Northwest Ohio; and the later phase being once the virus has landed in our locale. In the first phase, my office will strongly suggest to patients with symptoms of cold/fever/runny nose/sore throat (as well as anyone that he/she might bring with them to the office) that they stay home and reschedule their dermatology appointment to a date when they are free of symptoms. In this first phase, patients will be seen for emergencies in the office, but will be masked, which I will provide. In the later phase, my office will demand that they do not enter the premises with their symptoms. This information will be given to the patient when they make their appointment and on a reminder phone call made the day before their scheduled office visit. I will also screen patients *via* my online portals and alert patients about this new safety policy.

During this second phase in which there has been isolation of the virus in our community, I will also institute several additional measures such as avoiding shaking patients' hands, and trying to maintain a 3-foot separation from patients. I will also be wearing a n95 mask at all times to protect patients from me (in case I am an asymptomatic carrier) and to protect myself from patients. In this scenario, patients will not have to be masked. The office will, of course, encourage frequent hand washing and cleaning door knobs and countertops in between patient visits.

My office certainly intends to follow the CDC (Center for Disease Control and Prevention) guidelines as it relates to our office dermatology setting, and will adjust to any state or regional guidelines should they appear in the press and media. The intent of my measures is so that the office protects:

(1) Our healthy patients who are not infected from those patients who are sick or have a fever (and might be infected with COVID-19) as well as others in the building structure.

(2) My staff from patients who are sick, or from other staff members who are sick and may be infected.

(3) And myself.

In terms of patient protection, I reiterate that all patients on their appointment reminder phone call a day prior to their visit will be notified that we have instituted a policy that if they (or anyone that might accompany them to the office) have a cold/fever/runny nose/sore throat to reschedule to a time when they are well. I will also use my internet site to alert my patients to this new safety policy. If a patient needs to be seen even though they have a cold/fever/runny nose/sore throat, my office has a two-phase response. (N.B. such an occurrence should be rare, but will occur, such as a female on isotretinoin needing to be seen on a designated monthly return appointment). Prior to the identification of COVID-19 in Ohio, we will mask such a patient and see them. Standard precautions, including thorough cleaning of the rooms following their visit, would include use of alcohol-based hand sanitizers, disposable wipe cleaning of counter tops, door knobs and work areas with Clorox (or Lysol) wipes.

3. THE AUTO VISITATION FOR PATIENTS WHO HAVE SYMPTOMS YET WANT TO BE SEEN IN PHASE 2

After there is a documented case of COVID-19 in our community, then the only option for a patient with cold/fever/runny nose/sore throat to be seen by me would be the auto visit, in which I see the patient in their car. Such an auto visit begins by patients filling out the appropriate paperwork that they would obtain from my website. This paperwork would be given to me outside the building at the auto visit. The day prior to the auto visit (with some flexibility) my staff and/or I would take a thorough history of the problem. Additionally, they would call my office when in route to my office and then again when they arrive at a designated site near our front door. Since we do not want such patients even to enter the building (including no restroom availability with such visits), I will immediately stop whatever I am doing and go out to see them immediately. I will leave to see such patients from my separate door entry into the office complex. I also will be gowned in a polypropylene universal isolation suit, along with goggles, gloves and NIOSH-certified N95 respirator mask. I will return *via* my separate door entry and discard my protective gear.

In defense of using the car to see such patients, it is unknown how long the virus remains airborne. Once an examining room is vacated by a patient with coronavirus, there are no CDC instructions currently available as to the length of time before the room can be reused again.

Similarly, with the infected Diamond Princess cruise ship, reported on February 24, 2020 by Washington Post, none of the esteemed organizations (the Japanese Ministry of Health, The US CDC, and Prevention, the World Health Organization) had yet determined exact proper measures, chemicals, and length of time to disinfect that liner. By using car visitation, the office will not have to maintain records as to the name of all staff who had contact with such patients, as it would be only the doctor. Also, by doing car visitation, my staff, other patients, and other workers in the building will not exposed to COVID-19. The precedent for auto visitation was recommended by the CDC for the dog flu in September 2018.

With the auto visitation, I will not be able to do a full-service visit with such patients. There would be limited biopsies capabilities. There would be no full skin exams. If surgery is eminently needed, I will refer the patient to a surgeon in a medical building who will be able better handle viral control. If examination of the sensitive area is needed, I would suggest a visit to primary care services, urgent care, or emergency room.

In terms of protecting my staff, as noted above, they will not have patient contact with the auto visitation. I additionally will follow CDC guidelines that sick employees will have to stay home, even if that means that my office will be short of normal staff numbers. This means that one's staff have to be cross-trained in case of sickness of others.

I also have had my medical malpractice attorney review this policy and it was found to be legally sound.

CONCLUSION

I believe it is best to be proactive, vigilant, prepared, and careful with this possible epidemic. Less errors occur when one has a ready, thought-out approach to the problem at hand. One would want to be alert to any changes in CDC instructions and to check CDC's health care professional information daily. It is hoped that this epidemic is averted and all such precautions become moot.