Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Elsevier hereby grants permission to make all its COVID-19-related research that is available on the COVID-19 resource centre - including this research content - immediately available in PubMed Central and other publicly funded repositories, such as the WHO COVID database with rights for unrestricted research re-use and analyses in any form or by any means with acknowledgement of the original source. These permissions are granted for free by Elsevier for as long as the COVID-19 resource centre remains active.
26419
Rainfall associated with increased melanoma among non-Hispanic whites
Richard F Wagner Jr, MD, William Meyer, BBA, MS2, Department of Dermatology, University of Texas Medical Branch
The major environmental cause of melanoma is likely solar ultraviolet radiation (UVR). Thus, modifiers of UVR, such as rainfall and its associated cloud cover, have the potential to impact melanoma incidence. While prior research theorizes decreased rainfall may be associated with increased melanoma as drier weather encourages outdoor activity in climate change scenarios, this research may suggest otherwise. The authors obtained county-level melanoma incidence data from the National Cancer Institute’s Surveillance, Epidemiology, and End Results (SEER) Program and rainfall data from the National Oceanic and Atmospheric Association (NOAA) while controlling for age, race, ethnicity, income, latitude, altitude, and other UVR influencers. A 10-inch increase in yearly rainfall was associated with a 3.8% increase in county-level melanoma incidence ($p < 0.001$, $n = 1639$ counties) among non-Hispanic whites older than 50. This may add support to the intermittent exposure theory of melanoma as a greater number of rainy days may lead to sun exposure being more infrequent resulting in higher rates of melanoma.

Commercial Disclosure: None identified.

26432
A case of bullous porokeratosis—like eruption in the setting of Ehrlichia infection
Amy Zavell, MD, University of Missouri; Kara Braudis, MD, University of Missouri
A 75 year old male with history of Stage III CKD, HTN, MS with remote history of optic neuritis, OSA, IHD was admitted for persistent fever, hypotension, kidney failure, a-fib with RVR, and pancytopenia. Three days after admission, he developed an asymptomatic skin eruption consisting of erythematous macules with peripheral scale on the bilateral upper and lower extremities, chest and back, sparing the palms and soles. He denied history of similar rash and denied history of similar lesions in these areas with the exception of three lesions that would come and go on the right thigh. Three punch biopsies in addition to DIF were performed from the left upper extremity HE revealed cornoid lamellae flaking re-epithelializing bullae. DIF revealed granular IgA at the dermalepidermal junction. Three days after onset of this eruption labs came back positive for Ehrlichia infection. He was treated with doxycycline and high dose steroids. One month after discharge, the patient and his wife reported that his skin was now clear with no residual scale or skin changes. Eruptive porokeratosis have been associated with various causes of systemic immunosuppression including malignancy, HIV infection, and immunosuppressive medications. There have been a few reports of bullous porokeratosis in the literature, most commonly on the legs in association with edema. Eruptive porokeratosis have been noted to regress or improve once the malignancy has been treated or immunosuppressive medication is removed. We propose a case of bullous porokeratosis-like eruption in the setting of Ehrlichia infection, with resolution after completion of therapy.

Commercial Disclosure: None identified.

26433
Interventions for skin wellbeing clinics in for health care staff during the SARS-CoV-2 outbreak: A perspective from London (UK)
Nav Paul, MBBS, BSc (Hons), MRCGP, DPD, DRCOG, DPFSH, PGCert, MRCP, FRSA, Clinical Fellow in Dermatology, Department of Dermatology, Queen Elizabeth Hospital, Lewisham & Greenwich NHS Trust; Monika Salta, BSc, MD, FRCP, Consultant Dermatologist, Department of Dermatology, Queen Elizabeth Hospital, Lewisham & Greenwich NHS Trust; Marie-Douay Daly, BSc, MPhil (Cantab), MRCP (London), Consultant Dermatologist and Clinical Lead, Department of Dermatology, Queen Elizabeth Hospital, Lewisham & Greenwich NHS Trust; Luigi Citarella, Locum Consultant Dermatologist, Department of Dermatology, Queen Elizabeth Hospital, Lewisham & Greenwich NHS Trust; Rachel Healy, Consultant Dermatologist, Department of Dermatology, Queen Elizabeth Hospital, Lewisham & Greenwich NHS Trust; Antonia D’Cruz, Clinical Fellow, Department of Dermatology, Queen Elizabeth Hospital, Lewisham & Greenwich NHS Trust; Athina Fonias, Consultant Dermatologist, Department of Dermatology, Queen Elizabeth Hospital, Lewisham & Greenwich NHS Trust; Ljubomir Novakovic, Consultant Dermatologist, Department of Dermatology, Queen Elizabeth Hospital, Lewisham & Greenwich NHS Trust; Kavitha Sundararaj, Locum Consultant Dermatologist, Department of Dermatology, Queen Elizabeth Hospital, Lewisham & Greenwich NHS Trust; Marie-Louise Daly, BSc, MPhil (Cantab), MRCP, FRSA, Clinical Fellow in Dermatology, Department of Dermatology, Queen Elizabeth Hospital, Lewisham & Greenwich NHS Trust; Alison Shanks, Consultant Dermatologist, Department of Dermatology, Queen Elizabeth Hospital, Lewisham & Greenwich NHS Trust; Nav Paul, MBBS, BSc (Hons), MRCGP, DPD, DRCOG, DPFSH, PGCert, MRCP, FRSA, Clinical Fellow in Dermatology, Department of Dermatology, Queen Elizabeth Hospital, Lewisham & Greenwich NHS Trust; Monika Salta, BSc, MD, FRCP, Consultant Dermatologist, Department of Dermatology, Queen Elizabeth Hospital, Lewisham & Greenwich NHS Trust; Marie-Douay Daly, BSc, MPhil (Cantab), MRCP (London), Consultant Dermatologist and Clinical Lead, Department of Dermatology, Queen Elizabeth Hospital, Lewisham & Greenwich NHS Trust; Luigi Citarella, Locum Consultant Dermatologist, Department of Dermatology, Queen Elizabeth Hospital, Lewisham & Greenwich NHS Trust; Rachel Healy, Consultant Dermatologist, Department of Dermatology, Queen Elizabeth Hospital, Lewisham & Greenwich NHS Trust; Antonia D’Cruz, Clinical Fellow, Department of Dermatology, Queen Elizabeth Hospital, Lewisham & Greenwich NHS Trust; Athina Fonias, Consultant Dermatologist, Department of Dermatology, Queen Elizabeth Hospital, Lewisham & Greenwich NHS Trust; Ljubomir Novakovic, Consultant Dermatologist, Department of Dermatology, Queen Elizabeth Hospital, Lewisham & Greenwich NHS Trust; Kavitha Sundararaj, Locum Consultant Dermatologist, Department of Dermatology, Queen Elizabeth Hospital, Lewisham & Greenwich NHS Trust; Marie-Louise Daly, BSc, MPhil (Cantab), MRCP, FRSA, Clinical Fellow in Dermatology, Department of Dermatology, Queen Elizabeth Hospital, Lewisham & Greenwich NHS Trust.

Introduction: An acute increase of dermatologic conditions occurred in National Healthcare System (NHS) health care workers (HCW) during the SARS-CoV2 outbreak. Novel ‘skin wellbeing’ clinics were established to support colleagues. Methods: HCW self-referred to dermatologists during an 8-week period in spring 2020. Clinics were supported by clinical nurse specialists in tandem to a publication of a departmental advice leaflet. Attendees were provided with samples of emollients, dressings, prescriptions and consultations free of charge.

Results: A total of 90 electronic medical records were analyzed retrospectively. Parameters included age, sex, ethnicity, diagnosis, previous history, interventions, and investigations. Of 80 new attendances, the commonest complaint was hand dermatitis (57, 71%) followed by (PPE) related skin conditions (35, 41.3%) and flares of pre-existing skin disease (15, 18.8%). A total of 197 separate prescription items were issued. Topical corticosteroid prescriptions comprised of mild (9), moderate (23), potent (27) and very potent (14) preparations. 4 combined without antibiotics, 4 with antibiotics, and 4 with antibiotics and antifungal. The most commonly prescribed antibiotics were clindamycin 1% with benzoyl peroxide (1), and combined clindamycin 1% with benzoyl peroxide 5% (8). Oral prescription medications included lymecycline (1) and doxycycline (1). Remaining items included emollients, soap substitutes, cleansing solutions and barrier creams.

Discussion: Our study demonstrates a significant burden of occupational dermatologic disease in HCWs as a direct consequence of the pandemic. We discuss measures implemented locally to aid staff recovery and share our experience.

Commercial Disclosure: None identified.