As part of this pilot teaching scheme, trainees in Wales \( (n = 8–10) \) completed 2–3 online modules weekly prior to a consultant-facilitated interactive session on Microsoft Teams\(^8\) (Microsoft Corp., Redmond, WA, USA). Trainees also rotated in delivering literature updates on the relevant topic to further inform the sessions. Formal feedback was completed on various aspects of this format of virtual teaching.

Trainees rated signal connection strength, video quality, audio quality, ease of access, quality of teaching slides, overall quality of the Teams\(^8\) platform and ease of asking questions. The majority of responses were ‘Good’ or ‘Excellent’ across all domains (Table 1). Most trainees \( (n = 6; 75\%) \) felt the e-LfH modules along with tutor-led virtual sessions were a suitable alternative to in-person teaching, and 88% \( (n = 7) \) felt the modules were sufficient to cover Dermatology JRCPTB curriculum requirements in addition to regular clinical training. During trainees’ interviews, the ability to access modules ‘anywhere’ and the ‘lower risk of infection’ were major benefits. Access to teledermatology\(^5\) and high-quality images further augmented the teaching experience.

The HEE e-LfH e-Dermatology programme is a valuable, free resource that covers 160 topics including Specialty Certificate Exam questions, psoriasis, eczema, other common inflammatory diseases, melanoma and other skin cancers, and can be linked to NHS e-portfolios. The online sessions enhance traditional learning, support existing teaching methods, and provide a valuable reference point particularly during the shortfalls in training due to COVID-19. The experience for trainees may be further enriched by consultant input and informed discussion. The main limitations include access to technology, internet connectivity and lower engagement in larger groups.

Although face-to-face teaching was the preferred format by trainees, in its absence the e-LfH platform enables more interactive pedagogical techniques in supporting training and education during the pandemic and beyond.

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| Connection strength (%) | Video quality (%) | Audio quality, % | Ease of access, % | Quality of teaching slides, % | Quality of Teams\(^8\) platform, % | Ease of asking questions, % |
|-------------------------|------------------|-----------------|-----------------|-------------------------------|---------------------------------|-----------------------------|
| Excellent               | 37.5             | 25.0            | 25.0            | 37.5                          | 62.5                            | 37.5                        |
| Good                    | 62.5             | 62.5            | 62.5            | 37.5                          | 62.5                            | 25.0                        |
| Average                 | –                | 12.5            | 12.5            | 25.0                          | 12.5                            | –                           |
| Poor                    | –                | –               | –               | –                             | –                               | –                           |
| Very poor               | –                | –               | –               | –                             | –                               | –                           |

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Changes in UK dermatological surgery during the COVID-19 pandemic
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COVID-19 has resulted in 1.5 million cases and over 66 000 deaths (on 28 November 2020)\(^1\) in the UK with ‘lockdown’ introduced in March 2020. The British Society for Dermatological Surgery (BSDS) published guidance to dermatologists on 30 March 2020, with recommendations of ‘avoid, restrict and abbreviate’: avoid non-urgent clinics/surgeries; restrict number of visits, staff and aerosol generation; and abbreviate waiting and treatment times.\(^2\) UK Dermatology departments have experienced severe effects across their services. We sought to determine the impact of COVID-19 on UK Dermatological Surgery through anonymous surveys electronically distributed to all BSDS members in May–June 2020.

In total, 51 recipients responded: 21 (41%) general dermatology consultants, 19 (35%) Mohs surgeons and
11 (24%) registrars/other dermatology doctors from at least 30 departments, with 87% working in England. Of the respondents, 87% reported cancelling some or all routine/noncancer work and > 90% reported cancelling some/all non-head and neck basal cell carcinomas (BCCs). By contrast, almost 90% continued all/some 2-week-wait (2WW) activity. Head and neck BCCs and cases requiring Mohs surgery were most subject to case-by-case assessment, with respondents regarding symptomatic lesions as the most important triaging factor. Other key prioritization factors were patient age, comorbidities and lack of immunosuppression, although the latter did not affect 2WW activity. Most (68%) respondents reported deferring ‘less urgent’ cases, e.g. melanoma in situ, wide local excisions and low-risk squamous cell carcinomas, and 17 (33%) respondents increased referrals to other surgical specialities, particularly plastic surgery (77%). These case management strategies correspond with recommendations by Der Sarkissian and colleagues.\(^3\)

Other strategies employed were one-stop clinics (13/51; 25%) and teledermatology (28/51; 55%). The use of teledermatology increased markedly (Fig. 1), with 29/51 (57%) using it to manage over half their patients.

![Figure 1](image1.png) **Figure 1** Use of teledermatology in different stages of the COVID-19 pandemic.

![Figure 2](image2.png) **Figure 2** Use of personal protective equipment (PPE) in dermatological surgery. FFP, filtering facepiece.
Methods to reduce surgical patient visits included almost all respondents increasing their use of absorbable sutures and decreasing their use of secondary intention healing. Measures to reduce the risk of COVID-19 spread included increased cleaning time between patients (10/51; 20%) limiting staff numbers in theatre (15/51; 29%) and reducing numbers of patients in waiting areas (24/51; 47%).

Usage of personal protective equipment (Fig. 2) was high, with surgical masks, visors, and aprons always used by 89%, 95% and 95% of respondents respectively. Use of filtering facepiece (FFP3) masks was relatively low; ‘always used’ by only one-third of respondents, and ‘never used’ by almost 50%. Several respondents stated FFP3 masks were not available and/or their trust ‘did not recognize guidelines on skin surgery from the BAD’, or ‘dermatology was not a priority area’. Almost two-thirds of respondents always used bipolar cautery to try to reduce the plume; only one-third always used smoke extractors.

Respondents described different challenges at different stages of the pandemic (Table 1).

In the coming months, over half of respondents plan to screen patients with at least symptom questionnaires, and ideally pre-operative antigen swabbing and advising patients to self-isolate prior to surgery. Many respondents felt staff themselves should also undergo regular testing.

The pandemic has significantly reduced face-to-face opportunities for dermatologists to discuss, understand and develop practices with other dermatology departments. This survey highlights the common themes many dermatologists have faced during the pandemic and potential solutions (Table 2).

| Table 1 Challenges during the COVID-19 pandemic. |
|-----------------|-----------------|
| Time of challenge | Effects |
| Beginning of lockdown | Uncertainty in case triaging  
Patients not wishing to attend consultations  
Correct PPE use  
Staff redeployment to the front line  
Lack of consensus: ‘… even within units, there were differences of opinion’ |
| End of lockdown | Service restart with a need to prioritize patients  
Poor IT infrastructure and limited administration support for remote consultation  
A struggle with the quality of care  
Inability to make accurate diagnoses on video/telephone  
Risk of missing key diagnoses, e.g. melanomas  
Severe delays in treatment  
‘… sense a drive to push down quality … by those who do not understand’ |
| Future | A ‘tsunami’ backlog of patients, worsened by decreased throughput due to social distancing and increased cleaning times  
Reduced workforce due to occupational health concerns or at-risk staff  
Safety of vulnerable patients, particularly with the poor availability to staff of appropriate PPE: ‘… without (correct) PPE we put them at risk every time they come to the hospital’  
‘Careful balance between the need to remove an individual skin cancer against the risks associated’.  
Conducting surgery with PPE: ‘… it’s hot, sticky, more tiring, and more time-consuming’  
Anxiety regarding the possibility of further redeployment with potential second/third waves |

IT, information technology; PPE, personal protective equipment.

| Table 2 Commonly adopted solutions to deal with the COVID-19 pandemic. |
|-----------------|-----------------|
| Solution | Method |
| Reduce visits | Teledermatology for a significant proportion of follow-up patients  
One-stop clinics combining assessment and surgery where possible  
Dissolvable sutures; less complex repairs |
| Reduce the spread of COVID-19 | Increased appointment times to allow cleaning between patients and reduce the risk of pooling of patients in waiting areas  
Essential staff only in theatre  
Antigen testing of both staff and patients |
| Screening for COVID-19 infection | Use of appropriate symptom questionnaires  
Temperature checks on arrival to clinic (for staff and patients)  
Antigen swabbing of patients when capacity allows |
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Sense and sensibility: an Irish dermatology department in the era of COVID-19
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All changed, changed utterly
W. B. Yeats

The COVID-19 pandemic has had a monumental impact on healthcare delivery. Dermatology is a high-volume, outpatient-based, visual specialty, with complex patients and therapies. We summarize the adaptation in a dermatology department in Cork, Ireland, carried out to enhance safety and streamline practice (Fig. 1).

Pre-COVID-19 surge, tutorials were organized to re-skill staff in resuscitation, emergencies, practical skills, analgesia, end-of-life care and personal protective equipment (PPE) use. Medical staff volunteered in ‘COVID pods’. Dissemination of ‘fake news’ was confronted.1

During the COVID-19 surge, clinics were converted to teledermatology, with training to avoid communication pitfalls. ‘Did not attend’ rates decreased from 15% pre-COVID to ‘did not answer’ rates of 2%. Video consultations were introduced for common conditions such as psoriasis, eczema or acne. Lesions were excluded from video review due to the need for dermoscopy and/or biopsy. Face-to-face (FTF) reviews were held according to clinical necessity. Pigmented lesion clinics continued due to the risk of missed melanomas,2 with same-day excisions. Melanoma follow-up clinics were held off-site.

Patients requiring surgery were generally higher risk (older and/or immunosuppressed). The number of ‘direct biopsy’ appointments was increased. Parallel clinics/biopsy lists were run. Absorbable sutures were used. Topical therapy (e.g. 5-fluorouracil) was prescribed instead of cryotherapy or surgery. Wide local excisions were deferred, as were intralesional steroid and neuromodulator injections. Phototherapy and patch testing were initially deferred and then re-introduced on a restricted basis. The 48-hour assessment was performed at home.

Figure 1 Summary of departmental changes.