to conduct consultations remotely where possible, remote consultations rose from <30% before the pandemic to almost 80% of consultations at the height of the pandemic. After the national lockdown was lifted, remote consultations continued to account for >70% of consultations. Telemedicine has previously been shown to be an effective model for triaging referrals from primary care to 2-week-wait (2WW) skin cancer clinics. However, to our knowledge, no study has assessed the impact of telemedicine in assessing patients remotely at their initial primary care consultation prior to referral to secondary care. Our study aimed to assess whether the mode of consultation [face to face (F2F) or remote] in primary care affected the outcomes of consultations in 2WW skin cancer clinics. In total, 988 patients were referred to the 2WW clinic in September 2020. Of these, 37.9% (n = 375) were referred after F2F consultations in primary care. Thirty-seven per cent (n = 364) were referred after remote consultations, with the majority being telephone consultations with photographs (76%). The mode of primary care consultation was unclear in 21.1% (n = 209) of patients. A higher proportion of patients who had remote consultations were discharged (43.4%; n = 158/364) from the 2WW clinic than patients who had F2F consultations (36.2%; n = 136/375). There was a significantly higher number of benign lesions referred following a remote consultation in primary care compared with a F2F consultation (70% vs. 59%; P = 0.004). Interestingly, there was a higher proportion of benign lesions referred after telephone consultations with photographs vs. those without. The accelerated use of telemedicine in the COVID-19 era will provide useful information on how telemedicine can be optimized in the future. Lessons learnt during this time will inevitably shape the future digital landscape within the NHS. A key ambition set out in the NHS Long Term Plan published in January 2019 was to increase remote consultations within primary care. While remote consulting certainly has a role in some settings, our study highlights the value of F2F consultations for the initial assessment of patients presenting with lesions in primary care, in order to reduce the number of unnecessary referrals and hospital visits.

**BT08**

**Assessment of three different dermoscopy imaging systems during a fast-track skin cancer clinic**

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Dermoscopy is a noninvasive diagnostic investigation based on magnification, illumination and obliteration of light scatter on the skin surface allowing better visualization of structures beneath the stratum corneum. We aimed to assess image quality of lesions evaluated at a skin cancer clinic using three different handheld dermatoscopes; the Heine Delta 20T (contact) with an iPad; the MoleScope II (noncontact) with a Samsung 7 smartphone; and the Dino-Lite Edge with direct download to a MacBook laptop (noncontact). The Heine Delta 20T and iPad is the current standard used. The MoleScope is a mobile smartphone-attachable dermatoscope. The Dino-Lite is a handheld digital microscope that connects directly to the computer via a USB port. The cost of the Heine Delta 20T is roughly £1100, the MoleScope II £260 and the Dino-Lite £600. Twenty-three lesions were imaged with each device; 15 were pigmented. A total of 69 images were downloaded and transferred to Microsoft PowerPoint for review in random order. The images were scored by four consultant dermatologists, one general practitioner with a special interest and one associate specialist, blinded to the diagnoses. A score of 1–5 (poor-excellent) was attributed to each category: (i) detail/dermoscopic features; (ii) colour discrimination; (iii) magnification. Each assessor recorded whether – based on the image alone – they could make a diagnosis. The lesions were basal cell carcinoma (n = 6), seborrhoeic keratosis (n = 4), lichenoid keratosis (n = 1), benign naevi (n = 4), dysplastic naevi (n = 2), melanoma (n = 1), blue naevus (n = 1), sebaceous gland hyperplasia (n = 1), ruptured cyst (n = 1), pyogenic granuloma (n = 1) and dermatofibroma (n = 1). The mean score for each device and category was calculated as follows. (i) Heine: detail = 3.2, colour = 3.3, magnification = 3.2 (overall score = 3.2); 46.2% felt able to make a diagnosis. (ii) MoleScope: detail = 2.5, colour = 2.7, magnification 2.5 (overall score = 2.6); 43.5% felt able to make a diagnosis. (iii) Dino-Lite: detail = 3.2, colour = 3.2, magnification = 3.6 (overall score = 3.3); 57.2% felt able to make a diagnosis. Analysis on a PC screen allowed greater magnification than is generally employed in clinic, which may have affected assessors. The Heine is not primarily designed for digital dermoscopy. It requires two operators for image capture, whereas the other systems require only one. The MoleScope remains the most ‘mobile’, whereas the Dino-Lite is attached to a laptop/PC. Both the MoleScope and Dino-Lite can be used as noncontact dermatoscopes, avoiding contact medium use. Considering the current COVID-19 pandemic, these devices are less time consuming, more convenient and easier to clean. Overall, the Dino-Lite produced the best images. Despite the MoleScope scoring lower, it was comparable for diagnostic ability. It is proposed that the MoleScope and Dino-Lite systems may be optimal for use in teledermatology to facilitate virtual clinics.

**BT09**

**Standard of patient-sent images in teledermatology 2-week-wait skin cancer clinics during the COVID-19 pandemic**

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During the COVID-19 pandemic we have worked with patient-sent images to provide a clinical service. As a long-established teledermatology (TD) centre, we have undertaken TD using many different models and have historic data on the quality and outcomes with their use. For the purposes of this study we applied standard criteria concerning the image set...
quality and completeness for assessment of lesions in a 2-week-wait (2WW) skin cancer service, namely no more than one lesion per referral; and a regional, macro and dermoscopic photograph with at least one in each category being in focus (Quality Standards in Teledermatology, 2013). We assessed patient-sent images against these standards. In total, 496 consecutive 2WW referrals with patient-sent images were included between late March and early June 2020. It excluded patients without images or with general practitioner (GP)-sent images. The number of lesions, image characteristics and clinical outcome were determined via electronic patient records. In total, 424 (85.5%) sent images of a single lesion, of which 391 (78.8%) included regional images, 391 (78.8%) macro images and 287 (57.9%) both. In 200 (40.3%) at least one regional and macro image was in focus. After the first consultation, 134 (27.0%) patients were discharged with a treatment plan or no treatment. Previous work has illustrated that following medical illustration images taken in the community at a teledermatology hub, the discharge rate at first consultation was 61%. Such consultations are informed by image sets with dermoscopy and 100% completion of regional and macro photographs [Hunt WTN, Ali L, Marder H et al. A service evaluation between 2-week wait (2WW) skin cancer referrals via teledermatology and the standard face-to-face pathway at a teaching hospital. Clin Exp Dermatol 2020; 45: 473–6]. A similar audit of 500 GP-sent images for lesions differed from patient-sent photographs in that dermoscopy was present in 410 (82.0%) and 310 (62.0%) of photographs were in focus (Blayney S, Bogucki P, Sinha A et al. Lesion photography standards in primary care teledermatology referrals. Teledermatology and Digital Dermatology Symposium. Br J Dermatol 2020; 183: 168–77). This was an audit of non-2WW lesions and hence outcomes are not comparable. The use of patient-sent images has the potential to address problems of access to secondary care expertise. However, the quality of images is a factor in compromising the ability to offer definitive advice.

**BT10 Medical education in the COVID-19 era: a remote dermatology attachment**

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The way we work has changed drastically over the course of the last year. All aspects of our work, including undergraduate teaching, have had to undergo rapid change. Medical education has been disrupted and the development of effective – yet safe – teaching has been required at short notice. We developed a revised dermatology attachment for fourth-year medical students in Southampton. Prior to the COVID-19 pandemic, Southampton medical students undertook a 5-day placement in dermatology. This included a day of introductory lectures and small-group teaching, followed by clinical teaching and practical sessions in the clinical skills laboratory. In order to maximize learning opportunities while minimizing risk to patients, staff and students, the attachment required complete transformation. Even with effective vaccines and treatment, social distancing will remain a vital preventative measure. Teaching was delivered online for the first time in June 2020, for students who missed their attachment in March. Subsequent cohorts in September, November and January have been taught entirely remotely, including attendance at general and 2-week-wait (2WW) clinics. The Monday lectures are now viewed online; there are additional recorded lectures for students to access in their own time. On Tuesdays, students would usually attend the dermatology department for small-group teaching on skin lesions and inflammatory dermatology. These sessions are now delivered online in real time, using Blackboard Collaborate, enabling live video delivery of teaching with student participation, as well as breakout groups for smaller group sessions. On Wednesday, students attend general dermatology clinics online, with Blackboard Collaborate breakout groups. Students have the opportunity to take histories and observe clinical features on video; patients are informed and consented in advance of their appointments. A series of general clinics run simultaneously, with a separate 2WW skin cancer clinic running alongside. If a lesion of interest is seen in the skin cancer clinic, students can drop in to the virtual clinic room before returning to their general clinic room, maximizing exposure to dermatological conditions in the limited time available. On Thursday, further interactive teaching is provided, as well as suturing practice in the skills laboratory, prior to a formal assessment on Friday. Feedback received has been extremely positive from those teaching, as well as from students. Dermatology is a highly visual specialty that lends itself well to this style of learning. However, these teaching methods could be used as a model for medical education in other specialties.

**BT11 Lesions in lockdown: mobile dermoscopy in virtual dermatology clinics**

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Teledermatology is a useful tool in facilitating dermatology outpatient services since the advent of COVID-19. Assessment of lesions has become difficult to facilitate in large numbers. Teledermoscopy has been used for remote lesion assessment. However, the majority of teledermoscopy has been facilitated by healthcare professionals rather than the patient themselves (Vestergaard T, Prasad S, Schuster A et al. Introducing teledermoscopy of possible skin cancers in general practice in Southern Denmark. Fam Pract 2020; 37: 513–18). Patients referred with lesions deemed to be low risk are now often initially assessed via telephone consultation in conjunction with photographs of the lesion. The majority of patients are subsequently called for dermoscopy. However, many of those referred have benign lesions and could be safely discharged if