

IADVL Position Statement and Recommendations on Post Lockdown Dermatology Practice Amidst the Covid -19 Pandemic (IADVL Academy and IADVL Executive Committee)

Background

COronaVirus Disease 2019 (COVID-19) pandemic, caused by the SARS-CoV-2, continues to spread across the country and the number of cases crossed the ominous 50,000 mark on 6th May, 2020. Although it is reassuring that most infected people experience only a mild to moderate respiratory illness and recover without requiring special treatment, older people and those with co-morbidities like cardiovascular disease, diabetes, chronic respiratory disease and cancer, are more likely to develop severe disease and must be protected.^[1,2]

COVID-19 primarily spreads via respiratory secretions in the form of droplets (>5 microns) or aerosols (<5 microns), with possible indirect transmission through fomites (contaminated surfaces/objects) as well. Median half-life of SARS-CoV-2 is approximately 2.7 hours in aerosols, 5.6 hours on stainless steel and 6.8 hours on plastic, with viable virus still being detectable on steel and plastic surfaces at 72 hours (although the viability also significantly depends on ambient temperature and humidity).^[3] Thus the virus may survive on medical instruments and equipment for a significant period of time.

It must be remembered that transmission is also possible from pre-symptomatic or asymptomatic individuals.^[4,5] Shedding of the SARS-CoV-2 is highest from upper respiratory tract (nose and throat) early in the course of the disease, that is within the first 3 days from onset of symptoms.^[6] Preliminary data suggests that people may be more contagious around the time of symptom onset as compared to later on in the disease course. A possible faeco-oral transmission is possible, although conclusive evidence is as yet lacking.^[7]

The median incubation period for COVID-19 is 5.1 days; and most (97.5%) of those who develop symptoms do so within 12 days.^[8] Incubation period beyond 14 days has also been suggested, though it's a rare occurrence (101 out of every 10,000 cases).^[8] Symptoms of COVID-19 include fever (in 83%), cough (82%), shortness of breath (31%), muscle ache (11%), confusion (9%), headache (8%), sore throat (5%), rhinorrhea (4%), chest pain (2%), diarrhea (2%), and nausea and vomiting (1%).^[9] Loss of smell occurs in a large proportion of patients (up to 70%) and persists beyond cure in up to 38% patients.^[10]

While the spread of the pandemic has been slowed with the nationwide lockdown from 25th March to 17th May 2020, a concern of neglect of other medical conditions has

been raised. In view of this, the government has advised all health services including hospitals, nursing homes, clinics and telemedicine facilities to remain functional to cater to other diseases and patients.^[11-13] However, to maintain safety of healthcare workers (HCWs) and prevent spread of COVID-19, it is of paramount importance to adhere to certain best care practices while providing healthcare in these times.

Recommendations for Dermatology Practice

The dermatology practice advice would differ from single practitioner clinics to hospitals without, and those with, demarcated COVID care areas. Further, as the situation is evolving, newer findings may entail changes in recommendations with time.

1. **If feasible**, patients may be **seen only by appointment** as it's then possible to ensure that they take adequate precautions like donning masks and maintaining social distancing as they enter the clinics. History of fever or any respiratory symptoms and of risk factors for COVID-19 (including contact with an infected patient, residence in the defined containment zones) can also be elicited. All non-essential visits for follow-up could be curtailed, for example for mild/moderate acne, hair loss, cosmetic procedures and stable patients with chronic skin conditions. Monitoring visits for review of investigation may be considered to be done by tele-consultation. Further, the patients should be encouraged to download and setup the Arogya Setu app as recommended by the Ministry of Health and Family Welfare (MOHFW). **Elderly and those with co-morbidities** should be encouraged to avoid visiting healthcare settings where COVID-19 patients are also being catered to, unless absolutely essential.
2. In a hospital setting, it is ideal to have a **triage area at patient entry** to seek out those with symptoms suggestive of COVID-19 and refer them appropriately. In a clinic set up, a single entry point should be maintained and it is advisable to have a small demarcated area at the entry where the patients may be screened for presence of fever or respiratory symptoms, *provided mask* if they are not already wearing one and *asked to sanitize hands* with an alcohol based sanitizer poured onto the patients hands by an appropriately geared staff or taken by the patient himself/herself from one placed at a convenient spot for patient's self-use.
3. It is advisable to maintain **adequate ventilation** throughout the clinic and have separate air-conditioning

units for each room at the facility. Recirculation of cool air by room air conditioners, must be accompanied by outdoor air intake through slightly open windows and exhausts by natural exfiltration. Exhausts must also be kept operational in pantry/kitchen and toilets within the premises. As the virus thrives well within temperatures between 22–25°C and relative humidity of 40–50%, that is, typical air-conditioned environments,^[14] **room temperatures between 25°C and 30°C** should be maintained.^[15]

4. **Regular cleaning** of the facility, 2-3 times a day, is encouraged. The virus has been shown to survive on dry surfaces for extended periods, particularly when suspended in human secretions.^[16] A freshly prepared sodium hypochlorite solution (0.5-1%) should be used to decontaminate surfaces coming in contact with patient's skin, blood or body fluids regularly.^[17] For metallic surfaces like door handles, security locks, for equipment like stethoscopes and dermoscopes and for electronic items including mobile phones and laptops etc., where the use of bleach is not suitable, 60- 70% alcohol can be used to wipe down the surfaces.^[17] Damp mopping of floor with (up to) 1% sodium hypochlorite disinfectant is also helpful. Although disinfectant spraying is being utilized in outdoor environments in the current scenario, disinfectant fogging is not recommended for patient care areas.^[18,19] More research is required to clarify the effectiveness and reliability of fogging, UV-C irradiation, and ozone mists to reduce coronavirus environmental contamination.^[18] Thus, regular cleaning of all surfaces as advised above must instead be performed meticulously. Further, it is important to keep particulate dust levels to a minimum by regular cleaning and optimal exhaust usage, as particulate matter also represents a substrate allowing long term persistence of viruses in the atmosphere.^[20]
5. It must be borne in mind that in order for the virus to initiate indirect contact transmission, contact with a mucous membrane must occur and transfer sufficient viruses.^[16] Nasal inoculation is a frequent route for establishing the infection, while oral inoculation is also likely important.^[16] Thus, **touching face must be consciously avoided** in addition to all the above mentioned disinfection procedures.
6. **Waiting area:** Appointments should be given such that time in waiting is minimized. Attendants unless unavoidable, should be discouraged. Waiting area should have pictorial charts depicting preventive measures for patient's information. It must be ensured that adequate social distancing is maintained. The waiting area should ideally have minimal amount of easy to clean furniture. Avoid use of upholstered items and prefer stainless steel/leatherite chairs that may be regularly cleaned as mentioned before. In a larger healthcare setting, social distancing may be maintained at registration counters by marking spots at least 1 meter gap.

7. **Personal protective equipment:** It is imperative to presume every patient and attendant as potentially COVID-19 infected and precautions have to be taken as per notified protocols. Please keep yourself apprised about the recommendations of the local infection control departments. Further, all personal protective equipment (PPE) used should be of good quality and fulfill specifications outlined by the Government of India.^[21]

Broadly, while dealing with patients in facilities where prior triage has been done at patient entry point, a **three-ply surgical mask** would suffice for routine consults.^[21,22] If there is no triage area / holding area for patients due to resource constraints, wearing a **N 95** mask is advisable. Gloves should be used for patient examination if the same is required. **Full PPE overalls are not required for dermatology OPD consultations** and may create unnecessary anxiety in the patients' minds apart from diverting useful resources away from where they are most needed. A long-sleeved apron should be worn in the consultation room and should ideally be left there at the end of work hours or kept at another safe place. SARS-CoV-2 can remain viable on clothes for one day, but is easily amenable to inactivation by household disinfectants with no detectable virus being detectable after 5 minutes of exposure.^[23] Hence, the worn aprons can be exposed to household bleach for 5 minutes or alternatively washed at higher temperatures with regular detergents.

8. **Stationary use and handling** may be kept to a minimum and patient's prior records may be requested in a digital format beforehand. Similarly, e-prescription may be preferred if feasible. As per disease severity assessment, prescription for 1-2 months may be prescribed. In experimental settings, SARS-CoV-2 could be recovered from bank notes in decreasing quantum till 2 days following incubation;^[23] hence a **digital mode of payment** may be preferred in private setups pending further information OR the currency notes kept untouched for 2-3 days before use. Private clinics may consider surcharge for additional expenses on account of PPE, disinfectants etc.
9. The consultation table should be bare and uncluttered. **Patient seating** should be at a distance of at least one meter. As far as possible, clinical diagnosis may be decided on inspection alone and while palpating a patient, gloves must be used. Also, ask the patient to look away as you palpate. Keep the consultation time as brief as possible. While performing dermoscopy where essential, keep patient's face turned away and clean the dermoscope cap with 60-70% alcohol before and after use on each patient. Avoid use of dermoscopes where sterilization of the contact surface is not feasible. If oral examination is needed, instructions on protection as advised for dental/ENT OPDs must be followed *i.e.*, with a N-95 mask and goggles (plus use of face

shield when a splash of body fluid expected).^[22] Phototherapy can be continued for patients requiring the same. The contact surfaces should be regularly cleaned with 60-70% alcohol.

Sanitize hand with a 60% or more alcohol based hand rub or wash with soap and water for 20 seconds after each consultation, esp. if patient's prescriptions/medicine packs/other objects have been handled.

10. **Staff Management and Rotation-** It is imperative to train support staff regarding best practices at the clinic to keep up their morale and confidence. Mental health issues, if any also need redressal. Non-clinical staff should be trained on respiratory and hand hygiene, including cough etiquette, the proper techniques for using alcohol-based hand sanitizers and washing hands with soap and water, and about the use of protective gear and social distancing. Regular updates on clinic/hospital guidelines should also be shared with them and compliance monitored. The threshold for testing for possible infection should be low and adequate security for HCWs should be ensured. Only a minimum number of support staff required for functioning of the setting, depending on the patient load, may be deployed or rotation of staff may be considered, if feasible.
11. A prolonged close contact, defined as being within 2 meters of a COVID positive patient (beginning 48 hours before onset of symptoms; unmasked patient) for more than a few minutes, without due protection, may put the HCW at risk of acquiring the disease. Detailed **risk assessment** charts (classifying the exposure as high, medium and low risk and appropriate interventions required) by local (Institutional Infection Control Department) or international (CDC/WHO)^[24,25] bodies may be referred to in case of possible exposure and the exposure reported to the nodal health officer in the area. **Hydroxychloroquine prophylaxis** is recommended by the Indian Council of Medical Research (ICMR) for healthcare workers directly involved in care of suspected or confirmed COVID-19 patients.^[26] Utility to other healthcare workers is not established as yet.
12. Please be informed of updated Ministry of Health and Family Welfare (MOHFW) guidelines on infection and facility management. Home quarantine is now advised for mild cases^[27] and steps to be followed on detection of suspect/confirmed COVID-19 case in a non-COVID health facility have been detailed as well.^[28] Broadly, if the hospital authorities are **reasonably satisfied** that the source case/s have been identified and isolated, all contacts have been traced and quarantined and adequate disinfection has been achieved, the **hospital will continue to function**. However, the concerns, and thus the recommendations, are largely for health care facilities where an admitted patient comes out to be COVID-19 positive, rather than a walk in OPD patient where the risk to healthcare workers and facility is lesser. **But, all OPD patients should be advised to report their status, in case they are confirmed to be COVID-19 positive within 2 weeks of their reporting to the health care clinic.**
13. Use of broad **immunosuppressants** like cyclophosphamide, mycophenolate mofetil, methotrexate, azathioprine, corticosteroids may increase the risk of acquiring COVID-19 in view of impaired host anti-viral immunity (especially by mycophenolate mofetil, ciclosporine, azathioprine, steroids) and of severe manifestations (especially oral steroids) of COVID-19. On the other hand, withdrawal or denial in active disease may cause severe disease activation- for example in pemphigus, leading to mortality. Therefore, in COVID-19 negative patients, a risk stratified, case to case-based decision should be taken with a more conservative approach and use of alternative drugs like dapsone for autoimmune bullous disorders if possible. **Oral steroids should be kept at the minimum possible dose.**
14. **Biologics** cause dampening of immune response, however they have long half-life and rituximab due to prolonged profound effect on plasma cells should be avoided. Other biologics again may be continued based on disease severity and risk assessment, after taking informed consent. Small molecules like apremilast have shorter half-life and cause lesser immunosuppression, and maybe considered.
15. However, all patients on any immunosuppressants must be advised to ensure advanced social distancing, wearing masks and use of hand sanitizers. The patients should be counseled on the possible higher risk of infection and severe manifestations and must be encouraged to take all appropriate precautions. **Hydroxychloroquine prophylaxis** should be prescribed in case of possible exposure to a laboratory confirmed case, as per the recommendations of Indian Council of Medical Research (ICMR).^[26]
16. In a patient who acquires COVID-19 while on any kind of immunosuppressant, the decision to stop the same would depend on the risk assessment based on the severity of the patient's primary disease and of COVID-19 infection.
17. **Dermatological manifestations of COVID-19:** Dermatologists must be aware of cutaneous manifestations seen with COVID-19 to identify possible cases when encountered and to advise the treating physicians accordingly. Cutaneous lesions are uncommonly associated with COVID-19 and the ones described so far include^[29-31]: acral areas of erythema with vesicles or pustules (pseudochilblains), herpetiform and varicella like vesicular eruptions, digitate papulosquamous lesions, urticarial lesions, pruritic maculopapular eruptions, enanths, petechiae, purpuric flexural lesions and livedo or necrosis. Some of these manifestations have been described to occur before the onset of typical systemic symptoms (vesicular

eruptions) while most occur in an established case. The pseudo-chilblain pattern frequently appears in younger individuals late in the evolution of the COVID-19 disease and is associated with a milder disease course.

18. Effective communication with addressal of all queries of patients will allay fear and anxiety. Self-medication, and stoppage of medications without consultation, should be actively discouraged.
19. **Dermatologic emergencies** are not subject to restrictions on social distancing and travel and the patient should be attended in person for proper treatment upon physical examination.
20. If you are above 60 years of age, or have an underlying medical condition or are pregnant- please stay home. You may consider referring your patient to a colleague who is working.
21. **Procedures:** The basic essential procedures should be performed with due precautions. KOH and other smears can be done in clinics whenever indicated for patient management, taking due precautions as mentioned below. A detailed history of possible disease and exposure must be taken prior to any minor OT procedure. A specific clause about risk of transmission of COVID-19 may be added to the procedure consent form.

Skin biopsies that are *essential for diagnostic and therapeutic decisions should be performed* and procedures for **conditions causing discomfort to the patients or cutaneous malignancies** may also be planned. In some conditions, dermoscopy may obviate the need for a skin biopsy and use of the same is encouraged in such situations. Procedures in diagnosed COVID-19 patients and **purely aesthetic procedures in all patients should be deferred.** Use of disposables and absorbable sutures, wherever possible, may be preferred. The organic materials released from human tissue during vaporization with medical devices can potentially contain certain viruses, (e.g. HPV).^[32] Thus, though the risk of SARS-CoV-2 vaporizing out of blood or skin with laser, electrocautery or radio frequency devices is as yet unproven, the use should be restricted to only essential procedures and the energy levels should be kept at the lowest therapeutic levels to reduce plume formation.^[33] Spray cryosurgery would be a safe procedure and may be used instead, wherever suitable. Mandatory smoke evacuator usage to be enforced as this would reduce aerosols by 95%. Wherever possible, cold probe radio frequency devices may be used instead of electrofulguration/electrodessication devices. If feasible, negative pressure operating areas are preferred for procedures.

Procedures on the face/ and or time-consuming interventions may be avoided as that would entail greater risk of exposure. At present, **COVID-19 pre-testing is not advisable** before undertaking procedures and hence cannot be encouraged. In doubtful cases, a

medicine consult and a chest X-ray can assist. While performing any minor OT **procedure, minimal number of staff** should be present and social distancing must be maintained. Adequate ventilation must be ensured, and exhaust fans should be in order. Goggles/face shield, to protect against possible spillage of blood or fluids depending on the procedure, may be donned. Shoe covers must be used while in the minor OT. A gown may be donned if splashing of blood/body fluids is expected. A N-95 mask and head cap must be worn. Patient must wear a mask throughout, and his/her face turned away from the HCWs. Cleaning of surfaces, as mentioned before, of the minor OT should be considered following each day's procedures.

22. **Biomedical waste** in a biohazard bag, with the interior and exterior sprayed with 1% sodium hypochlorite solution should be sent for incineration
23. **Inpatients services** should be provided for emergencies and wherever supervised management is necessary. Tele-consultation triage may be carried out for referrals for COVID-19 suspected patients.
24. **Tele-consultation:** It is imperative to take an informed consent, follow standard procedures as practiced for a physical consultation, maintain documentation, and provide a signed prescription. The practitioner should also be familiar with possible medications allowed for each kind of tele-consultation encountered. Please note that the general guidelines of the Medical Council of India/ State Medical Councils on the issue of telephonic medication and online consultations still govern the practice of medicine by their registered members. Any deviation therefore may expose the members to adverse legal consequences.^[34]
25. Keep yourself informed about the prevailing scenario and be in touch with the state branches for updated recommendations and guidelines.
26. Stay safe!

Disclaimer

These guidelines are provisional and based on best evidence available in the current situation. However, these are subject to regulations by government agencies and may change as new evidence arises and our experience with COVID-19 broadens. The members are requested to seek and follow regularly updated MOHFW recommendations and keep themselves updated of the evolving situation.

Acknowledgements

We acknowledged all members of the IADVL Academy including ex-officio members for their critical inputs in the preparation of this manuscript.

Financial support and sponsorship

Nil.

Conflicts of interest

There are no conflicts of interest.

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References

- Jin Y, Yang H, Ji W, Wu W, Chen S, Zhang W, *et al.* Virology, epidemiology, pathogenesis, and control of COVID-19. *Viruses* 2020;12:E372. doi: 10.3390/v12040372.
- Yang J, Zheng Y, Gou X, Pu K, Chen Z, Guo Q, *et al.* Prevalence of comorbidities and its effects in coronavirus disease 2019 patients: A systematic review and meta-analysis. *Int J Infect Dis* 2020;94:91-5.
- van Doremalen N, Bushmaker T, Morris DH, Holbrook MG, Gamble A, Williamson BN, *et al.* Aerosol and surface stability of SARS-CoV-2 as compared with SARS-CoV-1. *N Engl J Med* 2020;382:1564-7.
- Arons MM, Hatfield KM, Reddy SC, Kimball A, James A, Jacobs JR, *et al.* Presymptomatic SARS-CoV-2 infections and transmission in a skilled nursing facility. *N Engl J Med* 2020. doi: 10.1056/NEJMoa2008457.
- Rothe C, Schunk M, Sothmann P, Bretzel G, Froeschl G, Wallrauch C, *et al.* Transmission of 2019-nCoV infection from an asymptomatic contact in Germany. *N Engl J Med* 2020;382:970-1.
- Zou L, Ruan F, Huang M, Liang L, Huang H, Hong Z, *et al.* SARS-CoV-2 viral load in upper respiratory specimens of infected patients. *N Engl J Med* 2020;382:1177-9.
- Bonato G, Dioscoridi L, Mutignani M. Faecal-oral transmission of SARS-COV-2: Practical implications. *Gastroenterology* 2020;5085:30449-2. doi: 10.1053/j.gastro.2020.03.066.
- Lauer SA, Grantz KH, Bi Q, Jones FK, Zheng Q, Meredith HR, *et al.* The incubation period of coronavirus disease 2019 (COVID-19) from publicly reported confirmed cases: Estimation and application. *Ann Intern Med* 2020;M20:0504. doi: 10.7326/M20-0504.
- Chen N, Zhou M, Dong X, Qu J, Gong F, Han Y, *et al.* Epidemiological and clinical characteristics of 99 cases of 2019 novel coronavirus pneumonia in Wuhan, China: A descriptive study. *Lancet* 2020;395:507-13.
- Lechien JR, Chiesa-Estomba CM, Place S, Van Laethem Y, Cabaraux P, Mat Q, *et al.* Clinical and epidemiological characteristics of 1,420 European patients with mild-to-moderate coronavirus disease 2019. *J Intern Med* 2020. doi: 10.1111/joim.13089.
- Consolidated Revised guidelines on the measures to be taken by Ministries/Departments of Government of India, State/UT Governments and State/UT authorities for containment of COVID-19 in the country. Available from: https://www.mha.gov.in/sites/default/files/MHA%20order%20dt%2015.04.2020%2C%20with%20Revised%20Consolidated%20Guidelines_compressed%20%283%29.pdf. [Last accessed 2020 May 10].
- New guidelines on the measures to be taken by Ministries/Departments of Government of India, State/UT Governments and State/UT authorities for containment of COVID-19 in the country for the extended period of National Lockdown for a further period of two weeks with effect from 4th May, 2020. Available from: <https://www.mha.gov.in/sites/default/files/MHA%20Order%20Dt.%2015.2020%20to%20extend%20Lockdown%20period%20for%202%20weeks%20w.e.f.%204.5.2020%20with%20new%20guidelines.pdf>. [Last accessed 2020 May 10].
- Enabling Delivery of Essential Health Services during the COVID-19 Outbreak: Guidance note. Available from: <https://www.mohfw.gov.in/pdf/EssentialservicesduringCOVID19updated0411201.pdf>. [Last accessed 2020 May 10].
- Chan KH, Peiris JS, Lam SY, Poon LL, Yuen KY, Seto WH. The effects of temperature and relative humidity on the viability of the SARS coronavirus. *Adv Virol* 2011;2011:734690.
- ISHRAE COVID-19 GUIDANCE DOCUMENT for Air Conditioning and Ventilation. Available from: https://ishrae.in/mailler/ISHRAE_COVID-19_Guidelines.pdf. [Last accessed 2020 May 10].
- Otter JA, Donskey C, Yezli S, Douthwaite S, Goldenberg SD. Transmission of SARS and MERS coronaviruses and influenza virus in healthcare settings: The possible role of dry surface contamination. *J Hosp Infect* 2016;92:235-50.
- Kampf G, Todt D, Pfaender S, Steinmann E. Persistence of coronaviruses on inanimate surfaces and their inactivation with biocidal agents. *J Hosp Infect* 2020;104:246-51.
- Guideline for Disinfection and Sterilization in Healthcare Facilities (2008). Available from: https://www.cdc.gov/infectioncontrol/guidelines/disinfection/index.html#anchor_1555614269. [Last accessed 2020 May 10].
- National guidelines for infection prevention and control in healthcare facilities. January 2020. Available from: <https://www.mohfw.gov.in/pdf/National%20Guidelines%20for%20IPC%20in%20HCF%20-%20final%281%29.pdf>. [Last accessed 2020 May 10].
- Setti L, Passarini F, de Gennaro G, Di Gilio A, Palmisani J, Buono P, *et al.* "Evaluation of the Potential Relationship between Particulate Matter (PM) Pollution and COVID-19 Infection Spread in Italy", SIMA position paper, 21 March 2020. Available from: http://www.simaonline.it/wpsima/wp-content/uploads/2020/03/COVID_19_position-paper_ENG.pdf. [Last accessed 2020 May 10].
- Novel Coronavirus Disease 2019 (COVID-19): Guidelines on rational use of Personal Protective Equipment by the Ministry of Health and Family Welfare Directorate General of Health Services. Available from: <https://www.mohfw.gov.in/pdf/GuidelinesonrationaluseofPersonalProtectiveEquipment.pdf>. [Last accessed 2020 May 10].
- Ministry of Health and Family Welfare Directorate General of Health Services [Emergency Medical Relief] Novel Coronavirus Disease 2019 (COVID-19): Additional guidelines on rational use of Personal Protective Equipment (setting approach for Health functionaries working in non-COVID areas. Available from: <https://www.mohfw.gov.in/pdf/AdditionalguidelinesonrationaluseofPersonalProtectiveEquipmentsettingapproachforHealthfunctionariesworkinginnonCOVIDareas.pdf>. [Last accessed 2020 May 10].
- Chin AWH, Chu JTS, Perera MRA, Hui KPY, Yen HL, MC, *et al.* Stability of SARS-CoV-2 in different environmental conditions. *Lancet Microbe* 2020. doi: 10.1016/S2666-5247(20)30003-3.
- World Health Organization. Health workers exposure risk assessment and management in the context of COVID-19 virus (4th March, 2020). Available from: https://apps.who.int/iris/bitstream/handle/10665/331340/WHO-2019-nCov-HCW_risk_assessment-2020.1-eng.pdf?sequence=1&isAllowed=y. [Last

- accessed 2020 May 10].
25. Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease 2019 (COVID-19). Available from: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>. [Last accessed 2020 May 10].
 26. National Task force for COVID-19(Indian Council of Medical Research) Advisory on the use of Hydroxychloroquine as a prophylaxis for SARS-CoV-2 infection. Available from: <https://www.mohfw.gov.in/pdf/AdvisoryontheuseofHydroxychloroquinasprophylaxisforSARSCoV2infection.pdf>. [Last accessed 2020 May 10].
 27. Government of India Ministry of Health & Family Welfare Directorate General of Health Services (EMR Division) Guidelines for home quarantine. Available from: <https://www.mohfw.gov.in/pdf/Guidelinesforhomequarantine.pdf>. [Last accessed 2020 May 10].
 28. Ministry of Health & Family Welfare Directorate General of Health Services EMR Division Guidelines to be followed on detection of suspect/confirmed COVID-19 case in a nonCOVID Health Facility. Available from: <https://www.mohfw.gov.in/pdf/Guidelinestobe followedondetectionofsuspectorconfirmedCOVID19case.pdf>. [Last accessed 2020 May 10].
 29. Galván Casas C, Català A, Carretero Hernández G, Rodríguez-Jiménez P, Fernández Nieto D, Rodríguez-Villa Lario A, *et al.* Classification of the cutaneous manifestations of COVID-19: A rapid prospective nationwide consensus study in Spain with 375 cases. *Br J Dermatol* 2020. doi: 10.1111/bjd.19163.
 30. Sachdeva M, Gianotti R, Shah M, Lucia B, Tosi D, Veraldi S, *et al.* Cutaneous manifestations of COVID-19: Report of three cases and a review of literature. *J Dermatol Sci*. 2020;doi:10.1016/j.jdermsci.2020.04.011.
 31. Tammaro A, Adebajo GAR, Parisella FR, Pezzuto A, Rello J. Cutaneous manifestations in COVID-19: The experiences of Barcelona and Rome. *J Eur Acad Dermatol Venereol*2020.doi: 10.1111/jdv.16530.
 32. Gloster HM Jr, Roenigk RK. Risk of acquiring human papillomavirus from the plume produced by the carbon dioxide laser in the treatment of warts. *J Am Acad Dermatol* 1995;32:436-41.
 33. Emadi SN, Abtahi-Naeini B. Coronavirus Disease 2019 (COVID-19) and dermatologists: Potential biological hazards of laser surgery in epidemic area. *Ecotoxicol Environ Saf*2020;198:110598.
 34. Telemedicine Practice Guidelines Enabling Registered Medical Practitioners to Provide Healthcare Using Telemedicine; By The BOARD OF GOVERNORS In supersession of the Medical Council of India. Available from: <https://www.mohfw.gov.in/pdf/Telemedicine.pdf>. [Last accessed 2020 May 10].

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Access this article online	
Website: www.idoj.in	Quick Response Code 
DOI: 10.4103/idoj.IDOJ_334_20	

How to cite this article: Khurana A, Pandhi D. IADVL position statement and recommendations on post lockdown dermatology practice amidst the Covid -19 pandemic (IADVL Academy and IADVL Executive Committee). *Indian Dermatol Online J* 0;0:0.
Received: 02-May-2020. **Revised:** 08-May-2020.
Accepted: 09-May-2020. **Published:** 16-May-2020.